Jail Health Care Standards Advisory Council Report

House Bill 3229 (2021 Regular Session)

September 15, 2022

Oregon Criminal Justice Commission

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The mission of the Oregon Criminal Justice Commission is to improve the legitimacy, efficiency, and effectiveness of state and local criminal justice systems.

Executive Summary

Oregon's cities and counties operate 39 local correctional facilities, including 31 county jails and eight municipal jails.[1] Adults in custody (AICs) in Oregon's jails receive health care while incarcerated, by medical staff employed by the jail, through in-facility contracted providers, or at community-based providers, such as local clinics or emergency departments. Oregon law provides a set of statutory jail standards at ORS 169.076 ("standards for local correctional facilities"), which include general provisions requiring Oregon jails to have written policies on admission and release medical procedures, medication and prescriptions, and provision of emergency medical and dental health care.[2] Voluntary, non-statutory jail standards are administered by the Oregon State Sheriffs' Association.[3]

House Bill (HB) 3229 (2021 Regular Legislative Session) tasked the Criminal Justice Commission (CJC) with convening an advisory committee to craft recommendations for minimum jail health care standards and recommendations for an independent jail commission to continue reviewing and refining jail health care standards in the future, among other tasks. A 16-member Jail Health Care Advisory Council (JHCSAC) was formed to carry out the tasks described by HB 3229 and to supply recommendations to the Oregon Legislature by September 15, 2022. What follows is a summary of recommendations developed by the JHCSAC and the CJC in response to this legislation. Questions about this report may be directed to Bridget Budbill, CJC Senior Policy Analyst, at 503-302-8780 or at bridget.budbill@cjc.oregon.gov.

Minimum jail health care standards recommendations:

1. Expand access to continuing education programs, trainings, and opportunities for health care professionals (existing and new) to gain experience working with incarcerated populations. Incentivize jail-setting medical employment with student loan assistance, hiring bonuses, or housing subsidies, whenever possible.
2. Employ a regional or statewide medication access program through which Oregon's local correctional facilities may purchase medications through a streamlined source at government rates.
3. Provide guidance, through independent jail commission, to Oregon jails on compliance with the Americans with Disabilities Act (ADA) on medication-assisted treatment. Provide resources to jails on medication-assisted treatment for AICs.
4. Create statewide or regional health care provider teams to support jails when AICs need medical care. Medical professionals employed through the state could provide jails with much-needed staffing support when local resources are unable to meet the medical attention needs within a given facility. The jail commission should be tasked with developing guidelines for when a facility will call upon the state's jail provider teams.

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[1] A local correctional facility is a jail or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds persons for more than 36 hours. ORS 169.005(4).
[2] ORS 169.076(2)(d-e); ORS 169.076(5).
[3] Oregon State Sheriffs' Association (OSSA) Jail Standards: Best Practices and Guidelines for the Operation of Jails in the State of Oregon, Eighth Edition (revised May 2019), available at https://oregonsheriffs.org/jail-standards/#:~:text=OSSA%20worked%20to%20create%20the,in%20the%20operation%20of%20all.

5. Support the expansion of telehealth opportunities to the greatest extent possible, when medically appropriate.
6. Place the burden of reinstatement of Oregon Health Plan (OHP) duties on the state rather than on the individual and expand OHP coverage to AICs in Oregon at every opportunity.
7. Support expansion of non-jail, non-state hospital, community-based or regional settings for behavioral health treatment, including secure residential, residential, and outpatient services.
8. Expand transition planning between institutions, including jails and state facilities, from which AICs are releasing, such as transition centers and peer support, to the greatest extent possible.
9. Medical screenings, including intake medical, suicide-risk, and behavioral health screenings, should be administered by jails upon the admission of an AIC, but the precise contents of these screenings would be best left to the independent jail commission to manage with Oregon's jails through administrative rules or policies.

Independent jail commission:

An independent jail commission should be located within an executive-branch agency, possibly housed within the Criminal Justice Commission or the Department of Correction's new Office of the Ombudsman, when it is operational. Membership should be Governor-appointed and Senate-confirmed, and it should include, at minimum, representatives of Oregon county and municipal jails, health care professionals, and people with lived experience receiving health care in Oregon jails. A robust self-nomination process should be developed. Members should ideally serve staggered six-year terms. Meetings should follow regular public meetings rules and include accessible means of public participation. The JHCSAC recommends that independent commission members should elect co-chairs (or possibly tri-chairs), with leadership responsibilities shared amongst persons from law enforcement, health care, and lived experience backgrounds. The independent commission should also have primary inspection authority of local correctional facilities, including authority to conduct unannounced inspections of local correctional facilities related to the provision of health care within those facilities. Inspections should include inspection of materials related to the provision of health care, but this is not intended to include protected patient health care information.

