Correctional Nursing in Dakota County: Analysis and Options

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And more than two dozen county jail administrators, public health directors, nursing supervisors and principals of for-profit healthcare companies.

Abbreviations used in this report:
AMA - the American Medical Association
ANA - the American Nursing Association
DCSO - the Dakota County Sheriffs Office
DOC - the Minnesota Department of Corrections
DOJ - the United States Department of Justice
NACo - the National Association of Counties
NCCHC - the National Commission on Correctional Health Care
RN/LPN - Registered Nurse / Licensed Practical Nurse

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Bridging today and tomorrow with planning and analysis to improve residents’ lives and their government
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Executive Summary

County jail administrators are required by state law to provide medical services to inmates. Medical services mean caring for physical and mental health conditions, including: on-site sick call clinics (inmate appointments with a physician), dental care, lab tests, prescription medication, and radiology. It also includes visits to offsite medical specialists or even hospitalization when necessary.

Just as all health care costs have seen sharp increases in the last decade, correctional healthcare costs also have soared. Counties pay most of the costs for jail inmates’ healthcare because many inmates do not have their own health insurance. Jail administrators are under pressure to cut costs, so medical services, including onsite nursing services, are part of the examination.

In Dakota County, nursing services have been provided at the jail by county Public Health nurses for more than a decade. Nurses either provide or arrange for most healthcare received by inmates in the jail, under the direction of a medical director. Nurses assess medical needs and complaints, arrange for care, order and dispense medications, keep inmate medical records up to date, and do many other tasks.

An initial purpose of this study is to determine where nursing services in the Dakota County Jail fall along the range between adequate and excessive or unnecessary. The lack of uniform statewide or national standards for care provided to jail inmates makes this a highly subjective judgment call. But there are administrative rules that describe healthcare processes and rudimentary healthcare practices that must be followed, and adherence to them is required for the jail to pass annual inspections by the state corrections department. By this measure, healthcare provided at the jail clearly is sufficient.

Over the last five years, almost a quarter of jails in Minnesota have moved away from the public employee model (that is, nurses who work for the sheriff or the county public health department) and have shifted to contracting for healthcare services with a for-profit company, most of the vendors from out of state with a wide geographic client base.

Benchmarking research with 14 other county jails shows that Dakota County’s Jail rates well in the services provided but also ranks fairly high in cost. On pages 17-19 in this report, summary information from the benchmarking work is provided with a graphic (scattergram) showing where Dakota County’s healthcare services compare along the high cost/low services versus low cost/high services continuum.

A second question for this study is whether equivalent healthcare services can be provided at a lower cost using a different staffing model, such as a for-profit company. The answer is difficult to determine, given the lack of recognized standards for the provision of healthcare. The only way to get an answer may be to actually conduct a Request for Proposals process.

Beginning on page 27, the last section of this report outlines several potential alternatives and variables to be considered, if making a change in the staffing model is considered desirable. They are: keeping the current staffing model, modifying the current staffing model to more closely resemble the for-profit model, partnering with other counties to share costs, contracting with a local healthcare provider, partnering with other counties using the for-profit staffing model, and developing a new hybrid of with a public/private model.
**Introduction**

**Purpose**
This project examines options for nursing care at the Dakota County Jail\(^1\) that provide the desired daily shift coverage at the lowest possible cost, while maintaining (or improving) current service and quality of care. The options will include an analysis of the current staffing model (including nursing services “bought” by the annual budget transfer from Public Health to the Sheriff as well as services that the Public Health and Sheriff Office budgets pay directly), as well as services provided entirely by contracting with a private firm, or a blend of both private and public services.

**Methodology**
The scoping document for this project\(^2\) initially focused solely on nursing services in jails. However, with many of the targeted benchmarking counties using for-profit companies, the project has expanded to consider more healthcare services for inmates than simply nursing. The for-profit companies generally provide much more than nursing under a single contract, and they do not discuss information about their costs beyond general services descriptions in their contract to those who are not their clients. Therefore, it is not possible to do meaningful cost comparisons for nursing services alone among counties that use contracted vendors.

The approach used for this study included:

- Defining and describing the range of services currently performed by nurses at the jail;
- Defining the legal or statutory standard of care for nursing services provided to county jail inmates, and assessing Dakota County’s current capacity to meet the standards;
- Researching national and state standards or best practices for on-site nursing services in local jails and comparing Dakota County’s current services to these standards or best practices;
- Considering potential benefits and costs of alternative service arrangements, such as changes in service options, coverage, and costs, by benchmarking to identify:
  - Staffing models used at other jails;
  - Description/inventory of nursing services provided at other jails; and
  - Contract arrangements for nursing services at other jails
- Presenting options for consideration that include comparison of benefits and drawbacks to each type of arrangement in the areas of services provided/quality of care, staffing schemes, and costs.

**Background**
County jail administrators are required by state law and administrative rules to provide (or provide access to) medical services for inmates who cannot pursue medical services independently because they are compelled to remain within the jail. Medical services is a broad term that includes care of physical and mental health conditions, chemical dependency assessments and treatment, coordination of care that could include hospitalization/clinic/diagnostic tests, dental care, lab tests, radiology (X-rays), dispensing medications, and coordination of care needed when inmates are released from the facility.

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1. The Dakota County Jail is formally known as the Dakota County Law Enforcement Center, but for purposes of clarity and brevity, the shorter title will be used throughout this report.
2. The project scope can be found in Appendix B on page 34 of this report.
Most jail inmates in Minnesota (and across the nation) do not have health insurance and have not received regular medical care. A lifetime of poor diet, poor health habits, drug or alcohol abuse, and other factors result in jail inmates who are typically sick more often, or have chronic diseases (hypertension, diabetes) in higher proportions than in the general population.

Greater health demands for inmates coupled with sharply increasing medical care costs are a problem faced by all jails in Minnesota, but because Minnesota’s incarceration rate is less than most other states, the budget challenge has been less intense here than in other parts of the country. In 2009 in Minnesota, the total average daily population in county jails was 6,887, which equals one person in jail for every 580 Minnesotans over the age of 18 in 2009.3

Minnesota’s incarceration rate is much lower than in most states and the nation. The federal Bureau of Justice Statistics reported in December 2011 that for the year 2010, the national rate of incarceration in the nation’s jails and prisons was 497 inmates per 100,000 population; the comparable figure for Minnesota in 2009 was 306 jail and prison inmates per 100,000 population.

Correctional healthcare costs, along with all other healthcare costs, have soared in the last decade at a rate of increase well above that of inflation.4 As jail budgets across Minnesota have tightened and health care costs continue to escalate sharply, jail administrators in many counties are re-examining costs for inmates’ medical care, including on-site nursing services.

At least 23 Minnesota county jails (of 87) have switched in the last several years from using county staff for nursing services to contracting with a comprehensive healthcare services company – including three in just the last six months.

In January 2012, there were at least four for-profit companies providing healthcare services in Minnesota jails, one of which is a Minnesota-based company. This subject has been a topic of frequent discussion among the correctional health members and jail administrators in the Minnesota Sheriffs Association over the last two years, with a primary focus on the lack of definition of what level of care, or quality of care, is required.

In Dakota County, nursing services have been provided at the jail by the county Public Health department nurses since the early 2000s. Nurses provide both acute and non-acute care to inmates who arrive at the jail with medical needs, including the range from care of minor injuries and ailments, managing chronic conditions, to acute care such as withdrawal from alcohol and other drugs, and assessments to determine the need for emergent care off-site. Because many inmates have chronic

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3 Data from the state Bureau of Criminal Apprehension, calculations by Office of Planning and Analysis staff.
4 In 2008, the Florida Office of Program Policy Analysis was directed by the Florida State Legislature to study the reason for skyrocketing inmate Healthcare cost increases in its state prisons. In their 2009 report, researchers found in just the five years between 2004 and 2008, medical costs nationwide increased 21% (for medical care, dental care, prescriptions, and hospital care). In the same five years, total healthcare costs in the Florida prison system increased 37%, though the increase was caused by factors other than inflation in healthcare. Some estimates of health care costs inflation are even worse. At an annual conference in October 2008, members of the National Commission on Correctional Health Care were told by a prominent correctional healthcare consulting company that between 2003 and 2008, the growth in correctional healthcare costs nationwide averaged 8.6% each year, and in 2006-2008, most counties responding to an annual survey by NACo reported exceeding their inmate healthcare budget.
health conditions that require prescription medications, nursing staff also order and dispense medications. Nurses conduct screening/interviews whenever new inmates are brought to the jail, and often consult with physicians on medication/treatment plans. Many inmates arrive at the jail lacking health insurance and with alcohol or drug dependency and mental health issues. Those and cardiovascular problems and diabetes are the most common medical conditions among the Jail’s inmates.

Nursing services that are provided at the Dakota County jail comprise only a fraction of the total services and cost of health care for jail inmates. In 2011, the Sheriff’s Office paid $809,000 for inmate medical costs other than nursing care. In the same year, $445,500 was transferred from the Sheriff’s Office budget to Public Health to offset nursing costs, and the Public Health budget included an additional $145,000 for nursing costs not reimbursed by the Sheriff. Thus, the Sheriff’s Office pays about three-quarters of the nursing costs and the Public Health department pays about one-quarter of the costs.

A combination of full-time and part-time Public Health registered nurses provide on-site coverage at the Dakota County Jail for a total of 83 hours on weekdays and 16 hours on weekends, for a total of 99 hours weekly. The Public Health budget pays for increasing overtime costs for its staff at the jail, and for on-site nursing coverage provided by a temp agency to fill in shifts when public health nurses are unavailable. The Public Health budget also pays for correctional nursing services that are not covered by the $445,000 allocation from the Sheriff’s Office, including a fulltime medical assistant and nursing supervisor, and part-time administrative/clerical support.

The $445,000 in the Sheriff’s Office budget for nursing services is insufficient to pay for round-the-clock on-site nursing coverage every day of the week, a coverage level that the Sheriff’s Office would like to reach. Currently, only Hennepin and Ramsey counties provide round-the-clock onsite medical coverage in their jails.

Note: Representatives of 10 southeastern counties, including Dakota County, met several times in the summer of 2011 to consider ways to collaborate to share services and cut costs at county jails. Data was collected from county jails for items under consideration: food, operations, inmate healthcare, and personnel. Discussions were helpful but now appear to have stalled.

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5 The nursing complement includes two fulltime and four less than fulltime equivalents, plus other on-call and casual staff. Costs are budgeted for all of those positions according to the percent of a complete FTE they comprise. Whenever a nurse needs to work extra hours in a given time period, s/he is paid overtime.
Requirements and Best Practices

Working in the Jail Setting

Correctional nurses have a difficult job. They have primary responsibility for providing or coordinating on-site and off-site healthcare to a captive and generally unhappy group of people, and whose high degree of boredom sometimes results in exaggerating or fabricating health issues. Nurses must decide whether to believe inmates' medical complaints and if so, the appropriate course of action -- in a setting where inmates are famously litigious and resources are few. These same conditions make it difficult to find nurses who are willing to work there and hard to keep them.

