File No. 19-14

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: September 5, 2019

TO: Theodore Lipscomb, Sr., Chairman, and Milwaukee County Board of Supervisors;
Anthony Staskunas, Chair, Milwaukee County Board of Supervisors, Judiciary, Safety, and General Services Committee
James "Luigi" Schmitt, Chair, Milwaukee County Board of Supervisors, Finance & Audit Committee

FROM: Michael Hafemann, Superintendent, House of Corrections
Earnell Lucas, Sheriff
Teig Whaley-Smith, Director, Department of Administrative Services
Scott Manske, Comptroller
Margaret Daun and David Farwell, Office of Corporation Counsel

SUBJECT: Correctional Health Care Self Operation (CHCSO) Project Phase I: Self-Operation Analysis Final Report

I. Summary

The humane and ethical treatment of those under the custody of Milwaukee County is our critical responsibility to the community. Experts advised Milwaukee County that any model for the provision of correctional health care (i.e. self-operation, third-party contract model, public-public or public-private partnerships, or a hybrid model) can be successful and result in cost-effective, high-quality care outcomes, if managed well. File 18-898 requested the development of a model for self-operation of correctional health care. For the last 9 months, a project team that includes internal and external stakeholders has developed the attached model, entitled Correctional Heath Care Self-Operation Analysis: Milwaukee County Jail and House of Correction ("CHCSO Analysis").

Conservatively, the Self-Operation Model would cost an additional $7.8 - $10.3 million in total over the next two years, and an additional $2.4 - $4.5 million per year for each year thereafter (see Section III – Budgetary Costs), but potentially more. This cost represents an increase from the current annual expenditure level of approximately $21.9 million, for total annual expenditures of $26.6 - $30.6 million for each of the next two years and approximately $25.9 - $28.0 million for each year thereafter (see infra

p.5). In addition to these costs, there are significant risks that also would be assumed by the County (see Section V – Risks). Experts advised that the risks may result in higher costs and/or negatively impact patient care, and the County acknowledges that every effort must be made to control costs and reduce or eliminate these risks, to ensure that County patients are provided quality health care.

Given the significant additional costs and risks, the Self-Operation Model is not recommended at this time. Instead, we recommend that the County focus on providing the highest quality health care possible to patients in our custody by:

(a) focusing on the quality of care as the primary policy goal, establishing a process for measuring that quality of care, and ensuring a standard is met,

(b) continuing third-party monitoring of the correctional health care contract, and

(c) reclassifying the special project manager position to a contract manager to continue to coordinate communication, problem solving, and continuous improvement among internal and external stakeholders.

Any decision the County makes should focus on the human lives in our care and custody. We must work together with diligence and empathy to find the best solution for our constituents and our patients – one that provides the highest standard of care in the most cost-conscious manner possible.

II. Background

On December 6, 2018, the Milwaukee County Board of Supervisors passed Resolution 18-898, stating "the Milwaukee County Board of Supervisors reaffirms and recommends that inmate medical services be directly provided by Milwaukee County, rather than a private vendor." Milwaukee County currently contracts for correctional health care services for incarcerated patients housed in the Milwaukee County Jail (MCJ) and the House of Correction (HOC). The evaluation of requirements for, and a plan for implementation of, self-operation of correctional medical care is identified in Resolution 18-898 as the responsibility of the House of Corrections, the Office of the Sheriff, the Office of Corporation Counsel, the Office of the Comptroller, and the Department of Administrative Services.

The self-operation of correctional health care is a complicated matter, especially in light of the County's history of self-operation, which resulted in the Christensen Consent Decree. In 1996, Milton Christensen filed a complaint alleging that conditions in the Milwaukee County Jail were unconstitutional. The lawsuit became a class action lawsuit, with the ACLU and the Legal Aid Society of Milwaukee representing plaintiffs. In 2001, the Circuit Court approved a negotiated settlement ("Christensen Consent

Decree") that initially resolved the litigation. It is a complex, forty-eight (48) page document containing myriad provisions. During a period of self-operation, the County was found in contempt of the Consent Decree in 2004. Later, in 2013, Plaintiffs returned to court and alleged that during this period of County self-operation, the provision of mental health care, dental care, and health care generally was deficient. In particular, Plaintiffs alleged there were inadequate numbers of appropriately trained personnel, and that the classification, housing, and treatment of inmates was deficient. Some inmates were not provided access to psychiatrists, dentists, or physicians; others were not provided appropriate medication. In response, the court issued an Order, mandating that the County enter into a contract with a third-party health care vendor in 2013.[1] An independent court monitor was assigned to monitor the enforcement of the Consent Decree ("Court Monitor"). The contractor selected at the time was Armor Correctional Health Services, Inc. ("Armor").