The independent commission should report to the Oregon Legislature on a biannual basis submitted on even years in advance of long Legislative Sessions held on odd years, providing updates on jail health care standards adopted, revised, or repealed, any issues with compliance, technical assistance provided to jails, and any other germane issues. The independent commission should be given the authority and budget to hire staff, such as an executive director.

Additional work is ongoing to fully analyze resource needs for implementation of these recommendations. A follow-up addendum will be issued describing implementation needs and timelines before the end of this year.

A copy of this report may be obtained by contacting the Oregon Criminal Justice Commission at 503-302-8780 or at cjc.grants@cjc.oregon.gov. The report may also be accessed via the Publications page at the agency's website: https://www.oregon.gov/cjc.

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Jail Health Care Advisory Council Membership

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- Captain Lee Eby, Jail Commander, Clackamas County, Oregon State Sheriffs' Association
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- Representative Lisa Reynolds, House District 36
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Acknowledgements

The Oregon Criminal Justice Commission (CJC) staff thanks the members of the Jail Health Care Standards Advisory Council for their consistent engagement, time, and expert contributions to the discussions resulting in this report. Additionally, Michael Kaiser, Shayla Nice, and Karen James, though not formally appointed members, provided critically important perspectives necessary to round out the expertise at the virtual meeting table, for which CJC staff is grateful. CJC staff also thanks the Oregon State Sheriffs' Association for generously allowing free and public use of their copyrighted jail standards for the betterment of this project's discussions.

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Section I: Background and Report Overview

A. Jail Health Care Standards Advisory Council Background

HB 3229 (2021 Regular Session) created, within the Criminal Justice Commission (CJC), the Jail Health Care Standards Advisory Council (JHCSAC), a 16-member body tasked with advising the CJC in providing the Oregon Legislature with recommendations for an independent jail commission, recommendations for seven specified areas of minimum health care standards in Oregon's jails, recommendations for any promising practices or pilot programs worthy of consideration, and costs of implementation of any recommendations, including possible funding sources.

B. Oregon Local Correctional Facilities Health Care Overview

Oregon counties and cities operate 39 local correctional facilities (jails): 31 county jails and eight municipal jails.[4] Local correctional facilities are local institutions used for the reception and confinement of adults in custody (AICs) for more than 36 hours.[5] The United States Supreme court, in the 1976 seminal case, *Estelle v. Gamble*, held that incarcerated persons must be provided health care while in custody and that to deny care regarding serious medical needs would be a violation of the Eighth Amendment's prohibition on cruel and unusual punishment.[6]

Health care in Oregon jails may be delivered in several ways: (1) by jail-employed health care staff; (2) by contracted-for health care staff through national providers, like WellPath or NavCare; (3) by contracted-for local providers, such as local physicians or nurse practitioners; (4) by taking adults in custody to external providers, such as local hospitals, or some combination of those options. A point-in-time count taken in 2019 of AICs in Oregon jails was 5,451 people, based on reports from 33 of Oregon's 39 jails.[7]

The Oregon Health Plan (OHP) is Oregon's state implementation of the federal Medicaid program; therefore, this report will refer to Oregon's extension of federal Medicaid benefits as "OHP" going forward. OHP provides health care coverage to low-income residents of Oregon.

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[4] Several Oregon counties contract with neighboring counties for jail bed space rather than operate an individual, in-county jail. There is also one regional jail in Oregon, the Northern Oregon Corrections Facilities (commonly called "NORCOR"), jointly operated by and serving Gilliam, Hood River, Sherman, and Wasco counties.

[5] ORS 169.005(4) (defining "Local correctional facility"). By comparison, "Lockups" may hold persons for up to 36 hours (ORS 169.005(5)), and "Temporary hold" facilities may hold persons for four or less hours (ORS 169.005(8)).

[6] *Estelle v. Gamble*, 429 US 97, 97 S Ct 285, 50 L Ed 2d 251 (1976) (providing that "deliberate indifference to serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain * * * proscribed by the Eighth Amendment" and that indifference may be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed"). The Oregon Supreme Court has construed this same principle through the Oregon Constitution in *Billings v. Gates*, 323 Or 167, 916 P2d 291 (1996) (providing that the "Eighth Amendment's 'deliberate indifference to serious medical needs' standard is the appropriate standard under Article I, section 16," referring to the Oregon Constitution's prohibition on cruel and unusual punishments found in Article I, section 16, of the Oregon Constitution (1857)).

[7] Though this figure is incomplete, the jails not reporting were small or very small jails, meaning that the figure is a fair representation of *most* of the state's jail population at that point in time.