In the Dakota County Jail, almost half the nursing personnel turned over in 2011 (five of 12 full-time or part-time positions, or 47.6%). That is an unusually high turnover rate that is attributed to many factors, particularly two retirements. Even in a more normal year, however, Public Health supervisors report almost constant recruiting challenges for correctional healthcare positions due to the type of work and the location (a correctional facility). Economics is also a factor; prime candidates for correctional nursing positions are nurses from hospitals or emergency rooms, but their salary levels make the County's correctional nursing positions unattractive. In the four years before 2011, the annual turnover rate among nurses at the jail varied between 9% and 33%.

In addition to the culture present in jails, delivering health care in a correctional setting is also particularly challenging because inmates are both older and in poor health compared to the general population. In early 2012, 44% of inmates staying in the Dakota County Jail self-reported that they had health insurance, though the actual percentage of insured inmates is believed to be less than that. Even for the inmates who are covered by health insurance, and certainly for those who have no health insurance, few have had regular medical care. Inmates are more likely to suffer from chronic diseases such as diabetes, hypertension (high blood pressure) or asthma, mental illness, alcohol and drug abuse, and communicable diseases such as tuberculosis, hepatitis and HIV.

According to the American Nursing Association's Correctional Nursing handbook, inmates also suffer from age-related conditions earlier in life. "Personal histories of poor nutrition, lack of preventive care, and high-risk behavior (drinking, smoking, drug use) are common in jail populations. This makes a 50-year-old inmate's health status comparable to that of a 65-year-old living in the community." 7

A how-to guide for contracting healthcare services in jails, published by the Community Oriented Correctional Health Services organization, puts it this way: “The culture of health care, which emphasizes prevention, healing, and empathy, is often in conflict with the (quasi-military) culture

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7 Corrections Nursing: Scope and Standards of Practice handbook published by the American Nursing Association, 2007. The ANA is the professional association for the three million registered nurses in the United States.
of corrections, which emphasizes command, accountability and control.”

For this correctional healthcare study, three important steps set the stage for future decisions:
1) determining what services are being provided at the Dakota County jail;
2) determining what services are required to be provided; and
3) considering whether any of the services provided are unnecessary, or conversely, whether required services are not being provided.

State laws and administrative rules
State law requires that all public or private detention facilities in the state, including county jails and municipal lock-up facilities, be licensed and inspected by the state Department of Corrections. Because local government facilities are considered to be under the control of the state, the statutory requirement that "professional health care (must be provided) to persons confined in institutions under control of commissioner of corrections" and further, to "pay the costs of their care” extends to inmates in county jails.

State law (MS 241) also requires that health care provided to inmates in county jails be guided by a health authority (which can be a contracted agency), and medical care decisions for inmates be made by a responsible physician (generally, this is one of many services provided under contract). Also, all correctional officers working within jail facilities must be trained in basic first aid, distributing medications, and recognizing urgent medical conditions.

Minnesota Administrative Rule 2911 was promulgated by the state Corrections Department to carry out responsibilities in MS 241. The section 2911.5800 directs health care provided to inmates, including:

- written policies and procedures for health care delivery (and training for correctional staff)
- services provided include medical, dental, mental health, and emergency care
- incoming inmates must be screened for health issues (current health status, health history, current prescriptions for medications, health insurance, drug/alcohol use, special needs), usually conducted with a questionnaire
- any inmate reporting (or for whom corrections intake staff observe) medical conditions must have a more thorough health appraisal conducted within 14 days of admission to the facility
- routine screening for all inmates for tuberculosis within 14 days
- a continuous response to health care complaints, including that healthcare staff assess and triage medical complaints daily
- sick call (inmates can be physically examined by a trained medical professional, such as a nurse) must occur daily
- provisions for informed consent
- confidential medical records must be kept
- designated space for healthcare staff and exams
- prescription medication must be securely stored by healthcare staff and distributed to inmates only in single doses
- staff training

8 “Contracting for Health Care Services in Local Jail Facilities: Achieving a Community-Based Standard of Care”, published by the Community Oriented Correctional Health Services organization, 2010, p 1.
9 MN Statute 241.021, Subd 1
10 Ibid, Subd 4
The mandated practices in Minnesota DOC Rule 2911 are similar to those described as standard practices by the national Community Oriented Correctional Health Services organization:\footnote{11}{“Contracting for Health Care Services in Local Jail Facilities: Achieving a Community-Based Standard of Care”, published by the Community Oriented Correctional Health Services organization, 2010, p 1}

- a functioning sick call system operated by medically trained staff, so inmates can communicate their health care needs and be professionally evaluated by medical staff
- a system allowing for triage of complaints, or prioritizing them
- a means of addressing medical emergencies
- adequate space and supplies to meet inmates' health care needs
- documenting care requested and provided in medical records
- consulting with outside expert medical resources to meet special needs
- developing policies and procedures to meet the special needs of those who are disabled, elderly, drug-dependent, and mentally ill
- staff training

Another source of information is the practice followed by the U. S. Department of Justice to investigate complaints or claims from inmates in prisons or jails. The DOJ investigators must decide whether a facility's health care system provides services that are constitutionally deficient or sufficient. Among other things, they look for adequacy of intake screening, and for access to acute, chronic, specialty, dental and mental health care. In addition to the Constitutional question, investigators check for negligence or malpractice issues. Healthcare in jails is considered to be insufficient if it “does not satisfy generally accepted professional standards of care,” which are further defined as “a decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment.”\footnote{12}{“Contracting for Health Care Services in Local Jail Facilities: Achieving a Community-Based Standard of Care”, published by the Community Oriented Correctional Health Services organization, 2010, p 5}

The health care and nursing care for inmates in Dakota County's jail meet requirements of the state administrative rules and the national guidelines described above.

**History of Correctional Health Care**

As already noted, today's practices, policies and procedures for correctional health care have been developed primarily from a long history of legal challenges. For decades, American judges refused to consider maltreatment claims from prison or jail inmates, leaving those decisions to be made by correctional experts.

Starting in the 1970s, a series of successful legal challenges by inmates resulted in a national consensus that improving physical conditions within the facilities - including attending to the inmates' medical needs – contributed to a happier, healthier population and helped improve security in jails and prisons. The federal government hired the American Medical Association to upgrade correctional care by developing a model health care delivery system for inmates.
By the end of the 1970s, manuals for running prisons and jails published by the U.S. Bureau of Prisons, the National Sheriffs Association and the American Correctional Association all referenced both the legal responsibility and administrative benefits (security and keeping order) of providing medical care to inmates.

Appendix A on page 31 of this report contains a more complete discussion about the history of correctional care.

Inmate Healthcare in Dakota County
Correctional healthcare services provided in the Dakota County Jail meet state requirements. If these services were deficient or sub-standard, the jail would not pass annual inspections by the state Department of Corrections (DOC). Until he was recently promoted the DOC Inspections Unit director, Tim Thompson was the inspector for the Dakota County Jail. He said for correctional nursing services, he found the Dakota County Jail to be consistently one of the best of the jails assigned him for inspections.

The question of whether any nursing services provided at the Jail are unnecessary is harder to determine. OPA staff interviewed all of the correctional health care staff working at the Dakota County Jail to catalogue practices, procedures and policies. The resulting encyclopedic description is found in Appendix C starting on page 36. Attorneys in the Dakota County Attorney’s Office investigate inmate claims of inadequate healthcare because they represent Dakota County nurses or correctional staff in any related legal action. Due to this legal background and subject matter expertise, they were asked for their view of the parallel questions of quality of care and adequacy versus over-reaching in services provided by nurses at the Jail.

The attorneys concur with the conclusion that Dakota County meets the standards required in the state law and administrative rules. However, because there are no specific standards to be met for the quality of healthcare that must be provided in the jail, they view the question in terms of risk and liability: generally, the more healthcare services provided, the less risk of a successful (and expensive) claim of inadequate healthcare based on either negligence, malpractice or a deliberate indifference.

Nurses provide both acute and non-acute care to inmates who arrive at the jail with medical needs, including the range from care of minor injuries and ailments, manage chronic conditions and acute care such as withdrawal from alcohol and other drugs. They respond to inmates’ health-related complaints by assessing and treating what they find. They consult with the medical director or other physicians about medication and treatment plans. When necessary, they arrange for and coordinate offsite care. They coordinate onsite sick-call clinics, and document every step in inmate medical charts. Many inmates arrive at the jail lacking health insurance and with alcohol/drug dependency and mental health issues. Those and cardiovascular problems and diabetes are the most common medical conditions among the Jail’s inmates.

The nursing staff and their managers/supervisors in the Public Health department would like to have the resources (more time or more staff) that would allow them to do more health care activities that are true

“Intake in the jail is not like checking into the Holiday Inn. It can be very chaotic. It’s much more like a hospital emergency room – you never know what will happen. Police bring in people with all sorts of medical conditions.”
— former jail nursing supervisor in Minnesota, interviewed September 2011
to the public health philosophy of disease prevention, such as educating inmates about the chronic diseases they have and how to improve their health with better management of those diseases. From their point of view, it’s unfortunate that their time is consumed by reacting to whatever health issues present themselves each day.

Several professional organizations, primarily the National Commission on Correctional Health Care, the American Correctional Association and the American Nursing Association, offer accreditation for prisons and jails (for correctional nursing practices, policies and procedures). NCCHC and ANA also offer certification in the specialty for professionals. While the Dakota County Jail is not accredited by any of those organizations, that is not usual in Minnesota; during this study, no other county jail in the state with such accreditation was found, partly because the accreditation process can be lengthy and time-consuming. No entity within the state systematically tracks jail accreditation. However, professional certification is more commonly found in Minnesota practitioners than facilities, and licensed registered nurses with this certification work in the Dakota County Jail.

Legal Interpretations and the Standard of Care

As noted, county jails must meet the requirements of state law and administrative rules in order to be licensed by the state Department of Corrections. A second measure of whether a jail meets its “requirements” is whether there are substantiated claims of healthcare violations against the Jail.

According to data from the Dakota County Attorney’s Office, in the 12 years from January 2000 to the end of 2011, there were four lawsuits against the county alleging inadequate medical care. Although some claims are still pending, the County has not paid a judgment in those 12 years. It is possible that an out-of-court settlement could have been reached on a claim for which no lawsuit was filed.

What level of care to provide – that is, when confronted with a certain set of facts and determining the appropriate course of action – is not prescribed on either the state or federal level. State administrative rules describe a framework of requirements, many of them related to process. State requirements address the need for certain procedures to be in place, and jails are inspected to be sure such procedures are both described and followed. But there is very little guidance about the content of those procedures. State law and rules leave a great deal of room for discretion in decision-making related to the level of care, or quality of care, provided to jail inmates.

Consider these examples:

- An inmate playing basketball injures his knee and has trouble putting weight on it. The next onsite medical clinic isn’t for three days, and he says he’s in constant pain. This inmate has a history of opiate drug abuse. Should nurses give him ibuprofen and see what happens, ask the consulting medical doctor for a prescription for narcotic pain relief, or rush him to the hospital for an Xray?
- An inmate with no history of asthma or allergies has trouble breathing and appears congested. He doesn’t appear to have any constrictions in his airway and is running a slight temperature. Should nurses ask the medical director for a prescription for an inhaler, or should they seek an Xray to see if his lungs are filling with fluid, as would happen with pneumonia?
- An inmate tells a nurse he has a blinding headache unlike any before. Does s/he send him to rest, suggest use of an over-the-counter pain medication, or does s/he act on her suspicion
that the problem could be a brain aneurism that could cause death if not treated aggressively and quickly?

