



Jail Health Care Cost Containment Workgroup

Report to the Legislature

As required by Third Engrossed Substitute House Bill 2127

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Executive Summary

The Jail Cost Containment workgroup was mandated by the legislature to explore different strategies to reduce costs for in-jail health care facilities and make recommendations based on their findings. To meet the legislative requirements, a workgroup consisting of representatives from city and county jails, the Department of Social and Health Services, the Health Care Authority, and the Department of Corrections (DOC) met to identify areas of concern to address. From this meeting four topics were selected and corresponding subcommittees formed to examine ways to reduce the jails' costs. The topics chosen were pharmacy, Medicaid, mental health and jail boarders. An additional Governance subcommittee was also formed to serve as an oversight group to the four subcommittees. These subcommittees have worked over the last several months and propose various recommendations which may facilitate cost savings as well as long-term operational improvements.

Legislative Mandate

In the 2012 Legislative Session, the Biennial Budget Bill (3ESHB 2127) mandated that DOC work with other state agencies and local jurisdictions to explore cost containment strategies for in-jail health care facilities and make recommendations based on its findings. According to 3ESHB 2127 Section 220(2) (i):

(i) The department shall convene a work group to develop health care cost containment strategies at local jail facilities. The work group shall identify cost containment strategies in place at the department and at local jail facilities, identify the costs and benefits of implementing strategies in jail health-care facilities, and make recommendations on implementing beneficial strategies. The work group shall submit a report on its findings and recommendations to the fiscal committees of the legislature by October 1, 2013. The workgroup shall include jail administrators, representatives from health care facilities at the local jail level and the state prisons level, and other representatives as deemed necessary.

Pharmacy Subcommittee

Goals:

Identify options to increase savings on pharmacy costs.

- ✓ Discuss the costs and benefits of various pharmacy contracting arrangements available such as joining a pharmaceutical purchasing group.
- ✓ Discuss the possibility of taking advantage of the Federal 340b pricing program (340b pricing is established and set by federal government allowing facilities serving underserved populations can obtain more affordable pharmaceuticals).
- ✓ Discuss the costs and benefits of a consistent formulary and medication therapy protocols among county and state correctional institutions optimizing a sustainable cost saving while improving quality of patient care and clinical therapy outcomes.

Recommendations:

1. City and county jails should consider utilizing the DOC pharmaceutical management and Formulary manual and the Offender Health Plan rules regarding medications. Several jails indicated they already closely mirror the DOC Formulary for efficiencies. By utilizing DOC procedures and guidelines, the jails could take advantage of efficiencies and cost savings benefits already established by DOC. Because DOC and jails frequently move offenders between their jurisdictions, an additional benefit might be gained if the use of the DOC Formulary makes it easier for clinicians to make decisions about prescription refills and continue the offender on the medication that arrived during transport.
2. DOC should invite county jail administrators to have representation on the DOC Pharmacy and Therapeutics committee and provide feedback as an advisory member.
3. DOC and jail administrators should share information on pharmaceutical purchasing, pricing and distribution within the allowances of existing contracts.
4. DOC will provide city and county jails health services clinicians with easier access to DOC protocols and guidelines. DOC will research a technology solution.
5. Increase the sharing of medical records between DOC and jails through an Electronic Medical Record (EMR) system. As EMR systems are considered at the state and local levels, information exchange between criminal justice and public health entities should be considered. A criminal justice EMR system would increase the continuity of care as offenders move through the systems. Currently the 2013 Legislature appropriated funds to the Department of Social and Health Services to acquire an EMR system. It would be beneficial if all criminal justice entities were tied into a system that also supported community services.
 - DOC has completed business requirements gathering and an agency assessment for an eventual EMR system with information exchange being a key business requirement.

Mental Health Subcommittee

Goals:

Identify options to lower the cost of mental health treatment.

- ✓ Identify ways to integrate mental health treatment among jails, prisons and community programs.
- ✓ Review the current system of mental health service provision in Washington State.
- ✓ Identify ongoing and previous efforts to improve the mental health system and where issues are continuing.
- ✓ Discuss recommendations to improve the mental health services for residents in the correctional system.