In 2016, the Court Monitor found that "more than 30% of the total required positions [were vacant, and] ... providing reasonable quality services in a timely fashion is extremely problematic when such a high vacancy rate exists."[2] Concurrent with this report, there were 4 deaths of people under the custody of Milwaukee County.[3] Consequently, Milwaukee County requested an audit of medical care at Milwaukee County correctional facilities.

In August of 2018, the Milwaukee County Audit was completed.[4] The audit recommended:

1. HOC management should examine whether existing contract penalties and withholdings are adequate, since Armor never achieved minimum staffing levels during the review period.

2. The HOC should explore hiring a contract manager with clinical expertise or contract out for management of the contract, which would lead to better enforcement of contract provisions and medical expertise on staff at the HOC.

3. Suggested contract modifications include: Require staffing plans and deployment by facility; Clarify the Peer Review requirement; Define Continuation of Care

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[1] For a detailed summary of the legal background, please see January 22, 2019 Inmate Medical Services Report Summary, available at https://milwaukeecounty.legistar.com/View.ashx?M=F&ID=6998016&GUID=13D2A3CE-3138-4CD2-835F-4C21219F9A4C (County Board File 19-14).

[2] Report on Settlement Agreement in the Christensen Case (May 16-20, 2016), available at https://www.documentcloud.org/documents/3191198-Ronald-Shansky-Inspection-Report.html

[3] "Milwaukee County to Audit Medical care in jails after 4 deaths," MJS (12-2-16), available at https://www.jsonline.com/story/news/investigations/2016/12/02/county-audit-medical-care-provider-jails-after-4-deaths/94692626/.

[4] Milwaukee County Office of the Comptroller, Audit Services Division. "Improved Staffing Levels from Armor, Assignment of a Contract Manager with Clinical Expertise along with Contract Revisions would improve inmate medical services," (Aug. 2018), available at https://county.milwaukee.gov/files/county/comptroller/Audit/Audit-Reports1/2018/InmateMedicalServicesReportORIGINAL.pdf

guidelines; Standardize the audit clause; Explore a required minimum staffing level in the booking area; Clarify the Formulary language; Require Armor to report paid time off and overtime on invoices; Require Armor to submit segregated invoices for Pharmacy and Specialty Services; HOC management should perform spot checks on Armor invoices and periodically review check signers and signatures.

In 2019, the County entered into a contract with a new medical services provider. The Correctional Medical Services Contract was the result of an RFP for Correctional Medical Services, which included the recommendations of the 2018 audit. The RFP team's focus included improving care outcomes for our patient population by working with the National Commission on Correctional Health Care's consulting arm, NCCHC Resources, Inc. The team sought advice from NRI regarding best practices in health care and identified areas of deficiency in the services provided between 2013 and 2019. The team considered the particular types of health issues seen in our patient population, emerging public health issues such as the opioid crisis, and methods to continuously improve care outcomes for our patients. In addition, the team focused on local and nation-wide concerns about the provision of correctional health care and made every effort to include oversight and control in the contractual relationship, so that the County would never again need to face the terrible tragedies resulting from poor care outcomes that have been reported in the news.

Concurrently, the County Board passed Resolution 18-898, stating "the Milwaukee County Board of Supervisors reaffirms and recommends that inmate medical services be directly provided by Milwaukee County, rather than a private vendor." Subsequently, the County created a project team to develop a model for Self-Operation of Correctional Health Care. This team consulted and received feedback from many areas of the County. Of particular value was the participation of the County's Behavioral Health Division, which advised from its experience on best methods to improve health care outcomes in a government-run facility.