In these scenarios, assuming a nursing assessment is done, any of the potential actions could be considered a legally appropriate response.

State laws and rules have been written with an eye to another set of guidelines: judicial decisions in hundreds of legal challenges over the last 40 years. Most of the time, what can be learned from those is the mistakes not to make. That is, as discussed in the previous section of this report, inmates who can show a correctional or medical official showed “deliberate indifference” to his/her need for health care are guilty of violating the inmate’s Constitutional right to care.

The “deliberate indifference” standard was born in the landmark Supreme Court decision in the Texas case Estelle v Gamble in 1976, which established that governments have an obligation to provide medical care to those who are incarcerated and unable to obtain it for themselves. The Court said failure to do so violates inmates’ constitutional rights not to suffer from cruel or unusual punishment (Eighth Amendment). The court concluded that the Eighth Amendment is violated by a jail official who shows “deliberate indifference (to an inmate’s) serious medical needs.” Please see Appendix A on page 31 for a more complete discussion about the legal history of correctional healthcare.

Though there has recently been some discussion among many national professional organizations, to date there is no single or uniform nationally recognized or enforced standard of care for correctional facilities. Courts have not described specifically what services must be provided to incarcerated people, so no uniform definition is available from the history of litigation.

However, the three national professional organizations described above (the National Commission on Correctional Health Care, the American Correctional Association and the American Nursing Association) publish guidelines and standard for correctional healthcare which the Dakota County Jail’s medical director and nursing staff consult regularly.

Over time, interpretation of two important legal challenges has resulted in a national consensus among professionals in the legal and healthcare industries regarding inmates’ rights to health care. These rights are succinctly expressed in the American Nursing Association handbook for correctional nurses:

- the right to access care
- the right to professional judgment
- the right to care that is ordered (by a medical professional)
- the right to informed consent
- the right to refuse treatment
- the right to medical confidentiality

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13 In Estelle v Gamble (1976), the U.S. Supreme Court said governments have an obligation to provide medical care to those who are incarcerated and unable to obtain it for themselves. (429 U.S. 97)
14 Ibid and in Farmer v Brennan in 1994, the U.S. Supreme Court said correctional officials were required to provide “adequate” medical and mental health care for inmates. (511 U.S. 825, 834 1994)
15 Corrections Nursing: Scope and Standards of Practice handbook published by the American Nursing Association, 2007. The ANA is the professional association for the three million registered nurses in the United States.
Law, health and correctional professions generally have agreed that to avoid malpractice and negligence claims, health care provided in prisons and jails should be equal to community standards -- that is, inmates should expect to be treated in a manner similar to that of any patient at a medical clinic in the community.

In an article\textsuperscript{16} in a monthly publication from the Minnesota Counties Insurance Trust organization in 2006, attorney Roger Rowlette wrote: “The distinctions between proper conduct, negligence and deliberate indifference are often difficult to discern, especially without the benefit of 20-20 hindsight. Therefore, it is suggested that, to avoid potential claims, when a difficult medical issue is present, jail personnel err on the side of caution and promptly seek an appropriate level of medical consultation, diagnosis and treatment.”

The community standard does not mean that jail inmates get the level of healthcare they want or demand. Jail administrators, in consultation with their medical directors, must balance the cost of providing care with the actual need, which is often different from what is requested by inmates.

For the jail’s nurses and medical director (who are professionally licensed) who provide services to jail inmates, Minnesota’s common law of negligence requires that services be provided that are consistent with the standard of care in the community. In state court, this definition is determined by the opinion of expert witnesses. Claims of negligence (or medical malpractice) are not often filed as lawsuits because attorney fees must be paid out of a verdict or settlement, so as a practical matter, only cases with the potential for major damage payouts are filed.

Constitutional violations using the “deliberate indifference” standard are filed in federal court. Attorney fees are awarded to an inmate who can prove even a single dollar of damage, so medically-based claims are more often filed in federal court. However, proving deliberate indifference is a much higher standard to meet than is negligence at the state court level.

Generally, the County is immune from claims that an insufficient amount of medical services were provided to jail inmates (absent a negligence or deliberate indifference claim) such as the need for more nurses, better care, more clinic hours, better equipment or tools, etc. The County leadership is expected to balance this need in its budgeting process with other competing services for which it provides discretionary funds.\textsuperscript{17}

The bottom line is that county jail officials must provide inmate medical care as a constitutionally protected right of inmates, and are probably going to pay most of the correctional healthcare costs because few jail inmates have health insurance. As a practical matter, the on-site staff who either provide or arrange for most of this care are nurses; few facilities the size of most of Minnesota’s jails can afford to employ a fulltime medical doctor, and in most of them that level of care is unnecessary.

\textsuperscript{16} The Legal Edge section of the Minnesota Counties Insurance Trust organization monthly publication, the Bulletin, in 2006, “Understanding the Claim of Deliberate Indifference in the medical Treatment of Jail Inmates”, by Roger L. Rowlette, Attorney, Johnson & Lindberg, P.A.

\textsuperscript{17} This paragraph and the preceding three paragraphs are from an interview with Dakota County’s First Assistant to the County Attorney, who effectively serves as legal counsel for the county’s administrative and elected leaders, and county staff.
Benchmarking

The benchmarking work for this study was conducted to provide some comparisons with other county jails in staffing models, services and costs.

Methodology

In this study, 14 counties\(^\text{18}\) were contacted to collect data about their healthcare staffing models and administration, services provided, and costs. The counties chosen include all metro-area counties, several others close to the metro area that are generally the largest jails in the state, and several smaller counties outside the metro area. The benchmarking counties are about evenly split between the public employee staffing model and the contracted services staffing model. Hennepin County is the only metropolitan-area county that was not included in the benchmarking work (see footnote below).

Much of the data was collected with a questionnaire (found in Appendix D on page 42), which was followed by telephone interviews to gather additional details. Data was collected in a table format to make comparisons easier. The complete Data Capture Table is quite lengthy and is not included in this report. There are gaps in the data gathering because some of the contracted companies were unwilling to provide data about staffing patterns and other subjects, deeming that information to be proprietary.

In the provision of healthcare/nursing services at county jails in Minnesota, the data below are among the benchmarking information that was collected. These are also among the factors that are included in Requests for Proposals issued for correctional healthcare:

- **Staff:** Who employs the medical director and the onsite medical staff, what levels of training do they have, and how many hours in a day are covered?
- **Who arranges for or coordinates both onsite sick call clinics, and outside or specialty care such as mental health providers, dental care, and others, and are those services under a single contractor?**
- **How are other necessary services provided: pharmacy (medications), X-rays/radiology, lab work, and are they under a single contractor?**
- **Who employs the staff who do administrative tasks: maintaining medical records and documentation, invoices and billing, collections, invoice verification, ordering supplies?**

A table showing summary information for the benchmarking work is shown on pages 17-19. In collecting data for this table, OPA attempted to compare the same data as much as possible for all the benchmarking counties. However, the for-profit companies did not provide some of the requested staffing information, and they do not divulge expenses for salaries for nursing staff they pay to provide contracted services. There are almost as many variations in provision of healthcare services as there are jails in this study.

\(^{18}\) All metropolitan-area county jails except for Hennepin were included (Anoka, Washington, Ramsey, Scott, Carver) in addition to the bigger remaining outstate counties: Stearns, Crow Wing, Sherburne, Chisago, Goodhue, Olmsted, Blue Earth, St. Louis and Wright. Despite numerous attempts, Hennepin County staff did not respond to data requests. Hennepin operates two adult jails with more than 900 inmates, and contracts with the nearby Hennepin County Medical Center for on-site nursing services and other medical care.
General Findings
Certain common features and practices can be found in the jails included in this study.

Like Dakota County, the benchmarked jails in this study have an area onsite set aside for medical exams and space for nursing staff to work, and for medical records/supplies. Many larger jails also provide more expensive items such as rudimentary labs and dental chairs to keep as much healthcare as possible on-site. Sheriff Offices generally pay for office supplies and equipment such as copiers and computers. Sheriff Offices and nursing staff often work out exchanges: the Sheriff Office often does background checks on prospective nurse staff, and correctional staff get seasonal flu shots, Mantoux tests, and other prevention services. Nursing staff often train correctional staff (and inmates) on disease prevention, suicide prevention, managing diabetes and high blood pressure, and many other topics.

There is a surprising range in the percent of inmates who need healthcare in the benchmarking counties. Four counties estimated less than 50%, two estimated 50%, three estimated 70%-75%, and four estimated somewhere between 80 – 90%. In Dakota County, nurses estimate 80% of inmates (not counting those who are considered “book and release”) request nursing attention at some point during their stay.

However, inmates’ most common medical issues showed less variance among the benchmarking counties. When asked to name the three most frequent reasons for contact with the nursing staff, the responses all included mental health, cardiac issues or hypertension (high blood pressure), and diabetes. Dakota County fits in this group. The need to re-start current prescription medication (for security reasons, many jails do not allow inmates to bring in their own medication), as well as insomnia and orthopedics were others in the short list of frequent medical complaints.

Correctional Healthcare Staffing Models

Public Employee Model
Until a few years ago, the typical model for healthcare in jails was nursing staff hired either by the Public Health department or the Sheriff’s office. Jails are required to hire a medical director to direct medical decisions made on behalf of inmates in jails; nurses worked in cooperation with, and under the direction of, the medical director. Because registered nurses have advanced training, the calls to the medical director were infrequent. However, in most public health staffing models, nurses work few evening hours and many don’t work on weekends (when most booking occurs); in many smaller jails, if there is any doubt about a medical problem, the inmate generally is promptly shackled and transported to the nearest hospital for assessment and treatment. In most public employee staffing models, the correctional deputies go through the units to dispense medication (after the medication carts are set up by nurses).

Most larger jails arrange for “sick call” onsite once or twice a week run by a medical doctor to see inmates with more serious complaints, with the visits first triaged by the nurses. Nurses also arrange for some type of mental health care, which is often provided onsite. Nurses typically do charting and maintain medical records, order supplies and prescriptions, collect specimens for lab work, and arrange for any off-site care needed by inmates such as Xrays, dentists or orthopedists.
Most of these “offsite” services are under contract to the Sheriff, whose administrative staff do invoicing and pay the bills. In some counties, the public health staff are compensated by the Sheriff to handle those administrative functions. In many cases, the lab work and filling prescriptions are done by local companies.

**Contracted services model**

Services can be contracted from either a for-profit company or from a non-profit community-based health services system, such as HealthPartners. In the contracted services model, as many or as few of these services as desired can be included. Almost all of them provide onsite varying levels of nursing care, sick call clinics, mental health care, and a medical director. Because they prescribe fewer medications and due to economies of scale, the for-profit national correctional healthcare companies get good prices for prescriptions and labwork, and negotiate lower prices for necessary offsite care. Generally, the contracted services’ staff take care of dispensing medications.

