Prepared by
Legislative Policy and
Research Office

Joint Task Force on Corrections Medical Care

Report on Access to Health Care Services for Oregon Adults in Custody

September 2022

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79th LEGISLATIVE ASSEMBLY
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September 15, 2022

To Members of the Senate and House Interim Committees on Health Care and Judiciary:

Submitted herewith is the final report of the Joint Task Force on Corrections Medical Care. The Task Force was created by House Bill 3035 (2021) to review specified aspects of the Oregon Department of Corrections' (DOC) delivery of health care services to adults in custody, including DOC's grievance process, medical standards of care, and adoption of an electronic health record (EHR) system. The Task Force is charged with delivering a report that may include potential recommendations for legislation to the interim committees of the Legislative Assembly related to health and the judiciary.

Sincerely,

Joe Bugher, Co-Chair

Andrew Suchocki, Co-Chair

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EXECUTIVE SUMMARY

Correctional facilities must balance a variety of complex factors when delivering health care to adults in custody of those facilities, including unique legal, safety, and demographic considerations. Oregon's Department of Corrections (DOC) is responsible for the custody and care of over 12,000 individuals criminally sentenced to one of the state's 12 correctional facilities. Adults in DOC custody are sicker than the general population, including higher prevalence of mental health issues and substance use disorder. Ensuring timely access to appropriate health care services plays a vital role in the health of adults in custody during incarceration

House Bill 3035 and the Joint Task Force on Corrections Medical Care

House Bill 3035 (2021) established the Joint Task Force on Corrections Medical Care to review specific aspects of DOC's health care delivery system, including the grievance process, medical standards of care, and progress on the adoption of an electronic health record (EHR) system. The measure charged the Task Force with delivering a report that may include recommendations for legislation to the interim committees of the Legislative Assembly related to health and the judiciary. The Task Force met ten times between March and September to learn about the factors impacting DOC delivery of health care and develop recommendations for ways to improve access to health care for adults in DOC custody. This report reflects Task Force recommendations for actions to be taken both before and after DOC's implementation of an EHR.

Recommendations

The Task Force recognizes and affirms that implementation of an EHR is essential to both measuring and improving the access to health care services for adults in DOC custody to health care. As DOC's EHR procurement was still currently in process at the finalization of this report, the Task Force recommends for action both pre- and post-EHR implementation:

[To be completed with finalization of recommendations]

This report is available at: [link to be inserted at finalization/OLIS posting]

SECTION 1. BACKGROUND

The delivery of health care services in correctional settings must balance requirements and considerations that are unique to that system. First, adults in custody (AIC) are among a narrow category of people that the U.S. Supreme Court has found have a constitutional right to medical care. This precedent carries an obligation to provide care and services that does not exist in most other settings. Second, justification for incarceration rests, in part, on a societal desire to protect public safety and safety considerations permeate most correctional activities.[1] This involves considering not only the safety of the general public but also that of other AIC, health care providers, and correctional staff. Third, the demographic composition of AIC differs notably from the general population in many areas, including gender, race, age, and socio-economic status. These factors all combine to make the AIC population poorer, older, and sicker. Incarceration has also been shown to contribute to worsening health of individuals, families, and communities.[2] Compared to the general public, AIC are more likely to have high blood pressure, asthma, cancer, and arthritis.[3] AIC are also more likely to have or acquire infectious diseases, including human immunodeficiency virus (HIV), hepatitis B and C, syphilis, gonorrhea, chlamydia, and *Mycobacterium tuberculosis*.[4] Studies have also shown that more than half of all AIC had mental health and substance use problems.[5] Most AIC eventually return to society, making appropriate treatment of health issues while in custody an important factor in potential recidivism and general public health and safety. These considerations have led the U.S. Department of Health and Human Services (HHS) to identify incarceration as a key social determinant of health in the Social and Community Context domain and call for additional research to understand how to improve services for people and communities impacted by incarceration as part of HHS' Healthy People 2030 campaign.[6]

Department of Corrections Overview

The Oregon Department of Corrections (DOC) is responsible for overseeing Oregon's 12 prison facilities (*see* Figure 1). Collectively, these facilities house over 12,000 adults sentenced to a prison term of more than 12 months.[7]

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[1] Or. Const. art. 1 section 15. Measure 26 (1996) amended the Oregon Constitution to add principles for the punishment of crime, "Laws for the punishment of crime shall be founded on these principles: protection of society, personal responsibility, accountability for one's actions and reformation."

[2] Brinkley-Rubinstein L., *Incarceration as a catalyst for worsening health*, Health Justice 1, 3 (2013). https://doi.org/10.1186/2194-7899-1-3

[3] Binswanger IA, Krueger PM, Steiner JF. *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population*, J Epidemiol Community Health 2009;63 (912-919), https://doi:10.1136/jech.2009.090662.

