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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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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 tend to be more ill 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 2022 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 both DOC and the Legislative Assembly.

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. As DOC's EHR procurement was still currently in process at the finalization of this report, the Task Force makes the following recommendations:

For the Department of Corrections.

1. **Continuous Quality Improvement.** DOC should ensure its continuous quality improvement program includes regular, structured internal and external review of health care-related grievances and care decisions to ensure that DOC meets community standards for access and timeliness in delivering care to adults in DOC custody. Implementation of an EHR system should support continuous quality improvement by supporting regular, publicly accessible reporting of key metrics.
2. **EHR Implementation.** DOC should ensure HER implementation prioritizes interoperability, continuity of care, and immediate access to necessary information.
3. **Workforce.** DOC should pursue specified efforts to expand and utilize its health care workforce.
4. **Access.** DOC should leverage opportunities to use connected technologies to improve access, including telemedicine.

5. **Reporting.** DOC should ensure inclusion of specified information in the report due to the interim committees of the Legislative Assembly related to the judiciary and health care by December 31, 2022. Regular reporting should be established until EHR system implementation supports public reporting.

For the Legislative Assembly.

6. **Office of the Ombudsman**. The Office of the Ombudsman in the Governor's Office should continue to be funded while individuals are incarcerated in Oregon correctional facilities
7. **Behavioral Health and Substance Use Disorder Funding.** DOC should be funded to provide mental health and substance use disorder treatment and services for the entire period of incarceration.
8. **EHR Implementation**. Future approval and funding for DOC's EHR system implementation should be contingent on demonstration of system's interoperability, promotion of continuity of care, and facilitate of immediate access to necessary information.
9. **Early Medical Release.** The Legislative Assembly should consider the creation of early medical (i.e. compassionate) release standards.

This report is available at:
https://olis.oregonlegislature.gov/liz/2021I1/Committees/JTFCMC/2022-09-14-09-00/MeetingMaterials

