Use of EHRs is an important innovation for patients in jails and prisons. Efforts to incentivize health information technology, including Medicaid EHR Incentive Program, are generally aimed at community providers; however, recent regulation changes allow participation of jail health providers. In the New York City jail system, the Department of Health and Mental Hygiene oversees care delivery and was able to participate in and earn incentives through the Medicaid EHR Incentive Program. Despite the challenges of this program and other health information innovations, participation by correctional health services can generate financial assistance and useful frameworks to guide these efforts. Policymakers will need to consider specific challenges of implementing these programs in correctional settings.

**KEY FINDINGS**

- Use of health information technology, including the meaningful use of electronic health records, in jail health systems enhances their ability to deliver coordinated, quality care to a difficult-to-treat patient population in a challenging setting.
- Participation by correctional settings in these programs can generate financial assistance and useful frameworks to guide these efforts, but lawmakers will need to consider specific challenges of implementing these programs in correctional settings.

**INTEGRATION OF ELECTRONIC HEALTH RECORD**

EHRs have been adopted, implemented, or upgraded to a certified version of an EHR in a manner that meets the goals of the program. These payments are delivered as providers demonstrate compliance with specific measures along 3 progressive stages. The first stage focuses on data capturing and sharing, the second on developing advanced clinical processes, and the third and final stage focuses on improving outcomes.

In jails and prisons, adoption of EHRs has mirrored that of community providers, with large systems making headway before smaller ones. Challenges to EHR adoption in correctional settings include the wide spectrum of care delivered, as well as reluctance to develop new health information infrastructure that may be perceived as contributing to legal liability. In the New York City jail system, the Department of Health and Mental Hygiene is responsible for the provision of health services. From 2008 to 2011, DOHMH implemented the eClinicalWorks EHR system across a health system that spans 12 jails and provides approximately 75,000 annual medical and mental health encounters to an average daily population of approximately 11,000 people.

This product has been modified to comply with regulations and that they are using their EHRs in a manner that meets the goals of the program. These payments are delivered as providers demonstrate compliance with specific measures along 3 progressive stages. The first stage focuses on data capturing and sharing, the second on developing advanced clinical processes, and the third and final stage focuses on improving outcomes.

In jails and prisons, adoption of EHRs has mirrored that of community providers, with large systems making headway before smaller ones. Challenges to EHR adoption in correctional settings include the wide spectrum of care delivered, as well as reluctance to develop new health information infrastructure that may be perceived as contributing to legal liability. In the New York City jail system, the Department of Health and Mental Hygiene is responsible for the provision of health services. From 2008 to 2011, DOHMH implemented the eClinicalWorks EHR system across a health system that spans 12 jails and provides approximately 75,000 annual medical and mental health encounters to an average daily population of approximately 11,000 people.

This product has been modified extensively to reflect the triple aims of our health system: patient safety, population health, and human rights. After a September 2012 regulatory amendment effectively allowed providers practicing in correctional health settings to become eligible, we decided to pursue certification and payments. (This regulation changed the definition of a Medicaid provider so that services rendered to individuals enrolled in a Medicaid program, regardless of whether public insurance was billed for the service, could count toward proof of providing care to a minimum Medicaid patient population of 30%.)

**INITIAL PHASE**

Participation in the MU program is voluntary, but limited to specific provider types including physicians, nurse practitioners, certified nurse midwives, and dentists. Physician assistants are also eligible, but only when they practice in a Federally Qualified Health Center that is “so led” by a physician assistant. After reviewing models in the community, we found that very few offered any incentive-sharing agreements, and those that did focused on funding continuing education. We opted for a layered gain-sharing model that featured both continuing education...
Important Features of Meaningful Use (Stages 2, 3) for Correctional Health

**e-Prescribing:** The jail houses its own pharmacy on site, so traditional e-prescribing with community-based pharmacies is not possible. We have introduced a pharmacy system with an interface with eClinicalWorks electronic health records system (eCW), which will allow prescriptions to be “generated and transmitted electronically” as defined in the measure.