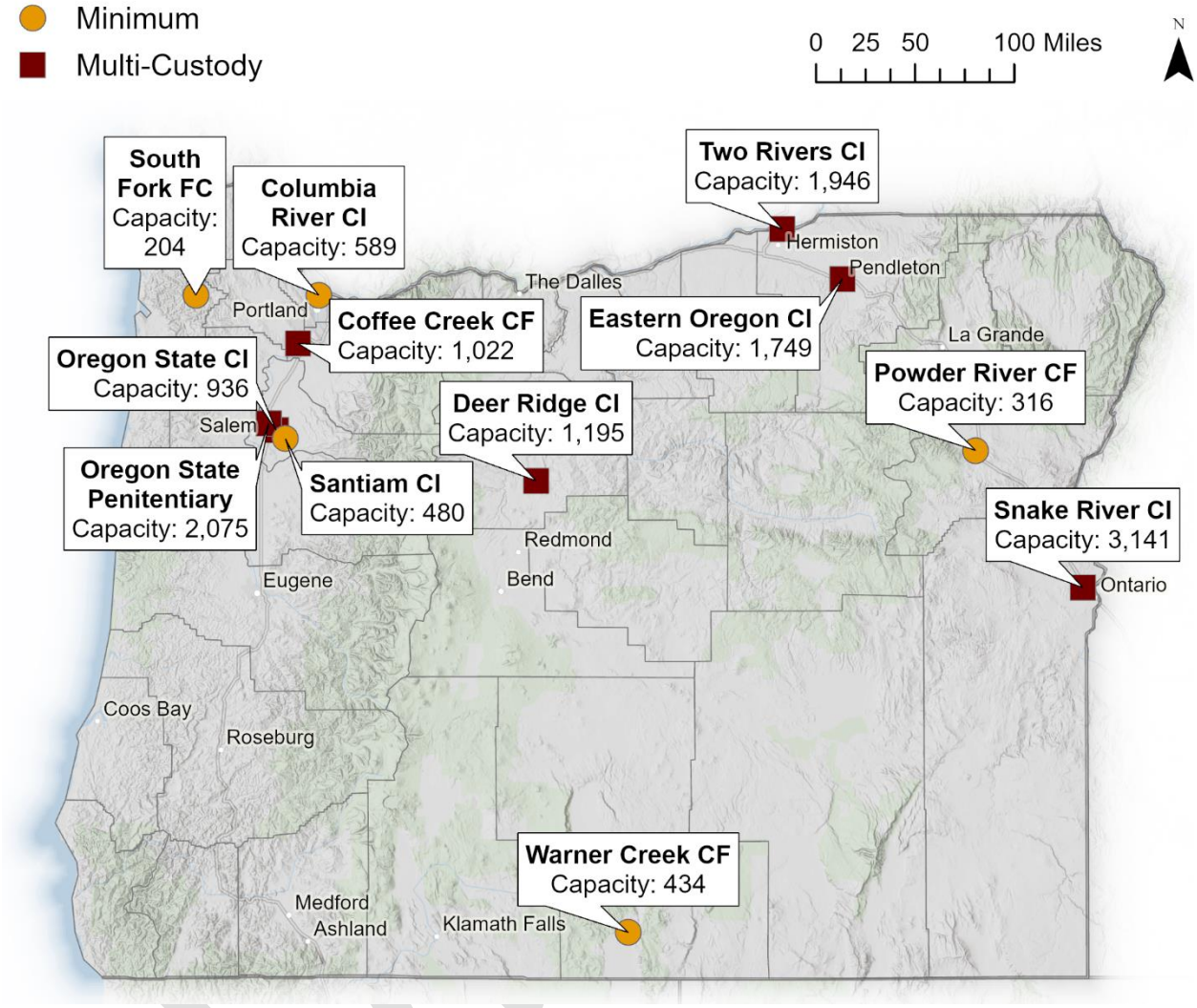
[4] Bick JA, *Infection Control in Jails and Prisons*, Clinical Infectious Diseases, Volume 45, Issue 8, 15 October 2007, (1047–1055), https://doi.org/10.1086/521910.

[5] James DJ, Glaze LE, *Mental health problems of prison and jail inmates*, Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics; 2006. https://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[6] U.S. Department of Health and Human Services, *Social Determinants of Health Literature Summaries – Incarceration*, available at: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration (last visited July 31, 2022).

[7] Oregon Department of Corrections, *Oregon Adults in Custody Population Profile*, August 1, 2022, available at: https://www.oregon.gov/DOC/DOCuments/inmate-profile.pdf (last visited August 12, 2022).

Figure 1: Correctional Institutions and Facilities in Oregon



Source: Legislative Policy and Research Office
Data: Correctional institution and facilities data from Oregon Department of Corrections Issue Brief January 2022. Basemap from Esri.
Notes: CF stands for correctional facility. CI stands for correctional institution. FC stands for forest camp. Department of Corrections institutions are classified into "multi-custody" or "minimum" security facilities. An AIC of any custody level (minimum thru maximum) may be housed at any multi-custody facilities. Those who are custody level 5 (maximum security) will be housed in a restrictive housing unit within the multi-custody facility and not in general population. Both OSP and SRCI have units designated to house custody level 5 AICs but, based on department and AIC needs, the Department of Corrections may have custody level 5 AICs housed in restrictive housing locations at our other multi-custody facilities.

Oregon's AIC population is over 90% male and averages 41 years of age.[8] AIC are predominately White (73.6%), with Hispanic/Latinx (12.8%) and Black/African American (8.6%) comprising the next most common race/ethnicities.[9] DOC currently admits

[8] *Id.*
[9] *Id.*

significantly more people per month than it releases, meaning the AIC population is on track to increase by nearly 1,000 individuals over the next two years.[10]

House Bill 3035 (2021) and the Joint Task Force on Corrections Medical Care

In the 2021 Regular Session, the Oregon Legislative Assembly passed House Bill 3035. The measure created an 11-member Task Force on Corrections Medical Care (Task Force) made up of legislators and five Governor-appointed members representing: a substance use disorder or mental health care clinician, a primary care clinician who serves Medicaid patients, former AIC or family member(s) of AIC, and representatives of the Department of Corrections. Specific Task Force appointments are noted in Exhibit A.

Exhibit A: Appointments to Joint Task Force on Corrections Medical Care

Member	Seat	Organizational Affiliation
Senator Michael Dembrow	Legislator (*non-voting*)	Oregon State Senate
Representative Maxine Dexter	Legislator (*non-voting*)	Oregon House of Representatives
Representative Ron Noble	Legislator (*non-voting*)	Oregon House of Representatives
Joe Bugher, *Co-Chair*	Oregon Department of Corrections Representative	Oregon Department of Corrections
Andrew Suchocki, *Co-Chair*	Clinician	Clackamas Health Centers
Heather Bernhardt	Family member of AIC`	n/a
Brittney Griggs	Clinician	n/a
Ana Moreno	Clinician	One Community Health
Michael (Eric) Nitschke	Former AIC	n/a
Warren Roberts	Oregon Department of Corrections Representative	Oregon Department of Corrections

HB 3035 charged the Task Force with reviewing specific aspects of DOC's health care delivery system:

- Review the process by which adults in DOC custody file grievances concerning access to and the provision of medical care to determine the level of accountability and transparency the process provides to adults in custody and the interests of the state and whether the process conforms with the right of AIC to community-level medical care.
- Review the current medical care standards of care in the department to determine whether the standards align with the right of AIC to community-level medical care.
- Review timelines and goals for the adoption of an electronic health records (EHR) system to ensure appropriate goals, timelines and outcomes are being achieved, with the priority being expedited adoption of the platform most able to improve continuity of care with community practitioners, the seamless sharing of records and the ability for outcomes and services to be reported to the public.