The project team presented informational updates and action requests to the Judiciary, Safety, and General Services Committee of the Milwaukee County Board of Supervisors at the following meetings: January 24, 2019 (Item 19-14); March 7, 2019 (Item 19-14, referred to Special Session March 19 for further action); March 19, 2019 Special Session (Item 19-14); April 11, 2019 (Item 19-14); May 9, 2019 (Items 19-454 and 19-14); June 6, 2019 (Item 19-14); July 11, 2019 (Item 19-14).

The project team also presented informational items related to this project to the Finance & Audit Committee of the Milwaukee County Board of Supervisors at the following meetings: February 1, 2019 (Item 19-14); March 14, 2019 (Item 19-14); May 16, 2019 (Item 19-14); July 18, 2019 (Item 19-14).

The reports referenced above are not duplicated in this report.

III. Budgetary Costs

The total costs for self-operation are presented in the table below and include staffing, risk and insurance, equipment and supplies, third party contracts, offsite care costs, pharmaceutical costs, and facilities and IT costs. The Project Team's calculations suggest that self-operation will result in a net increase in costs to the County in the following ranges:

	2020	2021	2022 –
Current Outsourcing Cost	$ 21,959,207	$ 22,527,918	$ 23,230,490
Self-Operation Estimated Cost	$ 26,632,329 to $ 27,142,243	$ 28,796,467 to $ 30,661,590	$25,974,587 to $28,051,592
Self-Operation Cost Differential *(increase in cost required to self-operate)*	**($4,598,190) to ($5,108,104)**	**($6,031,572) to ($7,896,695)**	**($2,626,232) to ($4,703,236)**

Detailed cost breakdowns are provided in the complete CHCSO Analysis.

In summary, these cost estimates ***include*** the following elements:

- Labor costs based upon BHD-equivalent positions and adjusted for CPI and assumed potential hiring bonuses;
- LMS-based personnel training;
- IT systems training;
- Office support and supplies;
- Pharmaceutical and off-site care cost estimates;
- Facilities and space planning estimates;
- IT and technical infrastructure build-out costs;
- Approximately $955,000 is assumed in increased cost each year for medical malpractice, cyber liability, and worker's compensation claims (covering premiums, deductibles, damages, attorney's fees, claim payouts, and claim management);
- $1.3 million is assumed in increased cost each year for general liability and damages, such as §1983 civil rights claims (covering premiums, deductibles, damages, attorney's fees, claim payouts, and claim management)[5]

[5] Milwaukee County's policy with WCMIC carries a $10 million dollar per claim liability limit. There is potential Milwaukee County may pay more than the $3 million dollar deductible in a policy year if there is a particularly unfavorable jury award or settlement over $10 million dollars in a single claim within that policy year.

Inversely, these cost estimates ***do not include*** the following elements:

- Persistent potential labor cost premiums for correctional health care;
- Overtime, turnover, and temporary workers;
- Specialized in-person training, if necessary;
- Staffing-up costs;
- Transition costs if the Wellpath contract needs to be extended due to court order or by practical necessity to move to self-operation; and
- Acute bad event costs (see below).

In addition, below find additional background on certain estimates:

- ***Cost estimate ranges and labor market risks***. The lower number in the cost estimates uses the midpoint of each salary range for medical personnel currently employed at the County's Behavioral Health Division, and does not include overtime costs, turnover, temporary worker costs, nor any premium that may be necessary to recruit individuals to work in a jail or correctional environment. The higher number in the cost estimates uses the top of each pay range for BHD medical personnel. The range methodology was used due to the difficulty of estimating overtime, turnover, temporary worker, recruitment premium, additional training, and wage premium costs, which are likely to be required (see section V on Labor Market Risks below). Current County staff would require expert assistance to provide these estimates, but they likely could be obtained, if desired. Expert assistance, such as an economist, should be obtained if these estimates are requested.

- ***Staffing up while contract is in place means 2020 and Q1 2021 costs will increase***. Self-operation costs in 2020 and Q1 2021 include the continuing Wellpath contract and NRI contract, due to the nature of the transition period. Therefore, in 2021, the County must budget for both self-operation staff for nearly the entire year and the final three months of Wellpath's contract, which terminates in April of 2021. These three months of service from Wellpath will cost approximately $5.2 million, not including additional off-site care and pharmacy costs.