Interviews with more than a dozen jail administrators for this study indicated that for jail administrators, who are under pressure to cut costs, the attraction for using contracted services is saving costs by increasing onsite care (thereby reducing the need for more expensive offsite care). But saving money is not always the first reason mentioned when jail administrators are asked why they use the contracted services model. Jail administrators also seek the relief of knowing someone else is responsible for making medical decisions and for dispensing medications. Contracted services often cover more hours with staff onsite (i.e. evenings and weekends) though not necessarily with their most highly-trained staff. State law requires correctional staff to have at least basic first aid training, but most correctional staff are oriented to law enforcement or public safety and are not comfortable with a medical or healthcare role. Inmates often attempt to discuss their health concerns with whoever dispenses medications, something correctional officers are not comfortable with.

### Benchmarking Summary Data Table

<table>
<thead>
<tr>
<th>County and Staffing Model</th>
<th>Medical Unit Coverage</th>
<th>Nursing costs</th>
<th>Total Health-care costs</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakota</td>
<td>59% of 24-7 263: total hours</td>
<td>$2,297 per ADP</td>
<td>$5,445 per ADP</td>
<td>Nurses onsite 7 am to 11:30 pm, M-F, 8 hrs/day weekends. Med passes shared by nurses and Correctional staff 3/day</td>
</tr>
<tr>
<td>Anoka</td>
<td>69% of 24-7 202: total hours</td>
<td>$3,015 per ADP</td>
<td>$6,050 per ADP</td>
<td>Nurses onsite 6:30 am to 11 pm every day (7 days/wk) Med passes shared by nurses and Cx staff 3/day</td>
</tr>
<tr>
<td>Washington</td>
<td>57% of 24-7 176: total hours</td>
<td>$3,774 per ADP</td>
<td>$6,289 per ADP</td>
<td>Nurses work eves M-F, 9 hrs/day weekends. Med passes done by Cx officers only, 3/day</td>
</tr>
<tr>
<td>Ramsey</td>
<td>100% of 24-7 442: total hours</td>
<td>$2,809 per ADP</td>
<td>$6,888 per ADP</td>
<td>Only Ramsey and Hennepin Cty have 24-7 nursing services Med passes done by nursing staff only, 4/day</td>
</tr>
<tr>
<td>Scott</td>
<td>28% of 24-7 80: total hours</td>
<td>$1,031 per ADP</td>
<td>$2,423 per ADP</td>
<td>Nurses work no eves, no weekends Med passes done by Cx officers only, 3/day</td>
</tr>
</tbody>
</table>

**Benchmarking Summary Data Table Continued on the next page →**

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19 All costs shown in the table are for 2011 unless shown otherwise.
<table>
<thead>
<tr>
<th>County and Staffing Model</th>
<th>Medical Unit Coverage</th>
<th>Nursing costs</th>
<th>Total Health-care costs</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carver Sheriff nurses</td>
<td>28% of 24-7 72: total hours</td>
<td>$2,388 per ADP</td>
<td>$2,875 per ADP</td>
<td>Nurses work no eves, no weekends Med passes done by Cx officers only, 4/day</td>
</tr>
<tr>
<td>Sherburne (See Note #1)</td>
<td>61% of 24-7 690: total hours</td>
<td>(data requested but not yet provided)</td>
<td></td>
<td>Nurses work evenings and weekends. Med passes done by nursing staff only, 3/day</td>
</tr>
<tr>
<td>Chisago Public Health nurses</td>
<td>25% of 24-7 42: total hours</td>
<td>$1,551 per ADP</td>
<td>$3,250 per ADP</td>
<td>Nurse works no evenings, no weekends Med passes done by Cx officers, 4/day</td>
</tr>
<tr>
<td>Olmsted (See Note #2)</td>
<td>54% of 24-7 226: total hours</td>
<td>[2012 → costs are estimated] $3,750 per ADP 2012 (new)* $6,260 per ADP 2011 (old)</td>
<td></td>
<td>Nurses work eves, 8 hrs/day weekends. Med passes done by CHC staff, 2/day (with exceptions)</td>
</tr>
<tr>
<td>Stearns MEnD: for-profit</td>
<td>37.5% of 24-7 222: total hours</td>
<td>$5,014 per ADP for MEnD; $7,157 per ADP for total</td>
<td></td>
<td>Nurses work until 7 pm Mon-Fri, 4 hrs/day on weekends Med passes done by MEnD staff, 4/day</td>
</tr>
<tr>
<td>Crow Wing (See Note #6)</td>
<td>37.5% of 24-7 200: total hours w/MEnD $1,026 per ADP for 2011 (estimated); $985 per ADP for 2010</td>
<td>$2,276 per ADP for MEnD annual; $2,845 per ADP for total medical costs in 2010</td>
<td></td>
<td>Nurses work until 7 pm Mon-Fri, 4 hrs/day on weekends Med passes done by MEnD staff, 4/day</td>
</tr>
<tr>
<td>Blue Earth (See Note #3)</td>
<td>24% of 24-7 40: total hours</td>
<td>$1,163 per ADP</td>
<td>$2,020 per ADP</td>
<td>Nurse works no evenings, no weekends Med passes done by Cx officers, 2/day (with exceptions)</td>
</tr>
<tr>
<td>Goodhue (See Note #4)</td>
<td>24% of 24-7 40: total hours</td>
<td>$4,500 per ADP in 2011 for all health care costs (before ACH started)</td>
<td>$3,701 per ADP annual for ACH contract (2012)</td>
<td>Nurse works no evenings, no weekends Med passes done by Cx officers, 2/day (with exceptions)</td>
</tr>
<tr>
<td>Wright (See Note #5)</td>
<td>26% of 24-7 64: total hours</td>
<td>$1,902 per ADP for Allina contract</td>
<td>$2,727 per ADP for all medical expenses</td>
<td>Nurses work until 6 pm Mon-Fri; no late evenings, no weekends Med passes done by Cx officers</td>
</tr>
<tr>
<td>St. Louis Nurses from Essentia (local health system)</td>
<td>38% of 24-7 160: total hours</td>
<td>$1,900 per ADP in 2011 for nursing at St. Louis Cty jail (not boarded out inmates)</td>
<td>$4,190 per ADP in 2011 for all medical expenses, including those for boarded out inmates</td>
<td>Nurses work until 6 pm Mon-Fri; 4 hrs on Sat and Sun Med passes done by Cx officers, 4/day</td>
</tr>
</tbody>
</table>
## Benchmarking Summary Data Table Notes

### Definitions:
ADP is the average daily population in the jail calculated for the year 2011. Cx is shorthand for “Correctional Staff”.

The second column includes two measures:

1. The number of hours in a week when nursing staff are working onsite, expressed as a percentage of the total possible (24 hrs x 7 days = 168 total possible)
2. The total number of hours worked in a week by all members of the medical unit onsite, meaning the total hours worked by all scheduled shifts.

Example: The Snickers County Jail employs two nurses who both work 40 hours per week, 8 am – 4 pm. They work a total of 80 hours but cover only 40 hours in a week. The Twix County Jail employs two nurses who work this schedule: Nurse A – 9 am to 4 pm M-F and 8 am to 1 pm Sat; Nurse B – 3 pm to 10 pm M-F and noon to 5 pm Sun. They work a total of 80 hours, but they cover 65 hours of the 168 possible in a week.

Neither of these include hours worked by contract staff for onsite clinics, such as medical doctor, psychologist/psychiatrist, dentist. The only non-medical staff time counted in this calculation is for administrative staff who maintain medical records.

The third column is the nursing staff costs in 2011 (where available) divided by the jail’s most recent annual average daily population.

The fourth column is the total healthcare costs in 2011 divided by the average daily population (including nursing costs).

### Notes:
1. Sherburne County Jail has a large ADP for the size of population because they rent 80% of beds to U.S. Marshals Office and to the federal Immigration Service. They are reimbursed for medical costs for federal inmates they house, which may help to mask the costs for their own inmate population. They are not able to separate medical costs for “their” inmates from the boarded inmates.

2. Olmsted County’s healthcare provider shares staff and provides services at both the jail and the workhouse and does not split out costs separately for the two facilities. The ADP stated is combined figures for both facilities. Olmsted switched to for-profit healthcare services in 2012, so total healthcare costs for 2012 are estimated. Costs for total healthcare costs are also shown for 2011, when the public health staffing model was used.

3. Blue Earth County – ACH was hired last year to provide healthcare to inmates, but they use the one full-time registered nurse from the County’s human services department who has worked in the jail for many years (with no other additional nursing staff). The annual ACH contract cost for 2012 includes a $3,500 monthly “retainer” to pay for costs not covered by ACH such as prescription meds, lab work, dentist and other offsite specialists. Costs above that amount are also paid by the county, but the monthly retainer allows for more predictable budgeting.

4. Goodhue County – the annual contract cost for 2012 includes a $4,000 monthly “retainer” to pay for costs not covered by ACH (see note above).

5. Wright County – the healthcare arrangement is a community-based hybrid of the more typical staffing models. The contract with the local hospital and clinic system (Allina) covers nurses (who also work in the local hospital), medical director, medical care (including offsite), emergency room visits w/discount on ambulance transport and discounted labwork at the hospital. The Allina contract does not cover mental health offsite, dental care, prescriptions.

6. Crow Wing County – the jail switched to the MEnd for-profit company mid-2011. Estimates for nursing costs are based on the first half of the year; similarly, full year costs for MEnd are based on the second half of the year.
In the scatter diagram at right, the horizontal scale is the per-inmate annual cost of healthcare services for 2011. The vertical scale represents totals of points assigned for services, with more points awarded for service arrangements that meet the jail’s goal: total hours worked, percent of 24-7 hours covered, whether evenings and weekends are covered, and whether medical or correctional staff pass out medication. For each of those four services, a county can be assigned up to four points.

The scatter diagram shown above is based on data found in the Benchmarking Summary Table on pages 17-19. The most desirable quadrant is to be placed in the upper left corner, where the services are the greatest and costs are lowest. Crow Wing and Olmsted counties both have switched in the last year to a for-profit service model. Olmsted County negotiated an unusually rich contract in services provided. Crow Wing County ranks slightly better than Dakota County because they have almost the same coverage (hours covered in a week by staff), but the correctional officers do not do med passes. Both counties have lower overall costs than Dakota County.

Findings
1. Cost: As the Benchmarking Summary Data Table on pgs 17-19 shows, costs for onsite services are not necessarily lower with contracted healthcare as compared to the public employee model. However, the annual total overall cost for healthcare in jails using contracted services is often less because the for-profit companies’ business model depends on successfully treating inmates onsite to avoid offsite medical visits, and prescription costs are less.

Dakota County’s budgetary split for correctional healthcare, allotting costs to both the Sheriffs Office and the Public Health department, is more complicated than most of those shown in the table on pgs 17-19. The Sheriff’s Office transferred $444,464 in 2011 to the Public Health department for nursing services, but that amount does not reimburse the department for all costs related to correctional nursing. The Public Health department paid $590,383 in 2011 for nursing
services at the jail, which is the total cost of all salaries and benefits for the nursing staff (including the nursing supervisor and nursing overtime costs) and the .2 FTE clerical assistance, plus $36,901 paid to a temp agency to supply nurses to cover shifts when county nurses were unavailable. Thus, in 2011, the Public Health department subsidized nursing services in the Jail in an amount of $144,883, or 24.5% of the total nursing services costs. In addition, the DCSO paid $809,000 in 2011 for other healthcare expenses for inmates, and paid for administrative staff time in addition to that amount.