[10] Oregon Department of Corrections, *Quick Facts*, March 2022, available at: https://www.oregon.gov/DOC/DOCuments/agency-quick-facts.pdf (last visited August 12, 2022).

Based on its reviews, the Task Force is charged with issuing a report that includes a recommended prioritized list of medical care, including mental and oral health and, similar to the Medicaid prioritization list, that meets community standards. The report must also include a recommendation of meaningful access timelines for each type of care that must be equitably available to all AIC in all DOC facilities.

HB 3035 also charged DOC with reporting to the interim committees of the Legislative Assembly related to health care and judiciary every six months beginning December 31, 2021 on the same aspects of DOC's health care delivery system. Specifically, DOC must report on:

- Progress on the adoption of an EHR system;
- The number of grievances filed by AIC concerning the provision of medical services;
- The medical services available to AIC in DOC facilities; and
- The progress and impact of a DOC program that assigns health care navigators to AIC, if applicable.

The December 31, 2021 and June 21, 2022 reports were also shared with the Task Force and are provided in Appendix YY.

HB 3035 also requires DOC, in consultation with the Oregon Health Authority, to report to the interim committees of the Legislative Assembly related to health care and judiciary by December 31, 2022 on AIC health trends and any other information DOC deems relevant to the effectiveness of the work of the Task Force.

Task Force Meetings

The Task Force met ten times between March 30 and September 14, 2022. At it's first meeting, the Task Force elected as Co-Chairs Joe Bugher, Assistant Director of Health Services, Oregon DOC and Andrew Suchocki, Medical Director, Beavercreek Health Center.

March 30	April 13	May 11	June 8	July 13
• Intros & Background • Draft Rules & Guiding Principles • Election of Co-Chairs	• Legal Framework • DOC Grievance Process	• DOC Health Care Delivery System & Process • Prioritized List of Health Services	• DOC EHR Procurement • Ombudsperson Recruitment	• Access to Mental Health & Substance Use Disorder Services

July 27	August 10	August 22	September 7 & 14
• Health Outcome & Quality Tracking and Measurement	• DOC Use of Telehealth	• DOC Patients Needs Report • DOC 2023 POPS • Preliminary Recommendations Discussion	• Finalization of Recommendations

SECTION II. DEPARTMENT OF CORRECTIONS GRIEVANCE PROCESS

State prison grievance processes took on greater importance with the enaction of the Prison Litigation Reform Act (PLRA) in 1996.[11] Intended to address an increase in prisoner litigation in federal courts, the PLRA requires AIC to exhaust all administrative remedies made available by the prison before filing a lawsuit against the prison. The Supreme Court has subsequently found that proper exhaustion requires compliance with the prison's deadlines and other procedural rules.[12] Failure to comply with the PLRA's exhaustion requirement can result in dismissal of an AIC's lawsuit.

DOC's grievance process is articulated in administrative rule.[13] The rules outline permissible grievance issues, the three levels of grievance, and the applicable filing and response timelines. DOC's grievance process allows AIC to file grievances for "any incident or issue regarding institutional life that directly and personally affects" the AIC, including "inadequate medical or mental health treatment."[14] While AICs may file grievances on multiple types of issues, the rules limit review to only "one matter, action, or incident per grievance."[15] Thus, if an AIC has grievance about multiple incidents or an incident that involves multiple staff or units, each of those grievances must be filed separately. In addition to the requirement that grievances be separated, AIC are also limited to having only four grievances open at any time or submitted in any given month.[16]

Grievance Levels and Timelines

DOC's grievance rules articulate three levels of grievances that AIC must exhaust: (1) grievance, (2) initial grievance appeal, and (3) final grievance appeal. Timelines for AIC submission and DOC response are the same at each level. AICs must submit their grievance or grievance appeal within 14 calendar days from the date of the incident (grievance) or DOC response (initial and final grievance appeals).[17] Unless the AIC can "satisfactorily demonstrate" why a grievance or appeal could not be timely filed, untimely grievances and appeals will be denied.[18] If a grievance or grievance appeal is returned for correction, AIC have the opportunity to resubmit the grievance or grievance appeal, but must do so within 14 calendar days from when the faulty grievance or grievance appeal was returned.[19] Once received, DOC has 35 calendar days to respond to the grievance or appeal. If further review is necessary, DOC may extend this timeline by 14 calendar days with notice to the AIC.[20]

[11] P.L. 104-134 (1996)
[12] *Woodford v. Ngo,* 548 U.S. 81 (2006).
[13] OAR 291-109-0100 *et seq*.
[14] OAR 291-109-0210(3).
[15] OAR 291-109-0210(1).
[16] OAR 291-109-0215.
[17] OAR 291-109-0205.
[18] *Id.*
[19] OAR 291-109-0225(2).
[20] OAR 291-109-0205.