- ***Transition costs are not included.*** Because Milwaukee County is under a Court Order that requires it to continue contracting for correctional health services, any transition would need to be approved by the Court. The transition date is contemplated to be April 1, 2021. If the Court does not approve the transition, the ongoing additional monthly cost would be approximately $1.7 million per month to retain Wellpath's services until the Court approves the transition, or the self-operation model is abandoned. This estimated monthly value for each month of continued Wellpath service does not include pharmacy or outside care costs, which are billed separately against cost caps for

auditability and cost sharing, and which are not included in Wellpath's monthly fee.

- ***Acute bad event costs are not included.*** Given Labor Market Risks (see section V below), it is possible that outcomes and patient care might not improve over current levels in a self-operational model, and it is also possible that outcomes and care could worsen. This will create acute bad event litigation risk and damages exposures that potentially are greater than recently-experienced levels. Regardless, litigation risk can never be reduced to zero, and in a self-operation model, the County will be the only potential party subject to suit and will therefore bear all costs related to any lawsuits.

IV. EFFICACY AND SUCCESS OF PRESENT MODEL

It is important to note in assessing the data provided above that any model for the provision of correctional health care can be successful and result in cost-effective, high-quality care outcomes, if managed well. Management is key in providing quality services to our patients. It cannot be stressed enough that the human element of care provision is one of the most vital. Patient care can be difficult in any environment, and every effort to support staff and provide quality training, access to resources, and continuous feedback and improvement projects should be made. Experience in providing these types of services can make the difference between a good and a bad outcome for a patient. Our patients often come to us at difficult times in their lives, and have not always received the best possible care. Our focus must remain an attempt to reduce or eliminate the impact that incarceration may have on their mental and physical health, while also attempting to provide care that will leave them ready to flourish upon release from our custody.

Beginning in April of 2019, the County transitioned to a new third-party vendor for the provision of correctional health care. As part of the transition, the County has also increased its efforts to monitor and oversee the contract. The following actions have been taken, with positive results:

1. Introduction of a Contract Monitor. The County's third-party Contract Monitor, NCCHC Resources, Inc., provides monthly reporting on the clinical and fiscal success of the vendor under its contract. This review includes patient chart reviews, utilization management, and an emphasis on compliance with NCCHC standards and the requirements of the Court Monitor under the Christensen Consent Decree. The monthly reports allow the County to identify areas for improvement and act quickly to correct any deficiencies that arise.

2. Quarterly CQI Meetings. Representatives from the HOC, MCSO, and Procurement participate in the current vendor's quarterly Continuous Quality Improvement meetings. The last meeting included the Regional Director of Nursing, Regional Manager, and the County's dedicated Health Services Administrator, Director of Nursing, CQI Nurse, and Medical Director. These meetings discuss areas of contract non-compliance, raise concerns regarding patient trends or issues, address procedural or facilities difficulties, and provide insight into corrective action plans in place to address any issues.

3. Staffing Levels. While use of temporary staff continues, the third-party vendor has successfully staffed the Chief Psychiatrist role through use of a locum, and has achieved 100% fill of roles in the mental health area. Ongoing work to improve staffing levels continues to increase the quality of care provided to our patients.

V. RISKS & COST CONCERNS

The Project Team's results indicate that it is possible for Milwaukee County to self-operate the correctional health care function, if the County is willing to invest the additional funds necessary. However, the Project Team remains concerned about several areas of risk not directly related to baseline cost estimates. These areas should be considered when determining whether to transition to a self-operated model of care.

1. Labor Market Risk. Self-operation requires that the organization be staffed appropriately. There are significant and numerous labor market risks that negatively impact the County's ability to self-operate.

    a. The labor market for health care is national. Nurses and doctors are highly mobile and can demand premium wages. Wages in Milwaukee are low (and lower still at Milwaukee County) compared to other large markets that pay wage premiums well in excess of cost of living adjustments due to high demand (e.g., Chicago, Minneapolis, Boston, New York City). This is anecdotally evidenced by the matriculation patterns of Marquette University's nursing graduates – the clear majority leave Wisconsin.

    b. Shortages can occur in the health care labor market (i.e., a "sticky" market) because it is time consuming for workers to obtain necessary credentials and training. This also creates significant upward pressure on wages.

c. Professionals experienced and trained in the correctional context will likely have an age-earnings profile that will create significant upward pressure on wages.