I. BACKGROUND

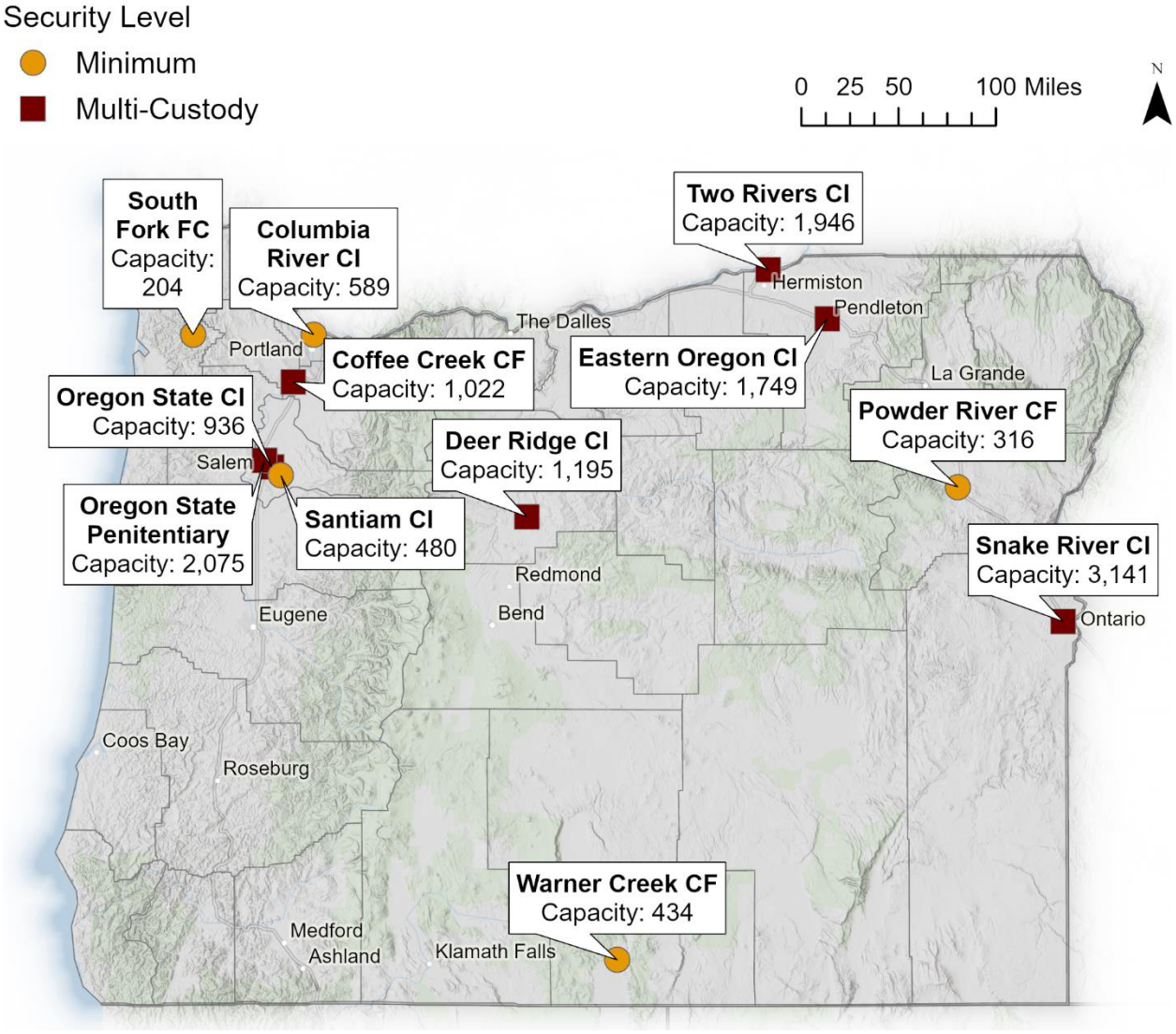
The delivery of health care services in correctional settings must balance requirements and considerations that are unique to that system. First, adults in custody (AIC) are among a narrow category of people that the U.S. Supreme Court has found have a constitutional right to medical care. This precedent 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 AICs, health care providers, and correctional staff. Third, the demographic composition of AICs 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, AICs are more likely to have high blood pressure, asthma, cancer, and arthritis.[3] AICs 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 AICs have mental health and substance use problems.[5] Most AICs 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]

[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.org/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 percent male and averages 41 years of age.[8] AICs are predominately White (73.6 percent), with Hispanic/Latinx (12.8 percent) and Black/African American (8.6 percent) comprising the next most common race/ethnicities.[9] DOC currently admits significantly more people per month than it

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

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 (*nonvoting*)	Oregon State Senate
Representative Maxine Dexter	Legislator (*nonvoting*)	Oregon House of Representatives
Representative Ron Noble	Legislator (*nonvoting*)	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	Neighborhood Health Clinic
Ana Moreno	Substance Use Disorder 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, the interests of the state, and whether the process conforms with the right of AICs 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 AICs to community-level medical care.
- Review timelines and goals for the adoption of an electronic health record (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 AICs 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 AICs concerning the provision of medical services;
- the medical services available to AICs in DOC facilities; and
- the progress and impact of a DOC program that assigns health care navigators to AICs, if applicable.