Grievance Review System Structure

Established in 1990 as recommended by an investigative report to the Governor, DOC's Office of the Inspector General (OIG) provides central program oversight and coordination of the grievance process through the OIG's Special Programs Unit. In addition to oversight of the grievance process, the OIG also has oversight responsibility for several other units:

- **Special Investigations Unit (SIU)** – investigates allegations of employee misconduct that fall outside the scope of human resources investigations and incidents of significant AIC misconduct.
- **Security Threat Management (STM) Unit** – provides oversight and accountability to the AIC who are perceived to pose the most serious threat to the safety and security of DOC institutions.
- **Central Intelligence Unit (CIU)** – gathers, verifies, analyzes, and disseminates intelligence information in support of the SIU, STM, Operations Division, and law enforcement on matters that involve imminent threats to security or the safety and well-being of others.
- **Hearings Unit** – conducts administrative misconduct hearings, involuntary mental health housing placement hearings, transitional leave hearings, restitutions hearings, and involuntary segregation hearings.
- **Special Programs Unit** – consists of programs that require independent oversight or involve legal risk mitigation and serves as the liaison to the Oregon Department of Justice (DOJ). In addition to handling AIC grievances, the Special Programs Unit also oversees Americans with Disability Act (ADA), discrimination, and Prison Rape Elimination Act (PREA) complaints.

With regard to AIC grievances, OIG responsibilities include training Facility Grievance Coordinators and other DOC staff/managers/administrators, ensuring compliance with department rules, policies, and procedures, and updating rules, policies, procedures, and forms. In addition, the OIG monitors risks and trends identified through the grievance review system and elevates information for corrective action to the appropriate DOC manager or administrator.

Each DOC facility has a grievance coordinator who accepts and reviews submitted grievances for compliance with the rules. The grievance coordinator also assists AICs to understand and navigate the grievance and complaint system. The grievance coordinator also assigns the grievance or appeal to the appropriate DOC staff, manager, or administrator and ensures that the response is provided to the AIC. Grievance and grievance appeals involving concerns about medical or mental health treatment are reviewed by various staff depending on the level of the grievance: initial grievances are reviewed by staff from DOC's Health Services Unit as determined by the nature/subject of the grievance; initial grievance appeals are reviewed by the Chief Medical Officer; and final grievance appeals are reviewed by the Assistant Director of Health Services. Grievances relating to medical and mental health treatment are organized into nine categories: (1) access; (2) clinical decision; (3) continue care; (4) time; (5) effective; (6) efficient; (7) provider; (8) safe; and (9) other. With the exception of

the “other” category, each category of grievance can be subcategorized, further specifying the nature of the grievance. An overview of all grievance categories and subcategories can be found in Appendix YY.

Grievance Review

DOC provided three years of grievance information to the Task Force, showing monthly grievance numbers by DOC facility from April 2019 to March 2022. This information showed that DOC processed between a low of 553 (February 2020) and a high of 1302 (January 2021) grievances per month. The number of AIC filing grievances as a percentage of total AIC population also fluctuated, with a range between 2.93 percent and six percent. Grievance filings were also impacted by external events impacting DOC’s ability to provide services, including the COVID-19 pandemic and wildfires and ice storms that impacted specific facilities. After grievances about security, grievances regarding health services are the second most common type of grievance received by DOC, generally constituting 20-30 percent of filed grievances. Appendix YY provides DOC grievance statistics in full.

Office of Corrections Ombudsman

Although charged with responsibilities broader than just review of AIC grievances, the Office of the Corrections Ombudsman potentially plays a role in resolving AIC complaints. The Office was established within the Governor’s Office in 1977, requiring the Ombudsman to be “a person of recognized judgment, objectivity and integrity who is qualified by training and experience to analyze problems of law enforcement, corrections administration and public policy.”[21] The Ombudsman has broad statutory authority to “investigate, on complaint or on the ombudsman’s own motion, any action” by DOC or DOC staff “without regard to its finality.”[22] The Ombudsman also has the power to subpoena records, documents, and individuals, as well as inspect any DOC premises without notice.[23]

Although the Office of the Corrections Ombudsman has existed since 1977, funding for it has been inconsistent, including discontinuation in the early 2000’s. Funding for the office was temporarily restored in 2021, but the position was not filled because funding was not included in the 2021-’23 biennium budget.[24] Funding was again restored for the Corrections Ombudsman during the 2022 legislative session.[25]

[ADD CURRENT HIRING STATUS]

[21] ORS 413.405 (2021).
[22] ORS 413.420 (2021).
[23] *Id.*
[24] Office of the Governor – Department of Corrections Ombudsman Program: Work Session Before the Joint Emergency Board, Oregon State Legislature (January 8, 2021).
[25] HB 5202 (2022).

SECTION III. ELECTRONIC HEALTH RECORDS ADOPTION

Electronic health records (EHRs) are real-time, patient-centered records that make information about a patient instantly and securely available to authorized users, particularly health care providers.[26] EHRs provide quick access to information that can help guide treatment decisions, including: a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results.[27] Studies have shown that EHR adoption can improve care coordination and quality, as well as save health care systems money by reducing redundant care, speeding patient treatment, improving safety, and keeping patients healthier.[28] In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act, included as a part of the American Recovery and Reinvestment Act (ARRA), allocated $35 billion to subsidize and promote physician and hospital adoption and "meaningful use" of EHRs.[29] As of 2019, 72 percent of office based physicians and 96% of non-federal acute care hospitals had adopted a certified EHR.[30]

When the Legislative Assembly established the Oregon Health Authority in 2009, it also established the Health Information Technology Oversight Council (HITOC) and charged it with developing a strategic health information technology plan for the state.[31] In 2017, HITOC issued its strategic plan for a "health information technology (HIT)-optimized" health care system.[32] Among the challenges noted in the strategic plan was the continued fragmentation of HIT adoption and the need to ensure inclusion of settings that address social determinants of health, including corrections.[33]

Efforts to modernize DOC's health care technology infrastructure, including the potential adoption of an EHR, date back over 15 years.[34] This includes the recommendation from the Work Group on Corrections Health Care Costs (Senate Bill 843, 2013) that DOC "implement an Electronic Health Records system that best fits the needs of the department."[35] The most recent effort began in 2019 with a request for information and led to a request for proposals in December 2021.