Recommendations:

1. Create statutory language to clarify the authority and procedure for administering involuntary antipsychotic medications in correctional settings. Towards that end, the subcommittee is providing the attached document titled: *Proposed Legislation: Involuntary Antipsychotic Administration in Correctional Settings*. This proposed statute will need to be honed by experienced crafters of legislation, but conveys the essential ideas and might serve as a reasonable starting point.

- This process requires legislation and policy changes, but would ensure cost savings through several means, including improved safety and better treatment outcomes.
 - This would allow jails to provide necessary and appropriate treatment within their facilities, rather than transporting patient/offenders off-site for the administration of involuntary antipsychotic medication. This is primarily a problem with regard to the restoration of competency to stand trial where defendants are stabilized through involuntary treatment at a state hospital only to return to jail and refuse treatment, necessitating their return to the hospital.
 - At the present time, jails do not have clear authority to involuntarily administer antipsychotics to offenders. Having clear statutory authority to treat these individuals will improve both offender and staff safety.
2. Ensure appropriate mental health support in the city/county jails.
 - Consider increased sharing of clinical protocols and guidelines, and possibly even shared clinician resources to help support smaller jails who have the most difficulty in staffing facilities.
 3. Seek out opportunities to increase shared health information between jurisdictions.
 - Increased information sharing between jurisdictions and community providers to support intake, medication continuity, treatment, and transition services.
 - This would support more effective transitions for offenders when they either transfer to DOC where medication is continued, or are released into the community.
 - This would improve clinical quality and patient safety if clinicians have greater access to health records as an additional source of information rather than generally accepting what the patient discloses. Continuity of treatment plans between jurisdictions for a patient could mitigate workload and medication costs.

Medicaid Subcommittee

Goals:

Recommend steps to enable jails to receive Medicaid funds when legal and cost beneficial. Explore the possibility of utilizing Medicaid funding for jail offenders that utilize inpatient hospital services off-site in the community.

Recommendations:

Please note that at the time of the workgroups, DOC had recently implemented ProviderOne (the State's Medicaid payment system), which then became more of the focus of the group. ProviderOne managed by the Health Care Authority (HCA) allows hospitals to submit all medical claims for DOC offenders electronically to the ProviderOne system and DOC, like HCA, have staff review and adjudicate the bills for payment.

1. ProviderOne will be used for centralized processing of claims from the jails.
2. This multistage project would require:
 - Creating or modifying the interface between the Jail Booking and Reporting System and the ProviderOne system.
 - Standardizing the rates and payment policies in the jails to mirror DOC.
 - Using a central processor for medical adjudication and billing.
 - Ensuring that all city/county jails have contracts with DOC.
 - Legislation and appropriate policy changes.

- An estimated implementation cost of \$767,000 for the biennium to DOC as reported to the 2013 Legislative Session in the fiscal note for ESSB-5892.
3. The Washington Association of County Officials reported a potential cost savings for city/county jails of \$1.7 million a year if inpatient medical billing was managed through the ProviderOne system paying at the Medicaid rate.
 4. Set a 2014/2015 implementation date to allow adequate time for communication, procedures, and data gathering.

Jail Boarder Placement Subcommittee

Goals:

Develop rules outlining when offenders in local jails may be placed at DOC facilities for medical/mental health care.

Recommendations:

1. DOC should develop policy standardizing the procedure for jails to request DOC accept an offender with high healthcare or security needs as a boarder. DOC has completed such a policy.
 - The DOC policy should include payment policies, request and approval for placement, standard agreement language and reporting and monitoring. (The Intrastate Boarder Agreements Policy, DOC 330.605, is complete, effective 6/3/2013.)
2. DOC should create an accessible central location for the primary contact, billing, and other key information on the DOC website. The work associated with this recommendation is currently underway and is close to completion.
3. Create procedures and facilitate training to ensure all jail facilities which DOC contracts with are Prison Rape Elimination Act (PREA) compliant. This process has already begun.
 - DOC previously hosted a PREA training seminar at the end of May in Olympia and is in the process of scheduling further training sessions with Washington Association of Sherriff's and Police Chiefs.
4. Ensure all city and county jails have contracts for jail boarders with DOC.