d. The positions will require at least two material upward compensating wage differentials to account for the undesirability of the workplace and the high-risk environment. Assuming the salary ranges for similar positions at the County's Behavioral Health Division can be used to estimate labor costs for the County's correctional facilities might significantly underestimate labor costs.

e. Potential applicants are likely to assume that they must reside in Milwaukee County, which could pose further challenges to recruitment.

f. Civil service rules will slow down the ability to make timely job offers in a competitive market.

g. The County's outdated compensation system and stagnant wages will limit the pool of applicants interested in working for the County. The County's inability to quickly change salary ranges will also slow down the ability to respond to labor market shortages.

h. The County's non-portable retirement benefits may also limit the pool of interested applicants.

Given the foregoing, existing recruitment, compensation, and retention tools may prove to be inadequate to draw the necessary talent in Correctional Health Care.

If the County is unable to fill and keep filled the necessary positions with appropriately qualified and trained employees, inadequate staffing will result, and doctors and nurses will face increasing workloads and higher stress, and potentially mandatory overtime. This will necessarily create significant risks to the quality of care and outcomes. Separately, the above labor market risk factors may also, in general and over time, generate a lower overall quality applicant pool, which would also create outcome and care risks. Combined, these factors might lead to care and outcomes that do not materially exceed current levels and in a worst-case scenario, could lead to patient care and outcomes below current levels, potentially at cost levels that greatly exceed the estimates included in this report. In addition, the labor cost estimates in this report do not include turnover, overtime, recruitment, or training costs.

While government traditionally excels at "doing more with less," health care is a human-driven industry. Doctors and nurses who are stressed or overworked may

not provide the same quality care as those who are rested and stress-free. Because of this human element, provision of constitutionally-mandated health care is not a function susceptible to infinite efficiencies and as explained above, self-operation could lead to significantly higher costs. To provide the highest quality care to our patients, it is important we acknowledge these significant labor market risks, the potentially harmful results that may occur from chronic understaffing,[6] and candidly assess the approach that is mostly likely to best address labor market challenges and mitigate these risks. Human life must always be our priority.

2. Training and Procedures/Policy Risk. The County may not have capacity to provide the appropriate health care training. The County would need a comprehensive set of policies and procedures, and to train staff in the appropriate procedures. It is unclear whether the County has this capacity in the correctional healthcare field. Training is a vital component in providing quality health care services. Lack of training in current best practices may result in outdated treatment methods that reduce care efficiency to our patients. Training also includes use of technology systems, which are complex. Today, substantial support is required to new staff to assist them in learning how to use the electronic health record. Mistakes or confusion in using the electronic health record can have a lasting impact on a patient's health and care outcomes. Many of the policies, procedures, and trainings that an outside vendor has access to are proprietary, and the County would have to create its own from scratch. Its ability to do so and the timeframe required is unknown at this time. Certainly it is possible that the County may need to invest additional resources for training and/or procedures/policy updating beyond the cost estimates captured here.

3. Operational Infrastructure Risk. With the County's limited financial resources, it is unclear whether the County can adequately invest and maintain the operational infrastructure necessary for self-operation, which would include separately acquiring and maintaining the IT systems and equipment that is currently provided by an outside vendor. In particular, electronic health record systems are vital to the provision of quality care to patients. Good electronic health record systems can be costly to purchase and maintain. Failure to obtain a good system may mean delays in entering patient data, sharing that data with other health care providers, and using that data to ensure proper and timely care. It is important to our patients that we invest financially in the systems supporting

[6] In general, national private sector health care providers draw employees from a national market and can cross-functionally staff people, have far fewer hiring process restrictions and far fewer wage limits, thereby making contractors nimbler and more flexible in responding to overall labor market inelasticity. In general, private vendors also can respond to labor shortages more quickly than can Milwaukee County. Further, Milwaukee County can assess fines for staffing shortages and contractors share liability with Milwaukee County when acute bad events occur.

their care. As above, as technology and industry best practices evolve, it is impossible to know with specificity what the County's short, medium, and long-term total operational infrastructure investment might be.

4. Insurance Risk. Currently, a significant amount of liability is covered by the vendor's insurance. If no vendor is in place, those liabilities become the County's and may impact future premiums and insurance ratings.