As of July 31, 2022, Oregon is home to 1,424,962 persons receiving healthcare through OHP.[8] A review of OHP enrollment from 2016 to 2019 found that, of 846,010 Oregon adult residents aged 18-64 enrolled in OHP (excluding persons also dually eligible for Medicare), at least 20,627 persons had criminal justice involvement (meaning, for the purposes of the report, persons who served a felony probation sentence or were serving a felony sentence in an Oregon prison; persons convicted of misdemeanors or who were arrested but not convicted were not included in the figures).[9] Thus, the number of persons on OHP with criminal justice involvement is almost certainly higher than the report's data sets could address. Per the report, persons with criminal justice involvement and who were enrolled in OHP were also found to be 70 percent more likely to receive Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families Benefits.[10]

Due to longstanding federal policy, the Medicaid Inmate Exclusion Policy, enacted as an amendment to the Social Security Act of 1965, persons lose their OHP coverage approximately 24 hours after their lodging in an Oregon jail (or prison) regardless of conviction status.[11] This means persons become uninsured, and all medical care costs that arise while the person is incarcerated fall to the jurisdiction in which the person is incarcerated (such as the county operating a local correctional facility at which the person is incarcerated), unless the person is moved to a medical institution, such as a local hospital.[12] Once the person is returned to jail, their OHP benefits are again inaccessible. OHP benefits are suspended, but not terminated entirely, while a person is incarcerated. The Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS) share responsibility for some tasks related to OHP benefits eligibility, suspension, reinstatement, and termination, while OHA is solely responsible for others.[13] Once a person who is OHP-eligible is released from an Oregon jail or prison, there are two ways in which they may seek to have their benefits reactivated (or applied for, if a person is eligible for, but was not previously enrolled in, OHP).

First, if the institution from which they are releasing has an "application assister," meaning a staff person based in the jail or prison, or a community-based organization or volunteer available, the person seeking OHP benefits reinstatement may request that person's assistance with contacting OHA's Health Services Division for benefits reinstatement. Many Oregon jails do not have OHP assisters available to support AICs at this time. Second, a person may also directly contact OHA to request benefits reinstatement. Per OHA administrative rule, persons released

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[8] Oregon Health Authority, Medicaid Monthly Population Report for Oregon, available at: https://app.powerbigov.us/view?r=eyJrIjoiMTRhMmNhZDktYzY4OS00MzIxLTg4NTAtNjc4NmVlNjA1NzI4IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9, July 31, 2022 (last accessed August 16, 2022).

[9] Renfro S., Levy A., Charlesworth C., McAlister S., Officer K., and Glaser C. The Intersection of Criminal Justice Involvement and Medicaid in Oregon. Center for Health Systems Effectiveness, Oregon Health & Science University 2021, available at https://www.oregon.gov/cjc/CJC%20Document%20Library/Intersection_Criminal_Justice_Involvement_and_Medicaid.pdf.

[10] *Id*. at 8.

[11] 42 USC 1396d, §1905(a)(xvii)(30)(A) (1965), available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

[12] *Id*.

[13] The CJC is presently creating a process map of Oregon's complex OHP benefits management process to aid in jail health care policy discussions going forward.

from custody must request their benefits be reinstated within 10 days of their release. Otherwise, their benefits will be terminated, and the person will have to entirely reapply for benefits anew.[14]

OHA is in the process of applying for a change in its federal Medicaid program, through a process known as a Medicaid 1115 Waiver.[15] This process allows states to ask for waivers to existing Medicaid policy in certain circumstances. OHA has requested, among other things, for an 1115 waiver to allow AICs to access limited OHP benefits while incarcerated.[16] At the time of this report, OHA and the Centers for Medicare and Medicaid Services, the federal agency with authority to negotiate Medicaid waivers with states, were still engaged in discussions. A decision on OHA's 1115 Waiver application is anticipated by fall of 2022.

C. Existing Oregon Jail Standards Sources

At present, there are three primary sources of jail standards that apply to how Oregon's jails operate: (1) codified standards provided in ORS 169.076, as well as other laws specific to jails within ORS Chapter 169; (2) the Oregon State Sheriff's Association (OSSA) Oregon Jail Standards, which are voluntary but are employed by nearly all jails in Oregon; (3) a manual of standards to be promulgated and managed by the Oregon Department of Corrections (DOC) per ORS 169.090(1), and (4) any additional provisions imposed upon jails by local governments or adopted internally by individual institutions.[17] In certain circumstances, jails may be subject to additional federal laws and regulations, such as the Prison Rape Elimination Act, should jails hold persons on behalf of the federal government.[18] Jails are also subject to federal statutory provisions, such as the Americans with Disabilities Act and the Health Insurance Portability and Accountability Act, as other examples.[19]

D. Additional Non-Binding Jail Standards Sources

In addition to binding and non-binding Oregon-based jail standards, a variety of other sources of best practices and model standards exist by way of other government bodies, national