Conclusion

The four subcommittees were able to develop recommendations believed to be capable of containing and possibly in some cases even reducing costs within the correctional system. Most of the recommendations involve strategies for increased coordination, communication and information sharing. While some of the recommendations such as sharing purchasing information, medication formularies and clinical guidelines are already underway and are not difficult, many of the other recommendations will require legislation and budget support to implement such as EMR systems, medical billings for jails adjudicated through ProviderOne, and full implementation of the Prison Rape Elimination Act standards. It was clear during this process that not all jurisdictions are certain the costs of the recommendations if implemented could be recouped in savings.

The meetings of the subcommittees encouraged an increase in information sharing and a coordination of efforts. While these subcommittees were formed to be responsive to the legislative mandate, efforts to maintain these committees representative of multiple jurisdictions should be considered by the stakeholders.

Appendix

Pharmacy Subcommittee Members:

Andre Rossi – Lead DOC
Kevin Bovenkamp – Lead DOC
Penny Bartley – Lead SCORE Jail
Noah Stewart – Okanogan County Jail
Margot Connele – Snohomish County Jail
Wendy Jones – Whatcom Co Sheriff's Office
Dean Webb – King County Public Health
Tim Hulet – DOC
William Hayes – DOC
Kammi Barbo – DOC
Robert Balkema – Kirkland Police Department
Cheryl Slagle – Spokane Co Sheriff's Office
Holli Stewart – Thurston Co Sheriff's Office

Mental Health Subcommittee Members:

Tim Hunter – Lead, DOC
Karie Rainer – Lead, DOC
Judy Snow – Lead, Pierce County
Curt Lutz – Chelan County Regional Justice Center
Kristina Ray – Spokane County Jail
De Dennis – Island County Correction Facility
Roxanne Payne – Kitsap County Jail
Ed Shannon – Puyallup Police Department
Holli Stewart – Thurston County Sheriff's Office
Rick Anderson – City of Olympia
Margot Connele – Snohomish County
Victoria Roberts – DSHS/DBHR
Michael Paulson – DSHS/DBHR
Tom Saltrup – DOC
Arthur Musser – Asotin County
Keri Waterland – DSHS/BHSIA
Bruce Gage - DOC

Medicaid Subcommittee Members:

Ronna Cole – Lead, DOC
Beth Goupillon – Lead, DOC
Ned Newlin – Lead, Kitsap County Sheriff's Office
Holli Stewart – Thurston County Sheriff's Office
Noah Stewart – Okanogan County
Brian Enslow – WSAC
Deborah Thompson – Thurston County Corrections Facility
Candice Bock – AWC
Margot Connele – Snohomish County

Tammy Williams – DOC
Robert Balkema – Kirkland Police Department
Cheryl Slagle – Spokane County Sheriff's Department
Jim Nelson – Lynnwood Police Department
Michael McGinnis – Lynnwood Police Department
Mark Westenhaver – Health Care Authority (HCA)
Sarah Clark – DOC
Heidi Robbins-Brown – HCA
Cathie Ott – HCA
Sandy Stith – HCA
Brian Jensen – HCA

Jail Boarders Subcommittee Members:

Sandy Mullins – Lead, DOC
Ron Sukert – Co-Lead, Clallam County Sheriff's Office
Richard Bomhoff – Co-Lead, Grays Harbor County
David Waymire – Skamania County Sheriff's Office
Deborah Thompson – Thurston County Corrections Facility
Ric Bishop – Clark County Corrections
Charlie Wend – Skagit County Sheriff's Office
Susan Lucas – DOC
Tammy Williams – DOC
Sarah Clark – DOC
Arthur Musser – Asotin County
Mark Baird – Snohomish County Sheriff's Office
Ken Bancroft – Asotin County Sheriff's Office

Governance Subcommittee Members:

Susan Lucas – Co-Lead, DOC
Ned Newlon – Co-Lead, Kitsap Co Sheriff's Office
Brian Enslow – WSAC
Candice Boch – AWC
Judy Snow – Pierce County
Clela Steelhammer – DOC
Debbie Payne – Snohomish County
Richard Bomhoff – Grays Harbor County
Ron Sukert – Grays Harbor County
Marin Fox Hight – Cowlitz County
Charlie Wend – Skagit Co Sherriff's Office
Martha Karr – Pierce County Jail
Curt Lutz – Chelan Co Regional Justice Center
James McMahon – WACO
Raeanne Myers – WASPC