5. Execution Risk. Because the County does not currently provide correctional healthcare, it does not have the experience of successes and failures that inform quality improvement. Also, if the County is only operating its own two facilities, it will not have the learning experience that someone operating multiple facilities would have. This lack of experience may hamper the County in keeping pace with beneficial changes in the industry. Excellent patient care does not happen overnight. Transitions can create confusion and delays that impact the provision of quality health care. Large hospital systems and other community clinics rely on their experiences and a continuous improvement practice to reduce failures and improve quality of care. Many of these systems have more than 30 years of industry experience and a large number of facilities and specialty care providers whose knowledge and skill can be tapped in emergencies. The County will rely entirely on its own staff or on a partnership with one of these large systems. This arrangement could mean that patient care outcomes are reduced as the County learns and grows in the healthcare space. It is important to note that the County's experience running a mental health hospital may not be transferrable to running an ambulatory care/long-term care facility. Even in private industry, for example, long term elder care and nursing is considered a complex and difficult field requiring physicians to operate outside their experience and specialty regularly, which has created significant care challenges. In summary, experts and research in this area conclude that the more inexperienced and outside of normal industry professional channels and networks a service provider is, relative to the spectrum of care that is needed, the more difficult it will be for the provide to quickly adopt industry-wide innovations, and can lead to lower care outcomes on average, over time, holding all else constant.

6. Macroeconomic Risk. Currently an outside vendor takes on a substantial amount of downside aggregated cost risk because a fixed fee contract is in place. If no outside vendor is in place, all risk of cost increases beyond those budgeted and planned for (regardless of source – i.e., labor cost increases, industry best practice developments, overtime, turnover, retention bonuses, pharmacy and outside care costs, etc.) would fall on Milwaukee County.

7. Team Risk. An outside vendor has a much larger team dedicated to correctional health. There are multiple people working in training, quality control, risk

management, etc. A significant service the vendor provides to Milwaukee County is full-time staff responding to FDA changes, industry developments, staffing shortages, etc. with great economies of scale. If there is no outside vendor, the County will not be able to rely on this larger network for problem resolution and as a source for emergency staff assignment. This risk is further exacerbated by the County's legally-mandated (and comparatively slow) hiring process and required processes to change compensation packages. Milwaukee County also cannot leverage economies of scale to access this same level of service.

8. Regulation, Compliance and Change Management Risk. Currently, monitoring and implementing regulatory change to meet regulatory or accreditation requirements are covered by an outside vendor. An outside vendor can leverage these costs over multiple locations. If there is no outside vendor, the County would be responsible for planning and executing these regulatory changes. It is unclear whether the County has this substantive ability to do so in the first instance, regardless of cost.

9. Infrastructure Risk. Currently, investments in technology or other long-term operational investments are covered by an outside vendor. An outside vendor can leverage these costs over multiple locations. If there is no outside vendor, the County would be responsible for planning and executing these long-term operational investments. It is unclear whether the County has this substantive ability to do so in the first instance in the correctional health care cost, regardless of cost.

10. Logistics Risk. Currently, the logistics for implementing correctional health care (e.g. hiring/firing, operating, training, procuring other goods and services) rests with an outside vendor. It is unclear whether the County has this substantive ability to do so in the first instance in the correctional health care cost, regardless of cost.

There are also risks in an outsourced model. They include:

1. Correctional Healthcare Industry Risks. There is the risk that the correctional healthcare industry may no longer be interested in working with Milwaukee County, or may become financial unable to do so. This risk may appear as a vendor breaching its contract with the County, or as vendors declining to participate in the Request for Proposals process. This risk should be continuously monitored, but does not appear to be a risk that needs to be immediately mitigated. This risk could be eliminated through a self-operation approach, but that approach would result in millions of dollars in increased annual costs (see table in Section 3).