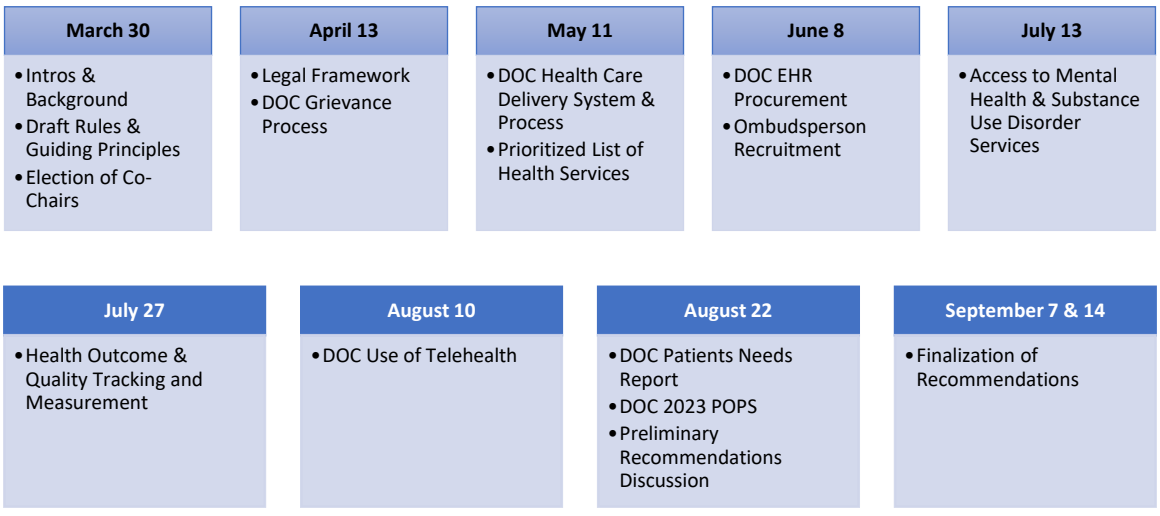
The December 31, 2021 and June 21, 2022 reports were also shared with the Task Force and are provided in Appendices A and B.

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 (*see* Figure 2). At the 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.

Figure 2: Task Force Meeting Dates and Topics



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 AICs 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 AICs 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 grievances 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, AICs 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 AICs 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, AICs 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 resource 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, restitution 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) continuing 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 C.

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.[21] 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 AICs filing grievances as a percentage of total AIC population also fluctuated, with a range between 2.93 percent and six percent. Grievance filings were impacted by a number of external events during the reporting period that impacted DOC’s ability to provide services, most notably the COVID-19 pandemic, as well as 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.

[21] Reported grievance information is posted to the Oregon Legislative Information System’s (OLIS) Meeting Materials page for the Task Force’s May 11, 2022 meeting.

III. Office of Corrections Ombudsman

Although charged with responsibilities broader than just review of AIC grievances, the Office of the Corrections Ombudsman also plays a distinct and independent 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."[22] 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."[23] The Ombudsman also has the power to subpoena records, documents, and individuals, as well as inspect any DOC premises without notice.[24]

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 2021-2023 biennium budget.[25] Funding was again restored for the Corrections Ombudsman during the 2022 legislative session.[26]

The Task Force received an update from the Governor's Office at its June 8, 2022 meeting on the hiring status for the Ombudsman position. This process was ongoing at the time of this report's finalization.

[22] ORS 423.405 (2021).
[23] ORS 423.420 (2021).
[24] *Id.*
[25] Office of the Governor – Department of Corrections Ombudsman Program: Work Session Before the Joint Emergency Board, Oregon State Legislature (January 8, 2021).
[26] HB 5202 (2022).

IV. 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.[27] 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.[28] 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.[29] 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.[30] As of 2019, 72 percent of office-based physicians and 96 percent of nonfederal acute care hospitals had adopted a certified EHR system.[31]

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.[32] In 2017, HITOC issued its strategic plan for a "health information technology (HIT)-optimized" health care system.[33] 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.[34]

Efforts to modernize DOC's health care technology infrastructure, including the potential adoption of an EHR system, date back over 15 years.[35] 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."[36] 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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[27] 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).
[28] *Id.*
[29] 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.
[30] P.L. 111-5 (2009).
[31] 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.
[32] HB 2009 (2009); ORS 413.300 *et seq.* (2021)
[33] Health Information Technology Oversight Council (HITOC), *Oregon's Strategic Plan for Health Information Technology and Health Information Exchange (2017-2020),* September 2017.
[34] *Id*. at page 23.
[35] Oregon Department of Corrections, *Business Case for Electronics Health Records System*, February 10, 2021, OregonBuys Bid Number S-DASOBO-00000463.
[36] 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:

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; and
    - 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; and
    - 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; and
    - alignment with the State's enterprise technology strategy and standards.[37]

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.

[37] 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.