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[26] The Office of the National Coordinator for Health Information Technology (ONC), *What Are Electronic Health Records (EHRs)?*, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-are-electronic-health-records-ehrs (last visited June 30, 2022).

[27] *Id.*

[28] Hillestad, R., Bigelow, J., Bower, A., Girosi, F., Meili, R., Scoville, R., & Taylor, R. (2005). *Can electronic medical record systems transform health care? Potential health benefits, savings, and costs*, Health affairs (Project Hope), 24(5), (1103–1117), https://doi.org/10.1377/hlthaff.24.5.1103.

[29] P.L. 111-5 (2009).

[30] Office of the National Coordinator for Health Information Technology, *National Trends in Hospital and Physician Adoption of Electronic Health Records*, Health IT Quick-Stat #61, March 2022. Certified EHRs meet the technological capability, functionality, and security requirements adopted by the Department of Health and Human Services.

[31] HB 2009 (2009); ORS 413.300 *et seq.* (2021)

[32] Health Information Technology Oversight Council (HITOC), *Oregon's Strategic Plan for Health Information Technology and Health Information Exchange (2017-2020)*, September 2017.

[33] *Id*. at page 23.

[34] Oregon Department of Corrections, *Business Case for Electronics Health Records System*, February 10, 2021.

[35] Work Group on Corrections Health Care Costs, *Report to Interim Committee of the Legislative Assembly*, December 31, 2014.

DOC EHR Procurement

DOC's Request for Proposals (RFP) for Health Services Electronic Health Records System specifies three strategic business objectives for proposed solutions to support:

1) **Provide "Continuity of Care" by ensuring that when changing care setting or providers the information required for medical care is not lost or delayed, including:**
    - Providing real-time access to medical record to Agency Health Services clinicians regardless of location or care setting.
    - Electronically exchanging standard medical data with external partners.
    - Effectively transitioning care plans to community providers upon release.
2) **Enable "Evidence-Based Decision Making" to support clinicians in always providing the best-known care for individuals AICS and the population overall:**
    - Real-time reporting for incident response and identification of at-risk AICs and wellness program support.
    - Population studies supporting health policy decisions.
    - Automated best practice and decision support for clinicians to ensure optimal decisions "easy to do the right thing, hard to do the wrong thing."
3) **Operate on a "Modern Technology Platform" that will save time, money, and lives through:**
    - Sustainable platform that is easy to maintain and adaptable to changes.
    - Reducing or eliminating the technology gap between community care and Agency Health Services care.
    - Alignment with the State's enterprise technology strategy and standards.[36]

Six proposers responded to the RFP. Proposals were evaluated on administrative and technical aspects according to the criteria specified in the RFP. The three highest scoring proposers were invited to a supplementary evaluation that included an interview process, demonstration, and pricing proposal. A Notice of Intent to Award was issued on May 24, 2022 to the apparent successful proposer based on the combined scores from both rounds of evaluation.

DOC is still in negotiation with the successful proposer at the time of this report's finalization and submission.

[36] Oregon Department of Administrative Services (DAS), Enterprise Goods and Services, Procurement Services on behalf of Department of Corrections, *Request for Proposals (RFP) for Health Services Electronic Health Records System*, OregonBuys Bid Number S-DASOBO-00000463.

SECTION IV. MEDICAL STANDARDS OF CARE & SERVICE PRIORITIZATION

Delivery of health care services in correctional settings must balance unique legal requirements with equally unique AIC health care needs. In addition to arriving with or developing physical or oral health needs, over 60% of Oregon AIC have mental health needs that would benefit from treatment.[37] Similarly, nearly 70% of Oregon AIC report some substance abuse, with over 50% having dependence or addiction.[38]

Legal Standards for Correctional Health Care

The U.S. Supreme Court has held that AICs are due a minimal amount of medical care during their incarceration because they are under governmental control.[39] In *Estelle v. Gamble*, the Court found that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' proscribed by the Eighth Amendment."[40] Subsequent case law has further defined what is meant by "deliberate indifference" and "serious medical needs." In evaluating what constitutes "serious medical needs," the Ninth Circuit has found that a "'serious' medical need exists if the failure to treat a prisoner's condition could result in further significant injury[.]"[41] Additionally, "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain are examples of indications that a prisoner has a 'serious' need for medical treatment."[42] Deliberate indifference exists if "the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[43]

With the U.S. Supreme Court establishing that governments must provide AIC with medical treatment for "serious medical needs", the availability of resources to provide that care takes on constitutional significance. Courts have weighed in on this issue as well, finding that, "[l]ack of resources is not a defense to a claim for prospective relief because prison officials may be compelled to expand the pool of existing resources in order to remedy continuing Eighth Amendment violations."[44] This means that lacking resources to provide medical treatment for "serious medical needs" has the potential to increase the legal liabilities of correctional facilities.

[37] Oregon Department of Corrections, *Quick Facts*, March 2022, *supra* note 10.
[38] *Id.*
[39] The U.S. Supreme Court has similarly found that involuntarily committed individuals have liberty rights protected by the 14th amendment, which include the right to adequate medical care. *See Youngberg v. Romero*, 457 U.S. 307 (1982).
[40] *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).
[41] *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992)
[42] *Id.* at 1059-60.
[43] *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).
[44] *Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014).

DOC Health Services Unit

DOC's Health Services Unit provides and coordinates delivery of health care services for AIC, including medical, dental, behavioral health, and pharmacy services. The Health Services Unit has over 600 employees consisting of both provider and administrative roles. Full-time staff currently include:

- 16 physicians
- 13 nurse practitioners
- 226 nurses
- 5 psychiatrists
- 12 psychiatric nurse practitioners
- 6 psychologists
- 91 qualified mental health practitioners
- 26 dentists[45]

Nursing staff engage in more than 1,000 patient contacts per day across all DOC facilities; staff physicians, nurse practitioners, and physician assistants provide more than 250 on-site primary care appointments per day.[46]

The Health Services Unit is accredited by the National Commission on Correctional Health Care (NCCHC). NCCHC is an independent, 501(c)(3) nonprofit organization that has developed standards covering the areas of patient care and treatment, governance and administration, personnel and training, safety and disease prevention, special needs and services, and medical-legal issues. The NCCHC accreditation program is voluntary and uses external peer review to survey correctional facilities for compliance with applicable NCCHC standards. NCCHC offers accreditation for correctional facility health services, mental health services, and opioid treatment programs.