Dakota County’s costs for both nursing staff and total inmate healthcare expenses are lower than those in Washington, Anoka and Ramsey counties, but higher than Carver, Scott and Chisago. All use the public employee staffing model. Dakota County’s total inmate healthcare expenses, however, are higher than those of any county using the for-profit (contracted) staffing model except Stearns County.

A strategy used by for-profit companies to control costs is that the medical director plays a very hands-on role in the facility, often personally conducting the sick-call clinics and actively consulting with mental health staff to enforce the policy of minimizing use of expensive psychotropic medications. This arrangement also means only one person makes decisions about the most expensive medical care (that is, offsite visits and prescriptions) instead of distributing that authority among several practitioners.

2. **Onsite staff coverage:** For-profit contracted healthcare services are much more likely to provide evening and weekend staff coverage, but generally not by staff with as much training as RNs. This pattern can be seen in other ways. For example, contracted services often address inmates’ mental health issues by providing a social worker with advanced training; the public employee staffing models tend to bring in more highly trained psychologists or psychiatrists for fewer hours. Some for-profit companies offer a physician assistant as the 24-7 on-call consultant or to conduct a sick call clinic, instead of a medical doctor.

3. **Distributing medication:** In many public employee staffing models, correctional officers are trained to dispense medications to inmates (commonly called “med passes”), and med passes generally are done four times daily. Often this division of labor occurs even when nurses are available onsite. The for-profit companies generally take over all med passes, but usually reduce them to twice daily (with some exceptions made for inmates with specific needs).

4. **Economies of scale:** Contracted services usually do not “pay” for services such as lab work or prescriptions under the contract, but they use their preferred vendor for both of those services and handle arrangements for orders and deliveries. Because the company brings the vendor more business than a jail could individually, costs are lower.

5. **Liability:** Most contracts require for-profit companies to carry several million dollars’ worth of liability insurance. If a successful claim results in a financial settlement against the County related to health care services, the contractor pays it within the limit of the policy. County taxpayers do not directly pay claims unless the amount exceeds the healthcare company’s policy limit.
6. In all of the counties in this study that have switched to a for-profit staffing model in the last three years, the public employee nurses who formerly provided correctional care were absorbed by the county’s public health department, unless the nurses chose to work instead for the new provider.

The motivation for the sheriff to hire the contracted service is being able to delegate to someone else the responsibility for anticipating and managing non-correctional issues (and to shoulder most of the financial liability resulting from those decisions). Another advantage is hiring someone else to manage and coordinate both onsite and offsite healthcare, manage contracts for services, and do all the necessary documentation/medical records maintenance and billing or invoicing.

It’s worth noting that in mid-2011, a new state law took effect that limited counties to paying amounts equal to medical assistance rates for medical services provided to inmates for offsite care, rather than market rates for such care. In the Dakota County Jail in 2011, that law change saved $28,739 for the 42 invoices that were received after July 1. The invoices totaled $43,712 but only $14,973 was paid using the MA rate, a savings of 66%.

In addition, rules are currently being written for implementing provisions of the federal healthcare reform act in 2014. States and counties are hopeful that the new rules will cover prison and jail inmates under the federal Medicaid program, so the cost for most inmate healthcare will shift from county taxpayers to the federal government – assuming Congress does not amend this provision.

Though others are in the business but not in Minnesota, at least four for-profit companies currently provide health care services in Minnesota. The table below provides a snapshot of information about them.

<table>
<thead>
<tr>
<th>Company</th>
<th>Client Counties</th>
<th>Company profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEnD Correctional Care</td>
<td>Stearns, Crow Wing, Sherburne, Morrison, Mille Lacs, Douglas</td>
<td>This is the only Minnesota-based company. Now headquartered in Rogers, it was founded by Dr. Todd Leonard after several years of working as the medical director for jails in central MN. MEnD currently has more than 20 employees, including physicians, RNs, psychiatric nurse clinicians, LPNs, medical assistants and medical technicians.</td>
</tr>
<tr>
<td>ACH Advanced Correctional Healthcare</td>
<td>Goodhue, Blue Earth, Rice, Wabasha, Steele, Winona, Mower, Renville, McLeod, Meeker, Rice, Faribault, Nicollet, Kanabec</td>
<td>Based in Illinois, ACH has 630 employees in county jails in 17 states. They provide comprehensive services including mental health professionals, physicians, nurses, dentists, lab and radiology, and pharmacy. The ACH executive management team is made up of medical professionals.</td>
</tr>
<tr>
<td>CHC Correctional Healthcare Companies</td>
<td>Olmsted, Freeborn, Pine County</td>
<td>Based in Denver, CHC has absorbed healthcare companies based in Illinois and Michigan. They now have 1,200 employees in jails and prisons in 25 states. They provide comprehensive services from inmate intake to release planning, including mental health and crisis intervention, physicians, nurses, dentists, lab and radiology, pharmacy and detox.</td>
</tr>
<tr>
<td>CMS Correctional Medical Services (now called Corizon)</td>
<td>Hennepin Workhouse, MN state prisons</td>
<td>CMS actually started in Roseville in 1979, but has been merged with several other healthcare companies and is now based in Brentwood, Tennessee and St. Louis, Missouri. A merger in June 2011 doubled the size of the company. More than 11,000 employees work in jails and prisons in 31 states. They provide comprehensive services including physicians, nursing, dental, optometry, substance abuse treatment, pharmacy, and lab.</td>
</tr>
</tbody>
</table>
Analysis and Potential Alternatives
As noted, the purpose of this study is to examine options for providing healthcare services to jail inmates at the Dakota County jail that provide the desired nursing staff coverage at the lowest possible cost, while maintaining current service levels and quality of care.

As discussed in the previous benchmarking section: when compared to other metropolitan-area county jails with the same (public employee) staffing model, Dakota County’s costs for both nursing and total healthcare costs are lower than most other counties. When compared to smaller jails using the contracted services staffing model, Dakota County’s healthcare costs generally are higher.

Cost of Inmate Healthcare
There is no national standard for a reasonable amount that jail administrators should budget per inmate for health care costs. This is likely due to the frequent and time-consuming need to recalculate such costs as health care becomes steadily more expensive, constant changes in costs resulting from applying advances in technology to the provision of healthcare, and is related to the concept that health care provided for inmates should be similar to healthcare provided for community members generally, a measure which changes depending on the community in question.

That doesn’t mean that correctional healthcare experts haven’t attempted to calculate an answer:

- At its annual conference in October 2008, members of the NCCHC were told by a prominent correctional healthcare consulting company that typical annual healthcare costs per inmate ranged from $2,007 to $5,840 annually, a range that fits many of the jails in this OPA study – and remember, this was in 2008 and healthcare costs have continued to inflate significantly each year since then.

- A 2010 study of healthcare costs in the seven largest county jails in Florida showed a range of costs from $2,800 to $5,800 annually on average per inmate in 2009. Three of the jails use public healthcare (ie public health nurses and county or state-owned offsite services) and four use for-profit contractors. All but one of them are accredited by both the NCCHC and the American Correctional Association, so many of their practices are similar to those of the Minnesota jails in this study.

Several counties in this study, who use the public employee staffing model, have costs above the standards described above. All of the counties in the study that are using contracted staffing models have costs lower than these standards except Stearns. Dakota County’s costs are within the range.

NCCHC advises caution in attempts to cut healthcare budgets, because so many of them are already so low that further cuts make litigation more likely. Rick Morse, a certified correctional healthcare provider, stated in an article in NCCHC’s publication CorrectCare in October 2008, “It seems that jails and prisons in virtually every jurisdiction are grappling with tough choices as they try to meet their budgets, and healthcare budgets are not immune to scrutiny. My first response to the question ‘what can we cut and do without’ is: Be careful - bad healthcare is more expensive than good healthcare. A narrow focus on cuts simply isn’t prudent. It exposes the facility to unacceptable liability, undermines the health care mission and present risks to inmates, staff and the public.”
Typically, the three biggest parts in a jail healthcare budget are staff, prescriptions, and off-site care. The Florida study (see page 6) found that RNs have more training than LPNs and therefore their license allows them a greater scope of practice, enabling them to successfully diagnose and treat a wider range of medical issues onsite. This in turn means fewer costs for expensive offsite visits and fewer visits or hours by physicians onsite. This is balanced by the fact that RNs are more expensive to employ, particularly if temporary nurses must be used to fill shifts for RNs who are absent for a variety of reasons. In Florida, two solutions were implemented to cut costs: first, using fewer temporary staff by improving working conditions and salaries to improve turnover rates; and second, creatively covering shifts by mixing RNs with staff who have less training and cost less.

A review of national correctional healthcare organizations and literature turned up several suggestions that have been used in jails across the country to cut costs. Several of them are already in place in the Dakota County Jail (shown by check marks):

- Re-examine how many prescriptions are being filled, especially for expensive mental health medications including sleeping aids. Generally, national pharmacy services are less expensive than local drug stores.
- Partner with nearby jails to share costs for onsite staff or offsite specialists, or both.
- Avoid using staff from temporary agencies to fill nursing shifts, because of the extra expense for this type of care
- Establish a co-pay (or user fee) for inmates to see onsite or offsite practitioners, as a way to discourage frivolous complaints
- Install an electronic medical records system
- Consider using tele-medicine, to avoid costs for secure transportation to offsite facilities
- Retrieve all previous medical records for a returning inmate to avoid duplicating work by starting over
- Change the length of shifts of onsite health care workers from 8 to 12 hours.
- Except in cases with acute medical needs, don’t conduct a detailed health evaluation or assessment or prepare a resulting care plan too soon, to avoid spending time on inmates who will not need services because they bail out of jail quickly.
- Avoid an “open” sick call when any inmate can see physicians; instead, use nurses to triage the complaints and manage the appointment schedule.

Service levels and staffing models
The scattergram on page 20 shows Dakota County’s costs for both nursing staff and total inmate healthcare expenses are lower than those in Washington, Anoka and Ramsey counties, but higher than Carver, Scott and, Chisago. All use the public employee staffing model. Dakota County’s total inmate healthcare expenses, however, are higher than those of any county using the for-profit (contracted) staffing model except Stearns County.

The jail administrators in the counties in this study who use public employee staff to provide nursing services (and a multitude of other services via contracts) generally are happy with the service. Many have considered, and rejected, the notion of switching to a for-profit company. In the public employee staffing model, the nature of the relationship between the jail administrator and the nursing staff seems particularly important. The jail administrators who are very pleased with this model share several
characteristics: there is excellent and frequent communication between the jail staff and the nursing staff; they share a mutually respectful relationship; a nurse supervisor or manager is considered a valuable and trusted member of the jail’s management team; and both camps work hard to preserve their collaboration and cooperative spirit.

Most of the jail administrators using for-profit contracted services are equally happy with the services they receive, though for many of them the arrangement is less than a year old. The high level of mutual trust is not there yet, but is counterbalanced by jail administrators’ obvious relief from direct responsibility for inmate healthcare worries.