V. Medical Standards of Care and 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 percent of Oregon AICs have mental health needs that would benefit from treatment.[38] Similarly, nearly 70 percent of Oregon AICs report some substance abuse, with over 50 percent having dependence or addiction.[39]

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.[40] 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."[41] 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 Court has found that a "'serious' medical need exists if the failure to treat a prisoner's condition could result in further significant injury[.]"[42] 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."[43] 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."[44]

With the U.S. Supreme Court establishing that governments must provide AICs 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."[45] This means that lacking resources to provide medical treatment for "serious medical needs" has the potential to increase the legal liabilities of correctional facilities.

[38] Oregon Department of Corrections, *Quick Facts*, March 2022, *supra* note 10.
[39] *Id.*
[40] 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).
[41] *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).
[42] *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992)
[43] *Id.* at 1059-60.
[44] *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).
[45] *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 includes:

- 16 physicians
- 13 nurse practitioners
- 226 nurses
- 5 psychiatrists
- 12 psychiatric nurse practitioners
- 6 psychologists
- 91 qualified mental health practitioners
- 26 dentists[46]

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.[47]

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 AICs begins at intake to DOC custody, which occurs at the Coffee Creek Correctional Facility for all AICs. 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.[48] The full intake process includes a baseline medical, dental, and mental health evaluation.[49] A medical evaluation with a review of the AIC's medical history should occur within seven days of admission.[50] 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

[46] Joe Bugher and 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).
[47] Oregon Department of Corrections, *HB 3035 Report*, June 21, 2022, https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256655.
[48] Joe Bugher & Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 46.
[49] OAR 291-124-0030(1).
[50] OAR 291-124-0030(1)(a).

within seven days of admission.[51] 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.[52] Mental health evaluations include screening for mental illness and suicide history though no expected timeline is given in administrative rule.[53] Mental health contact happens more quickly if the AIC has had previous interaction with DOC or intake reveals current use of mental health medications or active signs of mental illness.[54] The mental health evaluation process also includes identification of substance use disorder (SUD) needs, including the potential continuation of medication assisted treatment (MAT).[55] 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.[56] AICs with mental illness will be housed in a facility that can provide appropriate services.[57] The total intake assessment and screening process generally takes between 30-45 days.[58]

The intake assessment and screening process helps identify the health care needs of AICs. 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 AICs 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 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.[59] SUD treatment is also only offered at minimum security facilities, which means that AICs must have a classification level supporting placement in a minimum-security facility to be able to receive SUD treatment services.

[51] OAR 291-134-0030(1)(b).
[52] OAR 291-134-0030(1)(b)(A).
[53] OAR 291-134-0030(1)(c).
[54] Joe Bugher and Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 46.
[55] *Id.*
[56] OAR 291-134-0030(1)(c).
[57] *Id.*
[58] Joe Bugher and Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 46.
[59] *Id.*

Therapeutic Levels of Care

AICs can initiate visits with Health Services staff numerous ways, including a sick call process, talking to their housing officer, and written request ("kite").[60] 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 AICs with ongoing needs (e.g., multiple sclerosis, dementia, etc.) and provide care to AICs 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.[61]

- **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 AICs. [62]
- **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 an emergency in nature, can be subject to periodic utilization review. [63]
- **Level 3 Care and Treatment** (*medically acceptable but not medically necessary*). Defined as "care and treatment for nonfatal 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.[64]
- **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.[65]

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 AICs on the provision of services. This process also provides opportunity for clinical decision support and other education, and

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

serves to promote consistency in decision-making across facilities.[66] Due to its population size, Snake River Correctional Facility has its own TLC Committee; other facilities have regionally consolidated TLC Committees.[67] TLC Committees occur weekly and typically last around three to four hours. All facility providers are required to attend TLC Committees.[68] 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.[69] 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 percent 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 percent) and 2021 (1.39 percent); prior to the pandemic, DOC generally met the KPM target.[70]

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 a 30-day supply of necessary medications, safe sex kits, and Narcan for opioid overdose treatment. Health Services staff also identify AICs with severe medical or mental health needs that require ongoing treatment in the community and assist with referrals.[71] 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 2021-2023 Legislatively Approved Budget.[72]

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.[73] With income eligibility set at 138 percent of the federal poverty level, this means that most AICs will be eligible for OHP upon release from a DOC facility. OHP uses the Prioritized List of

[66] DOC uses the UpToDate platform to provide clinical decision support.
[67] Joe Bugher and Warren Roberts, *Presentation: DOC Health Care Delivery/Therapeutic Levels of Care*, *supra* note 46.
[68] *Id.*
[69] *Id.*
[70] Department of Corrections, *Annual Performance Progress Report: Reporting Year 2021*, September 17, 2021.
[71] OAR 291-124-0060.
[72] HB 5024 (2021).
[73] 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 an AIC.