Intake Assessments and Screenings

DOC coordination of health services for AIC begins at intake to DOC custody, which occurs at the Coffee Creek Correctional Facility. An initial assessment conducted by a nurse generally happens within hours of arrival at Coffee Creek and includes review of any urgent medical needs, obtaining medical history, and review of the county jail transfer summary.[47] The full intake process includes a baseline medical, dental, and mental health evaluation.[48] A medical evaluation with a review of the AIC's medical history should occur within seven days of admission.[49] A dental screening conducted by Health Services staff that includes visual examination of the teeth and gums, including noting any obvious abnormalities or AIC complaints should also occur within seven days

[45] Joe Bugher & Warren Roberts, Oregon Department of Corrections, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, May 11, 2022, https://olis.oregonlegislature.gov/liz/2021I1/Committees/JTFCMC/2022-05-11-09-00/MeetingMaterials (last visited August 12, 2022).

[46] Oregon Department of Corrections, *HB 3035 Report*, June 21, 2022, https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256655.

[47] Joe Bugher & Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 45.

[48] OAR 291-124-0030(1).

[49] OAR 291-124-0030(1)(a).

of admission.[50] A baseline dental intake completed by a licensed dentist that includes charting of the teeth and any indicated diagnostic x-rays should occur within 30 days of admission.[51] Mental health evaluations include screening for mental illness and suicide history though no expected timeline is given in administrative rule.[52] Mental health contact happens more quickly if the AIC has had previous interaction with DOC or intake reveals current use mental health medications or active signs of mental illness.[53] The mental health evaluation process also includes identification of substance use disorder (SUD) needs, including the potential continuation of medication assisted treatment (MAT).[54] If a mental health evaluation reveals a history of mental illness or suicide attempts or ideation, referral will be made to a mental health treatment provider for further evaluation.[55] AICs with mental illness will be housed in a facility that can provide appropriate services.[56] The total intake assessment and screening process generally takes between 30-45 days.[57]

The intake assessment and screening process helps identify the health care needs of AIC. Needs are coded according to acuity, with a higher code indicating more acuity:

- **Medical (physical health) Codes** – M1 to M5
- **Dental Codes**
    - *Caries Ratings* – C1 to C4
    - *Periodontal Ratings* – P1 to P4
- **Mental Health Codes** – MH0 to MH3
- **Developmental Disability Codes** – DD0 to DD3

After intake, DOC transfers male AIC to the appropriate facility based on a number of factors. Facility placement considerations include the AIC's classification level, which helps determine the appropriate facility security level and is informed by escape history, remaining sentence, detainers, and behavior. Medical needs also inform AIC facility placement determinations since not all facilities have the infrastructure or staffing to meet all medical needs. Specific medical needs that are not offered at all DOC facilities include infirmary level of care and mental health services.[58] SUD treatment is also only offered at minimum security facilities, which means that AIC must have a classification level supporting placement in a minimum-security facility to be able to receive SUD treatment services.

[50] OAR 291-134-0030(1)(b).
[51] OAR 291-134-0030(1)(b)(A).
[52] OAR 291-134-0030(1)(c).
[53] Joe Bugher & Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 45.
[54] *Id.*
[55] OAR 291-134-0030(1)(c).
[56] *Id.*
[57] Joe Bugher & Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 45.
[58] *Id.*

Therapeutic Levels of Care

AIC can initiate visits with Health Services staff numerous ways, including a sick call process, talking to their housing officer, and written request ("kite").[59] DOC is able to provide most routine services onsite, while others (e.g. advanced imaging, specialist visits, etc.) need to be coordinated with community providers. DOC's larger facilities have infirmaries that can handle AIC with ongoing needs (e.g. multiple sclerosis, dementia, etc.) and provide care to AIC that are preparing or recovering from surgery. Health care services that DOC Health Service staff cannot readily provide in the facility generally undergoes review using DOC's Therapeutic Levels of Care (TLC) process. This process prioritizes care and treatment into four levels. The levels are established in Oregon Administrative Rule and represent general categories of diagnoses, therapies, or procedures; staff may consider additional, individual factors in deciding whether to provide a particular service or treatment.[60]

- **Level 1 Care and Treatment** (*medically mandatory*). Defined as "care and treatment that is essential to life and health, without which rapid deterioration may be an expected outcome and where medical or surgical intervention makes a very significant difference or has a very high cost-effectiveness." Level 1 care and treatment is generally provided to all AIC. [61]
- **Level 2 Care and Treatment** (*presently medically necessary*). Defined as "care and treatment without which an AIC could not be maintained without significant risk of either further serious deterioration of the condition or a significant reduction in the chance of possible repair after release or without significant pain or discomfort." Level 2 care and treatment may be provided to AICs and, if not emergency in nature, can be subject to periodic utilization review. [62]
- **Level 3 Care and Treatment** (*medically acceptable but not medically necessary*). Defined as "care and treatment for non-fatal conditions where treatment or intervention may improve the quality of life for the AIC." Level 3 care and treatment may be authorized on an individual-by-individual or problem-by-problem basis.[63]
- **Level 4 Care and Treatment** (*of limited medical value*). Defined as "care and treatment that may be valuable to a certain individual but is significantly less likely to be cost-effective or to produce substantial long-term gain or improvement. Level 4 care and treatment will not be routinely provided.[64]

DOC uses a committee process to review health care services requiring coordination with outside providers. In addition to serving a utilization management function, these TLC Committees allow providers to advocate for AIC on the provision of services. This process also provides opportunity for clinical decision support and other education and