Advocates for the public health model express a philosophical belief that for-profit companies cut too many corners and the quality of care is less, which in turn will lead to more complaints and worse – to lawsuits with expensive settlements. Just one lawsuit payout can wipe out years of budget savings, they warn.

“Like everybody, we get challenged by inmates about their healthcare. I am very comfortable that I can defend our current practice, which is that they get the care they need if not the care they want. I’m not sure I could do that with a contract provider. Those vendors lowball their quote and then can’t deliver what they promised for that price. With healthcare services, I think we’re asking for trouble to do it for the lowest bid.” (comment from a jail administrator in a metropolitan-area county).

“I’m really happy with the services that our public health nurses give us. We aren’t just in this to save money. We also want to be sure we’re providing good care because in the end, it costs us less . . . we’ve heard lots of horror stories from other counties about shortcuts that the contracted companies are doing.” (comment from another jail administrator in a metropolitan-area county).

The for-profit companies counter that such talk is merely a scare tactic. They say it is not necessary to employ only registered nurses to provide excellent healthcare, and public employee models are much too quick to send inmates offsite for medical care and to write unnecessary prescriptions – and both practices are very costly.

“Our public health nurses did a good job for us. But they didn’t look hard enough at our costs.” (comment from a jail administrator in central MN using for-profit company services).

“The contracted model saves the Board (of Commissioners) money. It’s like competing with WallMart. They can provide more for less cost.” (comment from former public health/jail nursing supervisor in a county in Southeastern Minnesota that recently switched to a for-profit staffing model.)
Is there a difference in quality?
There is no evidence indicating quality of care is less in for-profit services – but it may be too soon to know with any certainty. If the jails using for-profit healthcare companies continue to pass state inspections and aren't being sued, the argument about quality of care may not matter.

Though the state Corrections Department officials actively (but unsuccessfully) lobbied against for-profit prisons in Minnesota in the 1990s, today they are more sanguine about for-profit companies providing some of the services necessary to operate government-run jails and prisons such as food, laundry and now health care. In fact, DOC uses a for-profit healthcare provider in its state prisons. DOC Inspections Unit Director Tim Thompson (who still keeps an inspection caseload) said DOC hasn't taken a position either for or against the for-profit healthcare companies in county jails. He said Inspectors use the same criteria and guidelines, which are described in Rule 2911, no matter who provides services in jails.

Thompson said to date, his inspectors have not noticed a pattern of lesser quality of health care in jails using for-profit companies. “As long as they comply with 2911, we stay out of that whole discussion . . . we haven’t seen anything that says one particular model is detrimental to the quality of inmate health care compared to the other.”

DOC does not systematically collect complaints from inmates, but the agency does receive dozens of complaints annually on a variety of issues from prison and jail inmates, including the quality or availability of healthcare. There is no requirement for complaints to be forwarded to DOC from jails, so this probably does not represent the whole universe of complaints from inmates. The DOC complaints tracking database does not include a field to record whether jails use the public health employee staffing model or the for-profit model, but since for-profit companies started providing services in the state, there has not been a change in the frequency or pattern of complaints. For the last decade, most inmate complaints related to healthcare have been related to access to mental health professionals. The range is from two to six per year from jail inmates and has not changed in many years.

The Minnesota Counties Intergovernmental Trust provides liability insurance and settles claims for 81 of the 87 Minnesota counties. Jennifer Wolf, MCIT litigation manager and risk manager, said medical malpractice or deliberate indifference claims are very rare in Minnesota and settlements are even more rare. There has been no discernible change in the number of those claims in the last five years, she said. MCIT does not take a position on the issue of recommending either public employees or for-profit agencies in correctional healthcare.

When asked for this study, three of the four for-profit healthcare companies currently holding contracts with jails in Minnesota refused to describe their history of complaints in either the administrative or legal channels. However, the owner of the lone company from Minnesota, MEnD, said his company has never lost a case when an inmate succeeded in getting a court hearing about a complaint.

Correctional Cost-effectiveness
In considering the question of return on investment (i.e. the cost-effectiveness of providing healthcare to inmates), it may be helpful to note that there is no objective or quantifiable way to measure whether health outcomes for jail inmates are better in jails that pay higher correctional healthcare costs than

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20 Interview with OPA staff January 23, 2012
21 Interview with OPA staff February 2, 2012
In those with lower costs. None of the benchmarking counties in this study are able to do health outcome measurement, partly because almost all of them use paper (not electronic) medical records. There is no question that while inmates are in county jails, their medical conditions are stabilized. That is, inmates’ high blood pressure or diabetes is brought under control, they receive drug and alcohol treatment, and their mental health issues are addressed. Many jails prepare a “discharge plan” for the inmate that suggests, among other things, actions needed to maintain his/her health and resources available to help do so. But there is no known systematic follow-up conducted post-release to learn how inmates fare.

**Potential Alternatives**

There is no clear answer to the question asked by the Sheriff’s Office in this study, which is whether the same quality of care can be provided to jail inmates at a lower cost by using a for-profit company. It appears the best way to learn the answer is to follow the path used by Olmsted County in 2011: conduct a Request for Proposals process. Decisions about several variables, and priorities, affecting cost of services will need to be considered in order to do so.

A range of options for providing inmate healthcare in the Dakota County Jail is described below. Each includes a description of its benefits and drawbacks, relative to the three desired outcomes: coverage, low cost, and quality of care.

1. **Keep the status quo**
   Nurses in the Dakota County Jail already rank well in the total number of hours worked and the hours covered in the jail. In recent years, costs have been lowered by using a national medication provider for prescriptions, and a national lab. Some offsite visits are eliminated by using a vendor with a portable system for Xrays. It is not clear, however, whether either the Sheriff’s Office or the Public Health director want to continue the same arrangement or prefer to change it.

2. **Mimic the for-profit model more closely within the public employee model**
   As noted above, nurses in the Dakota County Jail already rank well in the total number of hours worked and the hours covered in the jail. The Jail’s strategies also use several others common in the for-profit companies: outsourcing lab work and prescriptions, and using a portable X-ray vendor who comes to the jail when needed.

   The DCSO chief deputy and jail administrator have expressed interest in adding to the hours covered by nursing staff, particularly on weekends when a high percent of bookings occurs. They also indicated that they hope for a schedule that absolves correctional officers from the responsibility for distributing medications except in unusual circumstances. Currently, RNs are in the jail from 7 am to 11:30 pm Monday – Friday and from 8 am to 4 pm on Saturdays and Sundays. Med passes occur three times per day and are done by nurses when they are onsite.

   a) Consider using a staffing schedule that looks more like those used by the for-profit companies, in which RNs work during the day paired with an LPN or medical assistant, LPNs work the day on weekends and RNs work evening shifts (to be available during booking). If the weekend nursing shifts extend to 11 pm, or the same number of hours are worked but
end at 11 pm (3 pm – 11 pm instead of 8 am to 4 pm), the reliance on correctional officers to pass meds could be less.

Pros/Cons: Adjusting staffing coverage may cost more, but any extra staffing costs may be balanced by fewer visits for offsite care (particularly at night and on weekends) and will provide more peace of mind for correctional staff.

b) Consider two other strategies used by the for-profit companies: a more active or integrated role for the jail’s medical director, and less expensive mental health care. Most other jails in this study do not provide separate weekly onsite clinics with both a psychologist and a psychiatrist. Instead, a more common model is using a highly trained social worker onsite in consultation with an offsite psychiatrist. The Jail’s medical director should hold sole responsibility for approving all offsite care and all prescriptions. Uniformity in decision-making is difficult to achieve when several doctors share decision-making about appropriate medical care.

Pros/Cons: Liability concerns and time constraints might make it harder to find a medical director who is willing to play a more active and integrated role in medical decision-making at the Jail. The high level of mental health services available at the jail currently may help identify serious mental health issues early, before they can become a more serious problem.

c) Consider: In some county jails, the nursing staff are employees of the Sheriff, not the Public Health department.

Pros/Cons: That organizational arrangement appears to have little effect on the healthcare practices followed by nurses, but it eliminates any friction that might exist between two departments and allows the nursing staff to have clarity about where their organizational leadership comes from instead of being torn between two departments. It is conceivable that nurses who feel more independent might also make better choices about appropriate medical care if they feel less constrained about constant budget awareness.

3. Partnering with other (public employee model) counties to share costs

The multi-county discussion among a dozen southeastern counties that began in mid-2011 was a start in this direction, though some of those counties now use for-profit companies.

In the jails using the public employee staffing model, offsite services such as emergency care and transport, dental, mental health, pharmacy, lab, radiology and ordering supplies, are all arranged for independently. There might be an opportunity to cut costs through economies of scale by sharing contractors for those services, at least among the counties that share geographic proximity in the metro area: Anoka, Ramsey, Washington and Dakota.

Taking this idea a step further, partner counties could also consider hiring onsite healthcare staff jointly and sharing them, which could add flexibility in hours and locations that are attractive to staff.

Pros/Cons: Jointly seeking and contracting with vendors for offsite services, or even onsite staff, saves costs because of economies of scale. The savings would be offset by administrative costs, such as staff time necessary to facilitate a consensus process among the partners and negotiate priorities in services and other variables, seek vendors, and manage contracts.
4. **Contract with a local healthcare provider**

Two of the benchmarking counties in this study (St. Louis and Wright counties) have arrangements that tie them very closely to community healthcare providers. In these cases, the jail’s medical director works for the local hospital emergency room and conducts the sick call clinic onsite at the jail, and the nurses are supplied by the same employer. In Wright County, nurses work part-time in both the jail and the nearby hospital. Emergency transport is provided by the same organization at a greatly reduced rate, as are radiology, pharmacy and laboratory services.

**Pros/Cons:** Wright County has used this model for many years, a legacy of a long-standing and unique business community relationship with a local non-profit provider. The remarkably low cost of their arrangement may be hard to duplicate in today’s healthcare marketplace. Nevertheless, the economies of scale may allow for significant cost savings by contracting with a single organization for staff and many healthcare services, assuming Dakota County could find a willing partner. However, Wright County also has relatively low services compared to Dakota County’s current model, and this would need to be considered with any healthcare company.

5. **Partner with other counties using the for-profit correctional healthcare staffing model**

Several Minnesota companies have recently hired for-profit national correctional healthcare companies, but the process used by Olmsted County stands out. Olmsted County changed staffing models in late December 2011 from public health staff to a for-profit company. Their process was thorough and thoughtful, starting with an RFI and then RFP process that involved a great deal of probing for additional information and a lengthy contract negotiation process led by an experienced countywide contracts/purchasing manager. The new arrangement has been in place for less than two months, so it’s too soon to tell if both parties will be well satisfied with the arrangement a year from now. However, on paper, the services negotiated in the contract appear to be more comprehensive than others using for-profit companies for a reasonable cost (about $4,200 per inmate annually). Olmsted County jail staff have suggested partnering with Dakota County using the same provider.