Health Care Services (Prioritized List) to help determine and outline service coverage.[74] 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.[75] Every biennium, the Legislative Assembly funds the coverage of services up to a specified line on the Prioritized List (currently line 472 of 662).[76] 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 AICs. 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 ranking condition-treatment pairs and the legislature uses that Prioritized 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 noncoverage. 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 AICs as established by the Supreme Court.[77]

DOC's Therapeutic Levels of Care serve a prioritization function, albeit one that 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.[78] DOC's lack of an EHR system 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 the health care system monitored. Quality monitoring systems are customarily used in

[74] ORS 414.690 (2021)
[75] *Id*.
[76] ORS 414.025(13); ORS 414.690 (2021)
[77] *Peralta v. Dillard, supra* note 44.
[78] 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).

other health care system environments, including health insurance plans and OHP.[79] 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 prison 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.[80] 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.[81] 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.[82] RAND's assessment of CDCRs quality monitoring system highlighted significant variations in information technology systems among California's prisons due to the lack

[79] *See* the Health Effectiveness Data and Information Set (HEDIS) for health plans and Coordinated Care Organization (CCO) Metrics for OHP.
[80] 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).
[81] *Plata v. Schwarzenegger*, No. C01-1351 (N.D. Cal. Oct. 3, 2005).
[82] 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 care : the official journal of the National Commission on Correctional Health Care, April 2011, (100–121), https://doi.org/10.1177/1078345810397498.

of an electronic medical record (EMR).[83] Informed by RAND, CDCR has since implemented a robust quality monitoring system that incorporates 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.[84] These efforts have resulted in 19 of the 35 facilities being returned to CDCR's authority.[85]

[83] *Id.*
[84] California Correctional Health Care Services, *Health Care Services Dashboard*, available at https://cchcs.ca.gov/reports/ (last visited August 12, 2022).
[85] J. Clark Kelso, ***Receiver's Fiftieth Tri-Annual Report,*** June 1, 2022, available at https://cchcs.ca.gov/reports/ (last visited August 12, 2022).

VI. TASK FORCE RECOMMENDATIONS

The Task Force recognizes that successful adoption and implementation of an EHR system essential to the ability to objectively and meaningful track DOC's current standards of care, including the evaluation of compliance with community standards related to access, timeliness, and quality of care. With DOC's EHR procurement still in progress at the time of this report, the Task Force offers the following recommendations.

For the Department of Corrections.

1. **Continuous Quality Improvement.** DOC should ensure its continuous quality improvement program includes processes aimed at ensuring meaningful and timely access to health care services that aligns with national and community standards of care, particularly the Oregon Health Plan and including access to behavioral health and substance use disorder services and supports. The structure should incorporate:
    - Regular, structured review of AICs health care grievances and TLC Committee decisions to ensure ongoing compliance with access standards. This review should continuously evaluate whether the grievance and TLC Committee processes unnecessarily impact access and timeliness.
    - Routine input from medical, dental, behavioral/mental health, administrative, and security teams.
    - Implementation of a formal structure that allows AICs to participate and contribute to continuous quality improvement and that is distinct from the grievance process.
    - Contracting with an independent outside entity, such as a patient safety organization, to conduct audits of AICs grievances and TLC Committee decisions, ongoing charts reviews, and reviews of sentinel events.