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[14] OAR 410-200-0140(4)(c).
[15] Oregon Health Authority, "2022-2027 Medicaid 1115 Demonstration Application," Health Systems Division Medicaid Policy, available at https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx (last accessed August 21, 2022).
[16] Oregon Health Authority, "Improving Health Outcomes by Streamlining Life and Coverage Transition," 2021, available at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3786d_2.pdf (last accessed September 6, 2022) (a summary of the policy proposal specific to AICs).
[17] Though ORS 169.090(1) requires DOC to publish and distribute a manual of jail standards, functionally this role has been adopted by OSSA through the maintenance of the OSSA Jail Standards. DOC is presently reviewing its manual of jail standards.
[18] Prison Rape Elimination Act, Pub L §§ 108-79, 117 Stat 972 (2003), available at: https://www.govinfo.gov/content/pkg/PLAW-108publ79/pdf/PLAW-108publ79.pdf (last accessed September 4, 2022).
[19] Americans with Disabilities Act, 42 USC § 12132, Pub L 101-336, 104 Stat 327 (1990), available at: https://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm (last accessed September 4, 2022); Health Insurance Portability and Accountability Act, Pub L §§ 104-191, 110 Stat 1936 (1996), available at: https://www.govinfo.gov/content/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf (last accessed September 4, 2022).

accreditation organizations, and advocacy groups. Key examples include the National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails (2018)[20] and the American Bar Association's Standards for Criminal Justice – Treatment of Prisoners (2011).[21] Oregon jails may draw from these and other like-sources as they see fit. At the time of this report, one Oregon jail, the Clackamas County Jail, has achieved NCCHC Standards accreditation.

E. Existing Oregon Local Correctional Facilities Oversight Overview

1. State Level

The Oregon Department of Corrections (DOC) is the primary state-level agency responsible for jail inspections. DOC is required to inspect local correctional facilities to ensure compliance with the statutory jail standards established at ORS 169.076. Per DOC administrative rules, these inspections must take place "routinely."[22] Resulting jail inspection reports must be be forwarded to the jail's director, county commissioners, city council members, or city managers, and the jurisdiction's sheriff or police chief.[23]

If DOC finds a jail to be out of compliance with the statutory standards, the DOC jail inspector must notify the appropriate local authority responsible for the jail's operation in writing, stating the violation and/or condition of non-compliance and including a reasonable time within which the jail must achieve compliance.[24] If compliance is not met, the DOC jail inspector must notify the DOC Director of non-compliant jails, who then must refer the matter to the Oregon Attorney General, who has authority to enforce statutory jail standards.[25] DOC must also maintain a manual of jail standards per ORS 169.090.[26] DOC may also enter into agreements with public or private entities to conduct inspections of Oregon's jails, per ORS 169.070(2), a process which DOC has largely delegated to the OSSA.

2. Local Level

While ORS 169.080 gives DOC inspection authority and the Attorney General enforcement authority, ORS 169.040 also provides that county commissions (or county courts, if that is the local county government structure) are "the inspector[s] of the local correctional facilities in the county."[27] Accordingly, county commissioners must visit local correctional facilities operated by county at least once in each regular term and must examine fully the local correctional facility,

[20] National Commission on Correctional Health Care, "Standards for Health Services in Jails" (2018).
[21] American Bar Association, "Standards for Criminal Justice – Treatment of Prisoners, 3rd ed (2011), available at https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners/ (last accessed September 1, 2022).
[22] OAR 291-167-0015(2).
[23] OAR 291-167-0015(2)(a) and (c).
[24] ORS 169.080(1); OAR 291-167-0015(4)(a).
[25] ORS 169.080(2); OAR 291-167-0015(4)(b)
[26] ORS 169.090.
[27] ORS 169.040(1).

including, but not limited to, cleanliness, health, and discipline of AICs.[28] If it appears to commissioners that any laws have been "violated or neglected," they must immediately notify the district attorney of the jurisdiction.[29]

As a separate obligation, the district attorney's office must also convene a grand jury annually to "inquire into the condition and management" of each jail in the county and issue a report describing the inquiry.[30] The statute does not define report contents or publication specifics. District attorneys' offices typically publish these reports on their office websites.[31]

Additionally, ORS 169.040 also provides that the local health officer or a representative "may conduct health and sanitation inspections on a semiannual basis," but does not require them. If an inspection does take place and the local health officer finds a jail to be "insanitary or unfit for habitation for health reasons," the officer may notify the appropriate local governmental agency.[32] If the jail does not comply with health and sanitation conditions within an appropriate time, following a public hearing on the matter, the local health officer may recommend suspension of operation of facility to the local public health authority until conditions and practices improve.[33]