**Pros/Cons:** This approach could benefit Dakota County by taking advantage of Olmsted County’s expertise and experience gained during its thorough and comprehensive process, and its overall lower prices for the all-in-one provider. However, using the Olmsted services arrangement would mean services provided in the Dakota County Jail would be different than they are today. Assuming similar terms in a potential contract, onsite nursing coverage and medical doctor sick call clinics would be slightly less, more mental health care would be delivered but mostly with staff with less medical training, and correctional deputies would no longer distribute medications. Cost savings for Dakota County might be less than those in Olmsted, because Dakota County already uses a national lab and pharmacy at lower costs than those for Olmsted before their switch in service providers.
6. **Break new ground with a hybrid public/private model**

Jim Franklin is the executive director of the MN Sheriffs Association. Some members of the MSA have expressed concerns about quality of care provided by for-profit healthcare companies. Mr. Franklin is advising his members to consider a hybrid if they move away from the public employee services model -- keeping in place a nursing manager who works for the Sheriff to manage the contract. Sheriffs and their jail administrators have expertise in law enforcement and corrections but not healthcare. They fear being vulnerable to inmate lawsuits alleging inadequate care because they lack the expertise to manage the services provided and medical decisions made by employees of a for-profit correctional healthcare company. This manager position could be jointly hired by, and shared with, more than one county.

**Pros/Cons: Cost savings realized by moving away from a public employee staffing model mean little if counties are vulnerable to paying expensive claims due to inadequate quality of healthcare. A nursing manager would be an added expense, but might be prudent if s/he spotted risks and insisted on changes in procedures and protocols that correctional staff might not recognize. No county jail in Minnesota is using this model currently. The cost-effectiveness of this option is difficult to gauge because, absent a contractual relationship, for-profit companies will not divulge their success or failure in legal challenges because such information is proprietary.**
Appendix A – History of Correctional Health Care

The History of Correctional Health Care

As already noted, today's practices, policies and procedures for correctional health care have been developed primarily from a long history of legal challenges. The striking thing about correctional health care is that it has a relatively short history. Forty years ago, when the populous Baby Boomer generation caused overcrowding in most state prisons, living conditions in some prisons, especially in southern states, included inadequate heating/cooling systems, few provisions for personal sanitation, and rotten food.

The U.S. Department of Justice National Institute of Corrections and the National Commission on Correctional Health Care (NCCHC) jointly commissioned B. Jaye Anno, a certified correctional health provider, to write a reference manual for correctional nursing, called "Correctional Health Care: Guidelines for the Management of an Adequate Delivery System". This publication is considered the industry's gold standard and is the basis of NCCHC's certification program for nurses and jails. Though written in 2001, it is still considered current and has not been updated. Anno's book includes a lengthy discussion of the history of correctional healthcare, summarized here.

For more than a century, treating prison or jail inmates cruelly was tacitly an accepted part of punishment and courts generally turned a blind eye to complaints of maltreatment. Inmates had no political power, they did not vote, and had the added stigma of violating society's laws.

Starting in the mid-1960s, that attitude gradually started to change with some work done by the American Medical Association, public health and social workers, and the National Crime Commission. "Not until around 1970 did the medical profession express interest in the plight of prisoners' health care . . . Other authorities, namely the courts, confronted with instances of negligent or inadequate health care in correctional institutions, chose to ignore it, citing lack of expertise in prison administration to overrule decisions made by jail administrators. Relying on the "hands off" doctrine established decades earlier (due in part to a lack of a specific constitutional provision for dealing with inmates), until at least the 1970s courts abstained from reviewing the actions of prison and jail officials." 22

There was no systematic study of health issues among inmates until at least 1970, when the federal Law Enforcement Assistance Administration found that only about half of the nation's jails had any medical facilities at all. 23 A follow-up survey of jails across the nation by the American Medical Association in 1973 found few instances of medical personnel or facilities available to inmates, and on-site nursing services were unheard of:

- 65% of the jails reported the only medical available in the facility was emergency first aid; another 16% said not even first aid was available.
- almost 1/3 of jails said no physician visited the jail regularly and 11% said no physician was available even on an "on call" basis. Less than 40% of the jails reported any access to dental services.

At the national level, discussion about prison reform got a jump start after a U.S. District Court in 1972 found that the entire state prison system in Alabama violated constitutional rights so severely that it was placed under injunction and the Court demanded immediate remedies. Inmate rights to medical care were among the issues in Newman v Alabama, and cost considerations were not a reason to fail to

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22 Anno, pgs 10, 15
23 Anno, pg 12
provide care. Instances of medical neglect were so egregious, the court said, they "shocked the conscience of reasonably civilized people".  

Anno describes several other court cases following Newman that resulted in specific rights for inmates, including the right to personal hygiene habits and the products necessary to allow them (Holt v Hutto, 1973; adequate and sanitary living conditions (Gates v Collier, 1970); adequate drinking water and diet and food preparations in sanitary kitchens (Holt v Hutto, 1973); access to competent medical and dental care (Finney v Board of Corrections, 1974); access to detox or drug treatment (Wayne County Inmates v Lucas, 1974); use of exercise and recreational areas (Rhem v Malcolm, 1974).

**Constitutional challenges and “deliberate indifference”**

All those successful legal challenges set the groundwork for the landmark Supreme Court decision in the Texas case Estelle v Gamble in 1976, which established that governments have an obligation to provide medical care to those who are incarcerated and unable to obtain it for themselves. The Court said failure to do so violates inmates' constitutional rights not to suffer from cruel or unusual punishment (Eighth Amendment). The court concluded that the Eighth Amendment is violated by a jail official who shows "deliberate indifference (to an inmate's) serious medical needs."

The court said: "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met . . . denial of medical care may result in pain and suffering which no one suggest would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency."

The American Nursing Association's Corrections Nursing Handbook describes the three tests that further define deliberate indifference:

1. prison medical staff who ignore inmates' medical needs,
2. correctional staff who intentionally deny or delay access to medical care, or
3. correctional staff who intentionally interfere with treatment that has been prescribed.

Insufficient resources are not a reason to avoid meeting those three basic rights. This legal liability extends to anyone employed by the jail, including privately contracted medical or health care services.

Deliberate indifference is considered more than just negligence; a jail administrator must know that an inmate has a serious medical need and fail to take reasonable steps to deal with it. Subsequent court decisions have defined serious medical need as "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." [Farrow v West, 320 F3d 1235, 1243 (11th Circuit Court), 2003].

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24 Anno, pg 46
25 Estelle v Gamble, 429 U.S. 97, 1976
However, courts have allowed broad medical discretion. In a 1977 case, judges said the Eighth Amendment does not require courts or prison officials to resolve professional differences (between practitioners in the medical field) about the best choice of treatment.

Anno’s history of correctional healthcare concludes that by the mid-1970s, the thinking of national correctional experts moved in the direction that improving physical conditions within the facilities - including attending to the inmates' medical needs – contributed to a happier, healthier population and helped improve security in jails and prisons.

In 1975, the federal Law Enforcement Assistance Administration provided a grant to the American Medical Association intended to upgrade correctional care by developing a model health care delivery system for inmates. The guidelines were developed within a testing ground of six major correctional facilities and were reviewed by dozens of other correctional experts and associations. Results were quickly implemented in correctional settings nationwide.

By the end of the 1970s, manuals for running prisons and jails published by the U.S. Bureau of Prisons, the National Sheriffs Association and the American Correctional Association all referenced both the legal responsibility and administrative benefits (security and keeping order) of providing medical care to inmates.

**Jails and prisons’ potential role in disease prevention**

Before the rapid increase in health care costs during the 1990s, and as prison and jail populations shrank, correctional healthcare had evolved to embrace an important concept in the public health world: recognizing that disease prevention practices should apply to correctional facilities if for no other reason that when acute and chronic illness are not treated in jails, society at large often pays the price -- by design (a limit of a year's sentence) jail inmates go back to their families and communities and bring untreated diseases and conditions with them.

An example of applying this community disease prevention to current practices can be found in the Hampden (Massachusetts) County Jail, which was recognized in 2002 with the Innovations in American Government award from the Kennedy School of Government at Harvard University.

The Robert Wood Johnson Foundation, in particular, has funded community-oriented corrections healthcare pilot projects that infuse more intense care and educational practices in jails to counteract inmates' long histories of ignoring their healthcare needs.

Clearly, this degree of healthcare goes well beyond the standards and common practices that resulted from *Estelle v Gamble* and are further challenged by today's new normal economic conditions.

*These organizations and sources were consulted for information for this section: the National Commission on Correctional Health Care, the American Correctional Association, the American Nursing Association, the American Public Health Association, the American Medical Association, National Bureau of Justice Assistance, the National Institute of Corrections (US Dept of Justice), the American Correctional Health Services Association, the Academy of Correctional Health Professionals, the Robert Wood Johnson Foundation, the RAND Corporation, the Pew Center on the States, the Center for American Progress, the International City/County Managers Association, the National Association of Counties, the National Sheriffs Association, the National League of Cities, the National Conference of State Legislatures, the Council of State Governments, and several national periodicals.*
Appendix B – Project Scope

Project Scope: Correctional Nursing Services Options
Prepared by: Jane Vanderpoel, Office of Planning and Analysis
Date: September 2011

Background:
County jail administrators are required by state law and administrative rules to provide (or provide access to) medical services for inmates who cannot pursue medical services independently because they are compelled to remain within the jail. Medical services is a broad term that includes care of physical and mental health conditions, chemical dependency assessments and treatment, coordination of care that could include hospitalization/clinic/diagnostic tests, dental care, dispensing medications, and coordination of care needed when inmates are released from the facility.

As jail budgets across Minnesota have tightened and health care costs continue to escalate sharply, jail administrators in many counties are re-examining costs for inmates’ medical care, including on-site nursing services. Several counties have recently switched from using county staff for nursing services to contracting with an agency. This subject has been a topic of frequent discussion among the correctional health members of the Minnesota Sheriffs Association over the last two years, with a primary focus on the lack of definition of what level of care, or quality of care, is required. A workgroup sponsored by the state Department of Health addressed these issues and released a report in 2007. In addition, a coalition of 10 counties in southeastern Minnesota, including Dakota County, is separately examining a broad spectrum of cost-drivers at county jails with the goal of collaborating to cut costs, including costs for medical and health-related services.

In Dakota County nursing services have been provided at the jail by the county Public Health department nurses since the early 2000s. Nurses provide both acute and non-acute care to inmates who arrive at the jail with medical needs, ranging from care of minor injuries and ailments to acute care such as withdrawal from alcohol and other drugs, or assessments to determine the need for emergent care off-site. Because many inmates have chronic health conditions that require prescription medications, nursing staff also order and dispense medications. Nurses conduct screening/interviews whenever new inmates are brought to the jail, and often consult with physicians on medication/treatment plans. Many inmates arrive at the jail lacking health insurance and with alcohol/drug dependency and mental health issues. Those and cardiovascular problems and diabetes are the most common medical conditions among the Jail’s inmates.

Nursing services that are provided at the Dakota County jail comprise only a fraction of the total services and cost of health care for jail inmates. In 2011, $445,000 will be transferred from the Sheriff’s Office budget to Public Health to offset these costs, an amount that equals about one-third of total medical costs for the jail.

With this amount, a combination of full-time and part-time Public Health nurses provide on-site coverage at the jail for 80 hours (16 hrs/day) Monday-Friday and for 8 hrs/day on weekend days, for a total of 96 hours weekly. The Public Health budget pays for increasing overtime costs for its staff at the jail, and for on-site nursing coverage provided by a temp agency to fill in when public health nurses are unavailable within those 96 hours. The Public Health budget also pays for correctional nursing services that are not covered by the $445,000, including a fulltime medical assistant, a nursing supervisor, and part-time administrative/clerical support.