    DOC should ensure implementation of an EHR system promotes continuous quality improvement, including supporting regular, publicly accessible reporting of metrics in the domains of access, timeliness, and quality of care.
2. **EHR Implementation.** DOC should ensure that implementation of an EHR system, including the migration of existing health record information, prioritizes:
    - robust, real-time interoperability with outside health systems, including those used by most hospitals and Medicaid providers in the state to allow for seamless exchange of healthcare information and telehealth options for care by outside providers while incarcerated;
    - continuity of care for AICs during intake, incarceration, and upon release; and
    - immediate access to necessary information by both DOC Health Services' staff and external health care providers.

3. **Workforce.** DOC should pursue efforts to bolster and support DOC Health Services' 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 AICs to serve as peer supports and other roles within applicable credentialing standards;
    - supporting access to culturally competent medical and mental health providers for AICs; and
    - maximizing staff ability to provide care within applicable practice scopes, including use of nurse protocols, physician assistants, and clinical pharmacy.
4. **Access.** 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.
5. **Reporting**. The report required by House 3035 to be submitted no later than December 31, 2022 by should include an update on DOC's implementation or progress on Recommendations #1-5. The report should also include information on NCCHC's credentialing of DOC facilities, including compliance with applicable standards related to continuous quality improvement programs and inmate communication forms ("kite") processing timelines. Ongoing and regular reporting to committees of the Legislative Assembly related to health and the judiciary should be established until the publicly accessible reporting noted in Recommendation #1 is in place.

For the Legislative Assembly.

6. **Office of the Corrections Ombudsman.** The Office of the Corrections Ombudsman in the Governor's Office should continue to be funded as long as adults are incarcerated in correctional facilities in the state. The Corrections Ombudsman should be tasked with engaging with AICs, family of AICs, and DOC to learn from, inform, and support DOC's continuous quality improvement efforts. The Corrections Ombudsman should provide a report within 6 months of hire to the Governor's Office and the Legislature Assembly, identifying any additional staffing or resources the Office would need to fulfill this proposed role.
7. **Behavioral Health and Substance Use Disorder Funding.** 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 all forms of medication-assisted therapy, to every AICs for the entire period of incarceration.
8. **EHR Implementation**. Future approval and funding for DOC's EHR system implementation should be contingent on demonstration of meeting the priorities

identified by the Task Force in Recommendation #2 (interoperability, continuity of care, access to information).

9. **Early Medical Release.**[86] The Legislative Assembly should consider the creation of early medical (i.e. compassionate) release standards that could support the provision of appropriate and timely care to AICs with terminal illnesses and complex medical needs, as well as free up DOC workforce and facility capacity to provide care to other AICs.

[86] SB 1568 (2022) would have established the Medical Release Advisory Committee within the State Board of Parole and Post-Prison Supervision and established procedures for AICs to apply for early medical release from custody.

APPENDIX A: DEPARTMENT OF CORRECTIONS – HB 3035 REPORT (DEC. 2021)

APPENDIX B: DEPARTMENT OF CORRECTIONS – HB 3035 REPORT (JUNE 2022)

APPENDIX C: DEPARTMENT OF CORRECTIONS – GRIEVANCE CATEGORIES

Grievance Categories:

Access - Medical services
Access - Intake healthcare
Access - Chronic care services
Access - Mental health care/BHS
Access - Dental services
Access - Optical
Access - Off-site care
Access - Purchased services
Access - Access to medical supplies
Access - Gender-specific care and treatment
Access - Interpretive services
Access - Health Promotion Programs
Access - Second opinion

Clinical decision - Provider license/certification
Clinical decision - Appropriateness of treatment
Clinical decision - HS policy
Clinical decision - TLC

Continue care - At receiving facility
Continue care - Off-site care

Time - sick call request to encounter
Time - follow-up appointment
Time - follow-up communication
Time - follow-up procedure
Time - obtaining medical records
Time - med RX to receipt
Time - grievance response

Effective - Desired outcome not met
Effective - Denial of request
Effective - Disagree diagnosis/treatment

Efficient - health system process

Provider - unprofessional conduct
Provider - don't understand
Provider - cultural insensitivity
Provider - informed consent

Safe - HS environment sanitation or hazards
Safe - Adverse event/emergency response
Safe - Patient/staff safety

Other - specify