3. Oregon State Sheriffs' Association

While OSSA has no direct statutory responsibility to inspect jails, as noted previously, DOC has entered into an agreement with OSSA to carry out much of the jail inspection responsibilities for Oregon's jails. This concerns compliance with the statutory standards set forth in ORS 169.076(1-15). Additionally, most Oregon jails voluntarily participate in a process set forth in the appendices of the OSSA's Oregon Jail Standards. [34] As set forth in the OSSA Jail Standards, every two years, participating jails undergo a formal inspection led by a member of the association's jail inspection team.[35] On years in between formal inspections, jails are required to perform informal self-inspections.[36] Documentation must be maintained for formal and informal inspections.[37] Compliance is indicated based on three levels of performance: (1) full compliance; (2) partial compliance; and (3) noncompliance.[38] Upon formal inspections, the team leader must submit a completed report to the sheriff of the county or head of the city jail inspected.[39]

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[28] *Id*.
[29] *Id*.
[30] ORS 132.440(1).
[31] *See, e.g.,* Jackson County Special Corrections Grand Juries Reports, available at https://jacksoncountyor.org/da/General/Special-Corrections-Grand-Jury-Reports; 2021 Official Report Clackamas County Grand Jury, available at https://dochub.clackamas.us/documents/drupal/2816fa55-7844-4ec9-bbbc-9271eaa7ab19.
[32] ORS 169.040(2).
[33] *Id*.
[34] OSSA Jail Standards, Appendices 1-4 (181-94), available at https://oregonsheriffs.org/jail-standards/ (last accessed September 13, 2022).
[35] *Id*. at 181.
[36] *Id.*
[37] *Id*. 182-83; 187-88.
[38] *Id*. at 183.
[39] *Id*. at 185.

Section II: Independent Jail Commission

A. HB 3229's Independent Jail Commission Requirements

The CJC, in concert with the JHCSAC, was tasked with developing recommendations for the establishment of a permanent, independent jail commission (hereinafter, "independent commission") to, on an ongoing basis, review minimum health care standards in jails for the purpose of periodically updating and optimizing minimum standards, policies, and procedures for the provision of health care services to AICs in Oregon jails.[40] Per HB 3229, recommendations for the independent commission may include, but are not limited to:

(1) The name of the independent commission;
(2) The number, term and qualifications of members on the independent commission;
(3) The appointing authority for each member of the independent commission;
(4) The executive agency, if any, under whose auspices the independent commission will be established;
(5) Protocols for conducting business and holding meetings; and
(6) The frequency at which the independent commission must report to the legislature.[41]

B. Independent Commission Recommendations

1. Independent commission scope

The JHCSAC discussed the breadth of the independent commission's scope and authority. The independent commission should begin with health care standards as its objective and leave whether it should have broader compliance capacity to be answered after implementation of this initial range of duties. The independent commission should have primary authority over health care inspections of Oregon's jails, but other, existing inspections should be allowed to continue operations. The independent commission should have the authority to perform unannounced inspections of local correctional facilities concerning provision of health care to AICs, regardless of the facility's mode of providing health care (county employees, contracted services, etc.), including inspection of related materials. Materials subject to inspection are not intended to include protected patient health care information.

In addition to a compliance role, the JHCSAC discussed how an independent commission should also serve as a technical assistance resource to Oregon's jails. Discussion of other models of jail oversight indicate that compliance operations, without providing resources and guidance on

[40] *See* HB 3229 (2021 Regular Session), Section 1(4)(a-b), available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3229.
[41] *Id*.

improving conditions with a given facility, will not lead to better system outcomes for jail staff or AICs.[42]

2. Independent commission name

Recommendations:

- Oregon Jail Health Care Standards Commission
- Oregon Jail Health Care Standards and Resources Commission

3. Number and qualifications of members on the independent commission

The JHCSAC recommends appointing approximately 10 members to an independent commission, generally representing three broad constituencies: (1) Oregon jails; (2) people with lived experience as adults in custody in Oregon jails; and (3) health care professionals. In reviewing the membership of the JHCSAC, itself, the group recommends the following membership:

1. One member who has medical training and experience delivering health care services directly to patients;
2. One member who has training and experience as a pharmacist;
3. One member who has training in counseling, psychiatry or other similar field with experience delivering mental health services to clients;
4. One member who is the chief administrator at a large, county-based local correctional facility;
5. One member who is the chief administrator at a small, county-based local correctional facility;
6. One member representing a federally qualified health center;
7. One member who provides health care services to adults in custody at a local correctional facility;
8. One member who is the chief administrator at a municipal-based local correctional facility; and

9 & 10. At least two members who have lived experience seeking or receiving health care in an Oregon local correctional facility.