Workgroup Proposed Draft Legislation

Involuntary Antipsychotic Administration in Correctional Jail Settings

- 1) An incarcerated person has a right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm to self or others or substantial deterioration and there is no less intrusive course of treatment than medication in the best interest of that person.
- 2) The correctional facility shall adopt rules to carry out the purposes of this chapter. These rules shall include:
 - a) An attempt to obtain the informed consent of the person prior to administration of antipsychotic medication.
 - b) For short-term treatment up to thirty days, the incarcerated person's right to refuse antipsychotic medications unless there is an additional concurring medical opinion approving medication by a psychiatrist, psychiatric advanced registered nurse practitioner, or physician in consultation with a mental health professional with prescriptive authority.
 - c) For continued treatment beyond thirty days and up to ninety days, the incarcerated person has the right to periodic review of the decision to medicate by the medical director or designee.
 - d) Administration of antipsychotic medication in an emergency and review of this decision within one working day. An emergency exists if the incarcerated person presents an imminent likelihood of serious harm, and medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and in the opinion of the physician or psychiatric advanced registered nurse practitioner, the person's condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion.
 - e) Documentation in the medical record of the attempt by the physician or psychiatric advanced registered nurse practitioner to obtain informed consent and the reasons why antipsychotic medication is being administered over the person's objection or lack of consent.
- 3) Administration of involuntary antipsychotic medications beyond 90 days, other than in an emergency, shall be only by one of the following two mechanisms:
 - (a) Court order by a court of competent jurisdiction pursuant to the following standards and procedures:
 - (i) The administration of antipsychotic medication shall not be ordered unless the petitioning party proves by clear, cogent, and convincing evidence that there exists a compelling state interest that justifies overriding the incarcerated person's lack of consent to the administration of antipsychotic medications, that the proposed treatment is necessary and effective, and that medically acceptable alternative forms of treatment are not available, have not been successful, or are not likely to be effective.
 - (ii) The court shall make specific findings of fact concerning: The existence of one or more compelling state interests; the necessity and effectiveness of the treatment; and the person's desires regarding the proposed treatment. If the incarcerated person is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the incarcerated person as if he or she were

competent to make such a determination.

(iii) The incarcerated person shall be present at any hearing on a request to administer antipsychotic medication filed pursuant to this subsection. The person has the right: to be represented by an attorney; to present evidence; to cross-examine witnesses; to have the rules of evidence enforced; to remain silent; to view and copy all petitions and reports in the court file; and to be given reasonable notice and an opportunity to prepare for the hearing. The court may appoint a psychiatrist, psychiatric advanced registered nurse practitioner, psychologist within their scope of practice, or physician to examine and testify on behalf of such person.

(iv) An order for the administration of antipsychotic medications entered following a hearing conducted pursuant to this section shall be effective for the remainder of incarceration or 180 days, whichever is less, and any interim period during which the person is awaiting hearing on a new petition for involuntary antipsychotic administration.

or

(b) Review by an administrative process consisting of at least the following elements:

(i) Notice to the incarcerated person of the intention to seek involuntary treatment with antipsychotics for up to 180 days. Notice shall include the reasons the psychiatrist, physician, or psychiatric ARNP is seeking involuntary treatment with antipsychotics.

(ii) A hearing in front of a non-treating psychiatrist to determine whether the incarcerated person may be treated with involuntary antipsychotics.

(iii) The decision to treat involuntarily with antipsychotics requires the following findings: there was a bona fide attempt to secure informed consent prior to seeking involuntary treatment; the incarcerated person suffers from a mental illness; the incarcerated person is a danger to self, is a danger to others, presents a risk of serious property damage, and/or is gravely disabled due to the mental illness; treatment with antipsychotics is medically appropriate.

(iii) The incarcerated person has the following rights during the hearing: to be present at the hearing, to cross-examine witnesses, to call witnesses, to be represented by a lay advisor knowledgeable about mental illness, to remain silent, to be informed of the outcome of the hearing and the reasons for the decision, to appeal the outcome.

(iv) Nothing in this process precludes appeal to a court of competent jurisdiction.