[59] *Id.*
[60] OAR 291-124-0041(8)(a).
[61] OAR 291-124-0041(3).
[62] OAR 291-124-0041(4).
[63] OAR 291-124-0041(5).
[64] OAR 291-124-0041(6).

serves to promote consistency in decision-making across facilities.[65] Due to its population size, Snake River Correctional Facility has its own TLC Committee; other facilities have regionally consolidated TLC Committees.[66] TLC Committees occur weekly and typically last around three to four hours. All facility providers are required to attend TLC Committees.[67] TLC Committee meetings are deliberative in nature with the treating provider presenting the AIC's case and the TLC Committee engaging in conversation and consulting clinical decision support as needed. If a TLC Committee approves provision of services requiring coordination with outside providers or facilities, it takes an average of 25 days for a staff member to schedule with an outside provider; schedule timing is influenced by the acuity of the need for services, staffing and provider availability, and AIC classification level.[68] DOC's utilization of outside providers is measured as a Key Performance Measure (KPM) that is reported to the legislature. The KPM target is for 1% or less of health care encounters to occur offsite. With the COVID-19 pandemic impacting staffing levels and the availability of services in the community, DOC exceeded the target in 2020 (1.78%) and 2021 (1.39%); prior to the pandemic DOC generally met the KPM target.[69]

Release from DOC Facilities and Transition of Care

DOC takes specific steps to try and ensure appropriate transition and coordination of care upon an AIC's release from custody. Transition activities include provision of 30-day supply of necessary medications, safe sex kits, and Narcan for opioid overdose treatment. Health Services staff also identify AIC with severe medical or mental health needs that require ongoing treatment in the community and assist with referrals.[70] DOC also works with the Oregon Health Authority to support releasing AIC enrollment into the Oregon Health Plan, the state's Medicaid program. This coordination was bolstered by the funding of health care navigator positions within OHA as part of their 2021-'23 Legislatively Approved Budget.[71]

Oregon Health Plan and the Prioritized List of Health Services

The state's Medicaid program, the Oregon Health Plan, provides free health care coverage for individuals who meet income and other requirements.[72] With income eligibility set at 138% of the federal poverty level, this means that most AIC will be eligible for OHP upon release from a DOC facility. OHP uses the Prioritized List of

[65] DOC uses the UpToDate platform to provide clinical decision support.
[66] Joe Bugher & Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 45.
[67] *Id.*
[68] *Id.*
[69] Department of Corrections, *Annual Performance Progress Report: Reporting Year 2021*, September 17, 2021.
[70] OAR 291-124-0060.
[71] HB 5024 (2021).
[72] Federal law prohibits the use of federal funds for the provision of medical care to an "inmate of a public institution." Social Security Act sect. 1905(a)(30)(A). A "public institution" is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. 42 CFR sect. 435.1010. With limited exceptions (e.g., medical institution inpatient stays of longer than 24 hours), this means that state Medicaid programs cannot cover AIC.

Health Care Services (Prioritized List) to help determine and outline service coverage.[73] Managed by the Health Evidence Review Commission (HERC), the Prioritized List ranks condition-treatment "pairs" representing the comparative benefits of each service and considering both the clinical and cost-effectiveness of services.[74] Every biennium, the Legislative Assembly funds the coverage of services up to a specified line on the Prioritized List (currently line 472 of 662).[75] In addition to utilizing evidence and collaborating with experts on prioritization decisions, the HERC accepts public comment on every proposal and decision and makes its decisions during public meetings, ensuring transparency and accountability in its decision-making.

House Bill 3035 charges the Task Force with recommending a prioritized list of medical care similar to the Prioritized List for publishing on DOC's website. Completion of this specific task was challenged by the legal standards applicable to health care coordinated by correctional facilities for AIC. Specifically, a fundamental conflict exists around the consideration of cost-effectiveness information and the role available funding plays in the determination of coverage. On the OHP side, the HERC is statutorily required to consider the cost-effectiveness of health services in the development of the Prioritized List and the legislature uses that List to fund coverage up to a specified line. While OHP has an appeal process that can allow OHP enrollees to gain coverage of services placed below the Prioritized List funding line, placement of a condition or treatment below that line creates a presumption of non-coverage. This consideration of cost and available funding information conflicts with case law applicable to the delivery of health care services by correctional facilities that explicitly prohibits utilization of resource limitations as a defense to the requirement to provide adequate medical care to AIC as established by the Supreme Court.[76]

DOC's Therapeutic Levels of Care serve a prioritization function, albeit one that it is far more general than the Prioritized List. In addition to defining each of the TLC levels, administrative rule also gives examples for each of the levels. The Task Force reviewed each of the examples cited in rule for the four TLC levels, finding general alignment between what is covered using DOC's TLC prioritization and OHP Prioritized List.[77] DOC's lack of an EHR contributed to the inability of the Task Force to conduct a more comprehensive review of where specific services fall within DOC's TLC prioritization as that comparison would require extensive manual chart review not achievable in the timeframe for this report.

Outcome Tracking and Quality Measurement

Quality monitoring systems are a common tool for tracking the appropriateness and timeliness of care delivery, as well as improving the health of the individuals served by

[73] ORS 414.690 (2021)
[74] *Id*.
[75] ORS 414.025(13); ORS 414.690 (2021)
[76] *Peralta v. Dillard, supra* note 44.
[77] Legislative Policy and Research Office, *Presentation: Prioritized List of Medical Care Recommendation Discussion*, July 13, 2022, https://olis.oregonlegislature.gov/liz/2021I1/Committees/JTFCMC/2022-07-13-09-00/Agenda (last visited August 12, 2022).

the health care system monitored. Quality monitoring systems are customarily used in other health care system environments, including health insurance plans and OHP.[78] These systems can provide valuable insight into the value of money spent providing care and how it compares to both other states and systems. For prisons systems, quality monitoring can also serve as a tool to evaluate the adequateness of care delivery and help mitigate legal risk.