HB 3229 did not include appointed members with lived experience as persons seeking and/or receiving health care in an Oregon jail, nor did it include a representative of a municipal jail, on the JHCSAC. This recommended list adds those perspectives to the independent commission.

[42] *See, e.g.*, Michelle Dietch, *But Who Oversees the Overseers?: The Status of Prison and Jail Oversight in the United States*, Am J Crim L Vol 47:2, 219-221 (2020), available at: https://utexas.app.box.com/v/ButWhoOverseestheOverseers; Texas Commission on Jail Standards, available at https://www.tcjs.state.tx.us/ (last accessed August 8, 2022).

The need for at least two members (rather than one) with lived experience is necessary for several reasons. It recognizes that people with lived experience will, themselves, have different experiences based on their incarceration circumstances and health care needs. Additionally, people with lived experience tend to have more barriers to attending these kinds of meetings, typically held during regular business hours, such as requiring time off work. Lastly, the JHCSAC discussed the importance of removing any barriers to participation based on a person's past or present criminal justice involvement, as is often the case with appointments to boards and commissions, as lived criminal justice system experience is precisely the experience sought here.

Additionally, including representatives from both small *and* large county jails will ensure that different resource realities from Oregon jails are represented.

Recommendations:

- Create a commission generally inclusive of persons representing Oregon county and municipal jails, health care providers, and at least two members with lived experience seeking and/or receiving health care in an Oregon jail, thereby creating a commission of approximately 10 members as listed above.
- Allow the independent commission the flexibility of creating subcommittees, as needed, and adding members to subcommittees, to fulfill the expertise needs of each topic area.

4. Terms of members serving on independent commission

The term of members serving on an independent commission should be long enough to allow for genuine contributions from members, given the complexity of the topic and how long implementation of new statewide policies may take to administer. Term limits are recommended to ensure that different voices and perspectives are given opportunity to participate in this role.

Recommendations:

- Members of an independent commission should serve six-year terms.
- Each member may serve up to two consecutive six-year terms before a new person must take the seat.

5. Executive agency, if any, under whose auspices the permanent independent commission will be established

Given that policies, such as health care standards, heavily rely on the best possible information available, the JHCSAC has discussed the wisdom of relying on administrative rulemaking for the bulk of recommended standards rather than codifying provisions into statutes that are much more difficult to amend when new information arises. Thus, placing the independent commission within an existing executive-branch agency will provide the commission with the best framework to be responsive and effective. As such, the commission should be given independent rulemaking authority.

Executive branch agencies in which the JHCSAC recommended the independent commission to be potentially situated included:

- Oregon Criminal Justice Commission
- Oregon Department of Corrections, Office of the Ombudsman

6. Appointing authority for members of the permanent, independent commission

An effective appointment process for the independent commission is critical to ensuring its membership is responsive and ready to fulfill its scope of duties; it is also important that the independent commission be reflective of stakeholders most affected by and connected to the jail health care system. Creating a system through which appointments can be made with efficiency and stakeholder input is key to getting this work done and building trust that the independent commission is adequately representative.

Accordingly, the Governor's Office should make commission appointments, after considering nominations or recommendations from agencies, organizations, associations, entities, and self-nominations from interested persons. The Senate should then be asked to confirm the Governor's Office appointments.

Recommendations:

- Nominations or recommendations for membership should be requested from the agencies, organizations, associations, or entities representing members, constituents, or interests of persons described in the membership list.
- Persons should be allowed to self-nominate themselves for membership on the independent commission.
- The Governor's Office and Senate, when making and confirming appointments for independent commission membership, should consider a diversity of backgrounds, experiences, and identities.

7. Protocols for conducting business and holding meetings

The independent commission should operate as would any public body holding public meetings. Membership should elect a set of co-chairs, at minimum, and perhaps tri-chairs, if desired.

Recommendations:

- Members of the independent commission should elect at least two co-chairs, and perhaps tri-chairs, to ensure shared, representative leadership will lead meetings.
- Membership must have quorum to do business.
- Official business, such as adopting rules, must be agreed to by a majority of members.
- The independent commission should provide a virtual format for attending all meetings.
- The independent commission should have public comment and participation process that favor broad participation and are not burdensome to members of the public, such as requiring pre-meeting registration in order to participate. Independent commission staff and leadership may manage the public comment and participation process as needed to complete business and respect meeting requirements and available time.
- The independent commission should follow normal executive session rules in existence.