**Meaningful use measure performance tracking:** Although the community version of eCW rolled out the meaningful use adoption quality dashboards used to measure and track provider compliance with meaningful use measures when it became a certified in 2011, these dashboards were not implemented in the version of eCW used in the correctional setting. We expect to implement meaningful use adoption quality dashboards in the near future.

**Providing clinical summaries for office visits:** Patients in correctional settings do not have a safe place to securely store sensitive personal health information. The realities of a correctional setting, with its heightened security measures, prohibition on contraband, and lack of dedicated personal storage space, make the distribution of confidential health information to incarcerated patients highly problematic with potentially harmful outcomes.

**Providing patients with the ability to view online, download, or transmit health information:** We would like patients to have access to their records online upon release. However, many of our patients may not have an e-mail address required for patient portal use, or, if they do, they may be unwilling to share it with jail-based staff. One alternative would be to create a patient portal and offer to send access information to patients via text message.

Use of health information technology, including the meaningful use of EHRs, in jail health systems enhances their ability to deliver coordinated, quality care to a difficult-to-treat patient population in a challenging setting. Federal and local efforts to incentivize health information technology use are generally aimed at community providers; however, recent regulation changes allow jail health services to participate in and benefit from MU participation.

Although our initial efforts have focused on stage 1, we have identified and are addressing several key aspects of stages 2 and 3 (see the box on this page). Although these stages are challenging, correctional health providers must implement health information technology systems to deliver the community standard of care to some of our nation’s sickest individuals. We have found that adoption of the EHR must be supplemented by several other health information technology innovations that allow connection of the jail health service to community health records (see the box on this page). Furthermore, formal participation in the later stages of MU will require exceptions to be made for certain patient engagement measures that cannot be met in the security setting of jail. Correctional health services and other policymakers will likely need to advocate further changes to MU to ensure that patients in these settings can benefit from wider participation.

**About the Authors**
Michelle Martelle, Nathaniel Dickey, and Homer Venters are with the Bureau of...
Community medication information from commercial pharmacies: In 2011, we started contracting with a third-party pharmacy service to allow lookup of community prescriptions filled at commercial pharmacies for every newly admitted patient. This service yields important information, but only for about 25% of our patients, as inconsistent patient demographic information remains a limitation in the correctional setting.

Medicaid claims information for behavioral health patients: Starting in 2013, with a patient’s consent, we can access the Psychiatric Services and Clinical Knowledge Enhancement System, a Medicaid data warehouse that includes all claims information (both medical and mental health) for patients who have had a substance use or mental health diagnosis, psychiatric treatment, or psychotropic medication billed to Medicaid within the past 5 years. This information is extremely detailed and appears most useful to inform treatment (and correct diagnosis) of behavioral health concerns for patients in jail.

Community health information through a regional health information organization (RHIO): During this time, we have also achieved connection between our electronic health records and an RHIO, which is slated to connect to the statewide health information system early next year. Because community health systems are only beginning to participate in this process and individual RHIOs have not been connected to one another, there is less information available via our RHIO connection than the Medicaid claims database. However, importantly, we will be sharing information about jail-based care with the RHIO, making this information available to community providers.

Health home membership and program information: A final innovation will occur when we obtain access to information about New York State Health Home program membership and participation. The health home program represents the effort of New York State to identify a high-needs subset of Medicaid recipients and provide reimbursement for coordination of their care. Knowing this information will help expand the pilot programs currently in place to coordinate care for these patients between the jail health system and their community-based health home.

Contributors
M Martelle led the conceptualization, drafting, and revision processes for this article. B Farber and R Stazesky contributed to report conceptualization and design and revised the article with critical content. H Venters was responsible for oversight on report conceptualization and design, he also drafted and revised the article with critical content.

References


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Human Participant Protection
Institutional review board approval was not needed for this study as it represents public health quality improvement processes by the Bureau of Correctional Health Services.

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