In 2017, The PEW Charitable Trusts (PEW) published a 50-state report examining prison health care spending and delivery systems that included an evaluation of whether and how states were monitoring the quality of care provided.[79] That report noted that Oregon was one of 12 states that lacked a quality monitoring system for its prison system. Conversely, 35 other states had some sort of quality monitoring system, with six formally requiring those systems and integrating them into prison system oversight and decision-making. Among the states having a quality monitoring system, most tracked measures in the clinical areas of:

- Access or utilization
- Screening or prevention
- Infectious disease
- Behavioral health
- Chronic disease

States surveyed by PEW that lacked quality monitoring systems engaged in a range of related activities, including regular audits of practices and protocols, AIC grievance investigations, and mortality reviews.

The recent history of California's prison system offers insight into both the risks of not having a quality monitoring system in place and the considerations for developing and implementing such a system. In 2005, California settled a class action lawsuit alleging that the California Department of Corrections and Rehabilitation's (CDCR) medical services were inadequate and in violation of the Eighth Amendment and other applicable laws.[80] The settlement included the appointment of a receiver for CDCR to ensure timely access to providers and care. In order to help implement the receiver's turnaround plan, CDCR contracted with the RAND Corporation (RAND) to advise on the selection and implementation of performance measures. In addition to assessing the current state of quality monitoring and measurement, RAND was also charged with surveying quality monitoring systems used by other state prison systems and the Federal Bureau of Prisons, as well as recommending a "starter set" of measures.[81]

[78] *See* the Health Effectiveness Data and Information Set (HEDIS) for health plans and Coordinated Care Organization (CCO) Metrics for OHP.

[79] The Pew Charitable Trusts, *Prison Health Care: Costs and Quality*, October 2017, available at https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality (last visited August 12, 2022).

[80] *Plata v. Schwarzenegger*, No. C01-1351 (N.D. Cal. Oct. 3, 2005).

[81] Teleki, S. S., Damberg, C. L., Shaw, R., Hiatt, L., Williams, B., Hill, T. E., & Asch, S. M., *The current state of quality of care measurement in the California Department of Corrections and Rehabilitation*, Journal of correctional health

RAND's assessment of CDCRs quality monitoring system highlighted significant variations in information technology systems among California's prisons due to the lack of an electronic medical record (EMR).[82] Informed by RAND, CDCR has since implemented a robust quality monitoring system that includes a publicly posted monthly dashboard report indicating performance on key metrics, including measures in the domains of: scheduling and access to care, population health management, care management, continuity of care, medication management, availability of health information, grievance processing, resource management, staffing, and costs.[83] These efforts have resulted in 19 of the 35 facilities being returned to CDCR's authority.[84]

care : the official journal of the National Commission on Correctional Health Care, April 2011, (100–121), https://doi.org/10.1177/1078345810397498.

[82] *Id.*

[83] California Correctional Health Care Services, *Health Care Services Dashboard*, available at https://cchcs.ca.gov/reports/ (last visited August 12, 2022).

[84] J. Clark Kelso, *Receiver's Fiftieth Tri-Annual Report,* June 1, 2022, available at https://cchcs.ca.gov/reports/ (last visited August 12, 2022).

SECTION V. TASK FORCE RECOMMENDATIONS

The Task Force recognizes that successful adoption and implementation of an EHR is essential to the ability to objectively and meaningful track DOC's current standards of care, including the evaluation of access timelines and assessment of compliance with community standards. With DOC's EHR procurement still in progress at the time of this report, the Task Force offers recommendations for action both pre- and post-EHR implementation.

Pre-EHR Implementation Recommendations

For the Department of Corrections

1. DOC should develop a quality monitoring strategy for implementation alongside the EHR that can meaningfully track and publicly report metrics in key domains, including: access to care, timeliness of care, grievances, quality of care (acute, chronic, dental, and behavioral), and workforce.
2. DOC should pursue efforts to bolster and support DOC health service workforce, including:
    - Maximizing correctional facilities' ability to qualify as sites eligible for student loan repayment programs;
    - Pursuing partnership(s) that allows for medical students to serve in DOC facilities for clinical rotation;
    - Expanding opportunities for current and former AIC to serve as peer supports and other roles within applicable credentialing standards;
    - Ensuring AIC have access to culturally competent medical and mental health providers; and
    - Maximizing Health Service's staff ability to provide care within applicable practice scopes, including use of nurse protocols, physician assistants, and clinical pharmacy.~~Expanding the use of physician assistants as permitted by House Bill 3036 (2021)~~.
3. DOC should contract with an independent outside entity, such as a patient safety organization, to conduct an audit of TLC Committee decisions and report on compliance with national and community standards of care, including consistency with coverage provided to OHP recipients through the Prioritized List.
~~3.~~4. DOC should leverage current initiatives to expand access and use of connected technologies to further support the delivery of health care services, including expanded use of telemedicine.

For the Legislative Assembly

~~4.~~5. The Office of the Ombudsman in the Governor's Office should continue to be funded and the Ombudsman should be tasked with developing a proposal for how the Office can promote a meaningful and transparent grievance process, including identifying any staffing or resource needs the Office would need to fill its proposed role.

5.6. DOC should be funded or otherwise provided the resources to ensure that DOC can provide mental health and substance use disorder treatment and services, including medication-assisted therapy, to every AIC for the entire period of incarceration.

Post-EHR Implementation

For the Department of Corrections

7. DOC should implement publicly accessible regular quality monitoring reporting showing whether it is meeting metric goals in key domains ~~that can be publicly accessed~~.

6.8. DOC should report to the committees of the Legislative Assembly related to health and the judiciary upon implementation of an EHR, noting any efficiencies gained as a result of adopting recommendations contained in this report and specifying the ways DOC is using the EHR to promote timely access to health care services for AIC.

APPENDICES

[To be added at finalization]