However, the $445,000 is insufficient to pay for round-the-clock on-site nursing coverage every day of the week, a coverage level that the Sheriff’s Office would like to reach.
**Project Purpose:**
The most recent Public Health department goals document show this statement and strategy:

**Issue:** The number of inmates entering the jail with serious mental health issues and complex physical health problems is increasing, and providing proper care and treatment puts stress on the current staffing model in the Correctional Health Unit. In addition, it is increasingly difficult to recruit nurses to maintain an adequate staffing level in the Jail.

**Strategy:** In order to determine a sustainable model for assuring inmate health, Public Health staff will continue to work with staff from OPA and the Sheriff's Office to analyze the current model of delivering health care to inmates. The study is expected to conclude in first quarter 2012 and will compare the current model with alternative models to identify the best practice, programmatic and cost framework to provide quality health care in the jail.

This project includes identifying a range of options for nursing care at the jail that provides the desired daily shift coverage at the lowest possible cost, while maintaining (or improving) current service and quality of care. The options will include an analysis of the current arrangement (including nursing services “bought” by the annual budget transfer from Public Health to the Sheriff as well as services that the Public Health budget pays directly), and services provided entirely by contracting with a private firm, or a blend of both private and public services.

**Project Sponsors:**
Public Health Director Bonnie Brueshoff, Chief Deputy Tim Leslie
Project coordinators: Wendy Bauman, Deputy Public Health Director.
    Cmdr. John Grant, Jail Administrator

**Expected Audience:**
County Sheriff David Bellows
County Administrator Brandt Richardson
Community Services Division Director Kelly Harder
County Financial Services Director Matt Smith

**Methodology:**
- Define the range of services currently performed by nurses at the jail;
- Define the legal or statutory standard of care for nursing services provided to county jail inmates, and assess Dakota County’s current capacity to meet the standards;
- Research national and state standards or best practices for on-site nursing services in local jails and compare Dakota County’s current services to these standards or best practices;
- Consider potential benefits and costs of alternative service arrangements, such as changes in service options, coverage, and costs, by benchmarking to identify:
  - staffing models used at other jails;
  - description/inventory of nursing services provided at other jails; and
  - contract arrangements for nursing services at other jails
- Present options for consideration that include comparison of benefits and drawbacks to each type of arrangement in the areas of services provided/quality of care, coverage, and costs.

**Staff:** Jane Vanderpoel, management analyst, Office of Planning and Analysis
### Appendix C - Nursing duties chart

**Legend:**
- P = Phone or e-mail
- S = Support from other (internal/external)
- L = Loop report
- D = Document
- O = Order
- C = Coordination
- M = Model
- N = Note
- K = Knowledge
- D = Decision
- A = Action
- S = Support from other (internal/external)
- L = Loop report
- D = Document
- O = Order
- C = Coordination
- M = Model
- N = Note
- K = Knowledge
- D = Decision
- A = Action

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<td>Phone or e-mail</td>
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<tr>
<td>Nurse 2</td>
<td>Monitor vital signs</td>
<td>Support from other (internal/external)</td>
<td>S</td>
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<td>Nurse 3</td>
<td>Administer medications</td>
<td>Loop report</td>
<td>L</td>
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<tr>
<td>Nurse 4</td>
<td>Change dressings</td>
<td>Document</td>
<td>D</td>
</tr>
<tr>
<td>Nurse 5</td>
<td>Assess patient's response to treatment</td>
<td>Order</td>
<td>O</td>
</tr>
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**Notes:**
- All tasks are performed by the respective nurse.
- The order is to sequence the tasks accordingly.
- Support is provided as needed by other nursing staff.
- Documentation is essential for patient care.

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**Appendix C - Nursing duties chart**

**11/2011**

**Nurse Unit Study***

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**Corrections:**

Correction process where minor changes are made. Any changes made in the document will be noted to be tracked.
Correctional Nursing and Health Care Costs

February 2012

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[Text continues on page]
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<td>2/11/12</td>
<td>Medications were transferred from one hospital to another for patient with same admitting diagnosis. Medications were transferred to the receiving hospital.</td>
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<tr>
<td>2/11/12</td>
<td>Medications were transferred from one hospital to another for patient with same admitting diagnosis. Medications were transferred to the receiving hospital.</td>
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**Note:** All medications listed above are scheduled to be transferred to the receiving hospital on 2/11/12.
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**Definition:**

- Meds: Medication Administration

**Notes:**

- Days should not be double counted for the medicated short, verbalized, and placed.
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**Response:**

- Nurse passes medications 3 times daily, using a pre-stocked med cart taken
Additional Notes:

1. All risk working at the jail must have 30 hours of associate degree from accredited school.

2. A list of and instructions of duties/tasks for this job vary depending on the role.

3. The type of incentives of duties/tasks for this job vary depending on the role.

4. Things reported are not many (except food and release) inmates have health issues.

5. If something is not correct within the medical unit, inmate gets the correct treatment.

6. There are no outpatient visits to the jail.

7. Things need to be done.

8. This happens after, can happen up to 15 days after.

9. Outside security (hearing) is necessary.

10. Inmates who are treated in the jail


12. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

13. Timeframe needed to be received by one nurse. There are no outpatient visits in the jail.

14. This happens after, can happen up to 15 days after.

15. Outside security (hearing) is necessary.

16. Inmates who are treated in the jail

17. Nurse intervention.

18. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

19. Timeframe needed to be received by one nurse. There are no outpatient visits in the jail.

20. This happens after, can happen up to 15 days after.

21. Outside security (hearing) is necessary.

22. Inmates who are treated in the jail


24. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

25. Timeframe needed to be received by one nurse. There are no outpatient visits in the jail.

26. This happens after, can happen up to 15 days after.

27. Outside security (hearing) is necessary.

28. Inmates who are treated in the jail


30. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

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44. This happens after, can happen up to 15 days after.

45. Outside security (hearing) is necessary.

46. Inmates who are treated in the jail

47. Nurse intervention.

48. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

49. Timeframe needed to be received by one nurse. There are no outpatient visits in the jail.

50. This happens after, can happen up to 15 days after.

51. Outside security (hearing) is necessary.

52. Inmates who are treated in the jail

53. Nurse intervention.

54. Time to recover and more than one nurse. The nurse reports the complaint in our time frame.

55. Timeframe needed to be received by one nurse. There are no outpatient visits in the jail.

56. This happens after, can happen up to 15 days after.

57. Outside security (hearing) is necessary.

58. Inmates who are treated in the jail

59. Nurse intervention.
Appendix D – Benchmarking Questionnaire

Date: December 2011
To: County Jail administrators or correctional nursing services managers
From: Jane Vanderpoel (651-438-4423), management analyst, Dakota County Office of Planning and Analysis (email: jane.vanderpoel@co.dakota.mn.us)
Subject: Benchmarking – Correctional Nursing Project

Greetings! Staff in the Dakota County Office of Planning and Analysis are conducting a cost/benefit analysis project concerning correctional nursing costs in our County Law Enforcement Center (Jail).

As you’re aware, costs related to medical/health care for inmates are increasing rapidly in most county jails. In an effort to contain those costs, many jail administrators are considering new ways to provide correctional nursing services, including contracting with private companies.

Among our project objectives is to benchmark with other counties to compare how and to what extent correctional nursing services are provided in other counties. In our case, County public health nurses (a mix of full-time and part-time RNs and a medical assistant) provide correctional nursing coverage for 96 hours weekly (many of them with two staff present) in Dakota County’s jail. An offset from the Sheriff’s budget pays for most of the services provided, but it is not enough for the round-the-clock presence the Sheriff desires.

We seek to collect answers to the list of questions in this memo for the benchmarking part of this project. Thanks in advance for spending your valuable time on this and for sharing your expertise!

Jail Statistics
1. # beds, average daily population (this is to calculate the ratio of medical staff/inmate)

2. In your estimation (unless you have data), what % of your inmates who are booked into the jail require or seek some sort of medical attention during their stay in the jail?

3. What are your total annual (2011) costs for medical/health related care for inmates? (please include the cost of the contract and expenses not covered by it, including medical director, staff who provide onsite care, transport and treatment for emergency care, Xrays and lab work, prescriptions and over-the-counter medications, dental, mental health and support functions)
Staffing Model

4. What sort of training/education/certification do those doing correctional nursing at your jail have (RNs, LPNs, paramedics, nursing assistants, medical assistants, etc)?

5. Do you have a presence in your jail (for correctional health services) around the clock? Do you think that much coverage is needed?

6. How many hours in a week are covered by at least one on-site medical professional (as defined in question 4 above)? How many total hours per week are provided? (Note: you can just attach a staffing schedule and leave the math to the Dakota County staff, if that’s easier!)

Services provided

7. What type of condition is most commonly or typically treated (i.e. what medical complaints do the inmates present to staff? - cold/flu, wound care, manage diabetes or high blood pressure, mental health, substance abuse, others)

8. Does your jail include an in-house clinic (office space)? How many exam rooms or beds are in it?

9. Do you operate an in-house clinic (when inmates can see doctors, dentists, psychiatrists, etc within the jail), or do you always transport inmates outside the jail to the community for any sort of care they need?

10. If you use a contract service, does the contract pay for and include inmate access to “extra” costs associated w/nursing care such as trips to a hospital or outside clinic, Xrays and other diagnostic tests, lab work, prescriptions, medical equipment (syringes, crutches, etc)?

11. Please describe the approach to managing mental health issues and substance abuse issues.

12. During hours when no medical staff are available on-site, who handles medical issues? Who dispenses medications?

13. Do you charge inmates for a portion of their healthcare-related expenses, including off-site care, prescriptions or OTC meds?

Administrative/Support

14. How are medical records and other case documentation managed? What software do you use, if any? Who maintains the medical records (filing, organizing, updating, etc)?

15. If you use a contract to provide health care services, does anyone on the county payroll (public health RN, jail administrator) supervise the contracted staff? If not, how is your professional services contract managed?

16. No matter whose payroll the nursing staff are on (i.e. public vs contracted), does anyone in the jail have the authority to question professional judgement or discuss professional behavior?
17. Who handles billing for medical services provided to inmates? Who orders supplies of medications and does billing for prescriptions, medical supplies and equipment?

18. Is there any other administrative support provided for the correctional healthcare functions by county staff, such as clerical support?

19. If your correctional health care services are provided by county employees, are they employees of the Sheriff’s Office or some other department?

20. Do you do any sort of outcome measurement for correctional health care services?

**General, broader questions**
- How do you know that the healthcare service delivery model that you use is meeting the needs of your jail population? In other words, how do you know if you are providing too much or too little?

- Do you know of any correctional nursing best practices or suggested standards of care that you think should be followed – and if so, would you share them with us?

- If you have switched from county staff to contracted services in the last three years:
  - what are the positives of this arrangement?
  - what concerns do you have about the new model, if any?
  - would you consider it to have been successful?
  - why did you make the switch?
  - did you conduct any sort of cost/benefit analysis to help with the decision-making and if so, would you share it with us?

Thanks very much for your help!