8. Frequency at which the independent commission must report to the legislature

Recommendations:

- The independent commission should submit reports biannually.
- Reports should be submitted by December 31st of each even year, to allow for the Legislative Assembly to respond to report contents during long sessions held during odd years, e.g., reporting due December 31, 2024, in advance of the 2025 Regular Session.
- Reports should be submitted, in the manner described in ORS 192.245, to the House and Senate Committees on Judiciary or an interim committee of the Legislative Assembly related to the Judiciary, and any other germane legislative committees.
- Reports should include, but need not be limited to:
    - Any standards (administrative rules or policies) published, amended, or repealed, and rationales for changes.
    - Jails found to be in and out of compliance with standards, and if out of compliance, why, and actions taken by the commission and jail to improve the situation leading to non-compliance.
    - Every four years, the independent commission should include, with its regular biannual reporting, an evaluation of current reporting (e.g., any topics that should be added, repealed, or amended from regular reporting) and other germane information.
    - Reporting requirements should give the independent commission latitude to describe to the Oregon Legislature anything else it should be aware of or consider.

9. Other recommendations for the establishment of an independent commission

Recommendations:

- The independent commission should have the authority to hire and staffing and a state-supplied General Fund budget to maintain this staffing.
- The independent commission should have compliance and technical assistance authority and duties, including primary authority to conduct inspections of Oregon local correctional facilities' provision of health care to AICs.
- The independent commission should have the authority to conduct unannounced inspections of Oregon jails, as needed.
- The independent commission should make resources available to AICs, jail staff, and the general public for asking questions or reporting concerns about provision of health care in Oregon jails, including an online form for submissions and a phone number to call.

Questions or concerns should also be allowed to be made anonymously if the person prefers to remain anonymous.[43]

Section III: Minimum Health Care Standards Discussions and Recommendations

A. HB 3229's Health Care Standards Topics

The seven specific health care topics enumerated in HB 3229 include:

(1) Qualifications and licensure requirements for health care professionals;

(2) Access by adults in custody to a health care professional who is authorized to prescribe pharmaceutical medications;

(3) Staffing levels and round-the-clock, on-call health care services;

(4) Protocols to ensure timely transfer and continuity of care for adults in custody to and from a hospital following a determination by a health care professional that treatment at a hospital is medically necessary;

(5) Screening health care needs of adults in custody;

(6) Scheduling and administering appointments, including follow-up appointments, with health care professionals; and

(7) Establishing an appropriate, confidential space for the provision of health care services to adults in custody.[44]

The CJC and JHCSAC were also tasked with recommending any pilot project or tiered implementation the bodies deem worthy of consideration.[45] Finally, the CJC and JHCSAC are tasked with providing cost estimates and funding sources for implementation of all policy areas described above.

B. HB 3229 Jail Health Care Discussions and Recommendations

1. Qualifications and licensure requirements for health care professionals

ORS 169.076, Oregon's statutory jail standards do not impose any statutory criteria for health care providers' medical qualifications or licensure. However, myriad other statutes, administrative rules, and policies, operated by state agencies and professional oversight boards,

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[43] Examples of anonymous online concerns and questions forms are available at the Texas Commission on Jail Standards, "County Jail Complaints & Inquiries Online Form," available at: https://www.tcjs.state.tx.us/jail-complaints-inquiries/ (last accessed September 8, 2022), and the New York City Board of Correction, "File a Complaint Online," available at: https://www1.nyc.gov/site/boc/about/file-a-complaint-online.page (last accessed September 8, 2022).

[44] HB 3229 (2021 Regular Session), Section 1(3)(a-g), available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3229.

[45] *Id*. at HB 3229, Section 1(3)(h).

govern qualifications for health care professionals regardless of practice setting. No distinction in minimum qualifications for active licensure is made between, for example, a nurse who provides care in a county jail and a nurse in a private hospital.

The OSSA Jail Standards require that "[j]ail health care personnel must meet the same certification and licensure requirements as health care professionals who provide health care services to non-incarcerated persons."[46] Additionally, the OSSA Jail Standards provide that jails must maintain policies and procedures that define "the functions and supervision requirements for any unlicensed assistance (interns, students, other non-certified personnel) who are involved in providing health services" to AICs.[47]

After reviewing the sources of existing medical certification and licensure provisions in Oregon law, the JHCSAC members felt existing provisions adequately cover licensure and certification of health care professionals providing care in Oregon's jails.

Recommendations:

- Health care licensure and certification should continue to be administered by existing health care authorities; no new statutory provisions are necessary.
- Expanding access to continuing education programs, trainings, and opportunities for health care professionals to gain experience working with incarcerated populations should be pursued.

2. Access by adults in custody to a health care professional who is authorized to prescribe pharmaceutical medications

ORS 169.076(2)(e) requires that jails must have a comprehensive written policy with respect to medication and prescriptions. Additionally, ORS 169.076(5)(b) requires that jails have written policies for the security of medication. Myriad state statutes and administrative rules govern who may prescribe and/or dispense medications. The JHCSAC discussed the benefits of removing any unreasonable barriers to AICs accessing health care within facilities. The JHCSAC discussed concerns about codifying policies and procedures regarding precisely how and when health care professionals shall or will prescribe medications in favor of clinical decisions being left to a jail's medical director, in concert with any state laws and administrative regulations, current or enacted in the future. However, the JHCSAC also discussed ways in which *access* by AICs to health care professionals authorized to prescribe medications may be improved, as well as improving jails' access to medications.