2. Audit-Identified Risks. As pointed out by the Office of the Comptroller Audit report, and confirmed through discussion with the NCCHC Resources, Inc. (Contract Monitor), there are risks that need to be addressed by an outsourcing model. Those risks, and the steps that the County has taken to address them, are as follows:

    a. *Assignment of a Contract Monitor with Clinical Expertise* – Milwaukee County House of Correction received authority in January 2019 to enter into a Professional Services Agreement with NCCHC Resources, Inc. (NRI) for the provision of fiscal and medical monitoring services of the current contract with Wellpath (current outsourcing vendor). (Resolution 19-196).

    b. *Identification of specific timeframes and high-priority items (such as health assessments, sick call, priorities of care, refusal documentation, etc) in the contract terms.* Per the report (file 19-192), these provisions were specifically placed into the contract.

    c. *Maintaining adequate staffing levels, and necessary penalties if such staffing levels are not maintained* – From the report (file 19-192), the contract with Wellpath included a major overhaul of the staffing methodology, moving from an FTE-based model in the current contract to a care-hours model in the RFP and future contract. This shift, suggested and supported by the Court Monitor, Dr. Shansky, places an emphasis on clinical roles and requires that such roles be staffed 100% of the required hours. Staffing requirements, as stated in the RFP, included related penalties for failure to meet staffing requirements. These staffing requirements are also closely watched and reported on by the Contract Monitor.

    d. *Increased focus on the requirement of NCCHC accreditation and clear requirements that all care provided to inmate-patients be based on the NCCHC's standards, regardless of the status of accreditation.* The contract with Wellpath requires that Wellpath provide all care in a manner that, at a minimum, meets NCCHC standards. In addition, the contract requires that Wellpath receive NCCHC accreditation within an eighteen month period.

    e. *Technology requirements for maintaining patient information and interfacing with other care facilities for continuing treatment, when patient is served by an outside clinic or hospital.* These requirements were

placed into the RFP for contract services, and included in final contract with Wellpath.

f. *Outsourcing contractor abandons inmate healthcare contract and services to inmates.* While this is unlikely to happen, the County needs to provide a plan to address this risk. This will be a task that will need to be assigned to the Contract Monitor.

VI. RECOMMENDATION

Based on the concerns mentioned above, and the successes documented in management of the third-party vendor, the Project Team does not recommend moving directly to self-operation at this time. Instead, the recommendation is to:

1. Focus on the quality of care provided to our patients as the primary policy goal. The County should continue to work with NRI and Wellpath to establish a process for measuring that quality of care and ensuring a standard is met;

2. Continue with the third-party contract monitoring provided by NRI and the correctional health care provided by Wellpath, with a focus on quality of care as the primary policy goal;

3. Abolish the Special Project Manager Position and create a Contract Manager position to continue to work with Wellpath, NRI and County officials to resolve issues and identify areas for continuous improvement, based on the policy goals stated in (1) and (2) above.

If the County instead determines to move forward with a self-operation model, it is recommended that

(a) more time be given to launch the model,

(b) a market study be conducted in conjunction with a labor economist to determine reasonable wage ranges for medical staff and other essential personnel,

(c) new positions or other human resources adjustments be made to match anticipated required wage ranges,

(d) other changes considered to permit the County to quickly respond to staff shortages, and

(e) sufficient resources be allocated to fund all required positions at the recommended wage ranges, fund estimated overtime, turnover and recruitment expenses, temporary workers, training programs, and infrastructure build-out and policy/procedure development.

VII. Next Steps Moving Forward with Self-Operation

1. Allocating Funds. The tax levy targets for the 2020 budget were set in Q1 of 2019 and did not account for the Self Operation Cost Differential as that cost was not known at the time. Consequently, the 2020 recommended budget is unlikely to include the Self Operation Cost Differential of $5,108,104. Moving forward with a Self Operation Model would require a policy decision to allocate the Self Operation Cost Differential by either (a) pulling operating resources from other cost centers, (b) identifying additional revenue, or (c) withdrawing from the County's reserves.

2. Creation of Positions. Upon successful allocation of the funds, DAS would submit the 2020 position requests for County Board consideration and approval.

3. Hiring of Initial Staff. Once the positions are created, key leadership staff would be hired in 2020 pursuant to the model established in Exhibit A. This leadership staff would complete the Self Operation Model and prepare a 2021 budget request.

4. Communication with Court. The Self Operation Model would have to be approved by the Court. Milwaukee County would likely need to present the Court with a proposed implementation model, proof of sufficient funding and successful actions taken to begin implementation of the Self Operation Model.

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Attachments
Correctional Heath Care Self-Operation Analysis: Milwaukee County Jail and House of Correction ("CHCSO Analysis")