First, creation of a state-facilitated source for local correctional facilities to access medications commonly needed or in-bulk would save local jails' resources – both staff time and money – and

[46] OSSA Jail Standards, Health Care Services Personnel Qualifications, G-108, 147, available at https://oregonsheriffs.org/jail-standards/ (last accessed September 13, 2022).
[47] OSSA Jail Standards, Use of Students/Interns, G-109, 147 (specifying that, if "unlicensed, assistants should be permitted to work only while directly supervised by a certified health care professional, such as a physician, nurse, physician's assistant, or nurse practitioner and limited to only functions that are well within the limits of their training and expertise").

would aid in streamlining the availability of those medications to AICs in jails across the state. At the time of this report, the CJC is gathering more information about programs in other states that may serve as instructive models for this process.

Second, a more specific instance in which AICs may have inconsistent access to medications is when a person is incarcerated with a substance-use disorder (SUD), such as an opioid-use disorder (OUD), and may be in medical need of medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). Whether Oregon jails provide MOUD or MAT is a facility-by-facility decision. The U.S. Department of Justice Civil Rights Division (DOJ) recently released guidance that clarifies that the Americans with Disabilities Act (ADA) protects persons who are in treatment or recovery from an OUD.[48] This is because, typically, a person in treatment or recovery from OUDs qualify as having a disability under the federal statute, and the ADA prohibits discrimination on the basis of having a disability.[49] Per the DOJ guidance, this means that a "jail's blanket policy prohibiting use of MOUD would violate the ADA."[50] Incarcerated persons who are prescribed medication to treat OUDs under the supervision of a licensed health care professional are protected to continue doing so under the ADA.

Thus, ensuring that Oregon jails are not blanket prohibiting MOUD or MAT and instead leaving the provision of whether and when MOUD and MAT are medically appropriate up to the facility's medical director, is necessary for improving AIC access to necessary medications and for ensuring facilities comply with the ADA. Ample evidence also exists that making MOUD and MAT available within jails will make facilities safer for AICs and staff, while also saving valuable resources.[51]

Recommendations:

- Employ a regional or statewide medication access program through which Oregon's local correctional facilities may purchase medications through a streamlined source at government rates. The DOC or OHA may be natural fits for this coordinating role.
- Provide guidance, through the independent commission, to Oregon jails to ensure awareness of ADA compliance issues with blanket prohibitions of AIC access to MOUD or MAT.
- Provide resources, including funding and technical assistance for grant-writing, to jails to provide MOUD and MAT to AICs.

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[48] U.S. Department of Justice Civil Rights Division, "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery," April 5, 2022, available at: https://www.ada.gov/opioid_guidance.pdf (last accessed August 19, 2022).

[49] *Id*. at 2 (describing that people with an OUD are typically considered to have a disability because, "they have a drug addiction that substantially limits one or more of their major life activities" and "[d]rug addiction is considered a physical or mental impairment under the ADA").

[50] *Id*.

[51] National Academies of Sciences, Engineering, and Medicine, 2019. Medications for opioid use disorder save lives. Washington, DC: The National Academies Press, 99-100, available at https://doi.org/10.17226/25310 ("For people with OUD involved with the criminal justice system, a lack of access to medication-based treatment leads to a greater risk of returning to use and overdose after they are released from incarceration. * * * Given their impact on mortality, it has been argued that withholding medications for OUD during incarceration is unethical, as would be withholding insulin or blood pressure medication").

3. Staffing levels and round-the-clock, on-call health care services

Existing statutory jail standards require that jails must "provide sufficient staff to perform all audio and visual functions involving security, control, custody and supervision of all confined detainees and AICs, with personal inspection at least once each hour."[52] This standard is not specific to medical professionals. Jails must also provide for emergency medical and dental health, and have specific written policies providing for, among other things, a records system to include requests "for medical and dental attention, treatment prescribed, prescriptions, special diets and other services provided."[53]

During JHCSAC discussions of staffing levels and round-the-clock, on-call health care services, several themes emerged. First, key resource shortages have put Oregon jails, in particular, in challenging circumstances in finding and retaining medical professional staffing. Shortages of qualified medical professionals have plagued many states, including Oregon, throughout the COVID-19 pandemic, a circumstance which exacerbated an *existing* staffing shortage problem whereby many Oregon counties have long faced shortages of health care providers, such as primary care and mental health professionals.[54] Jails and other correctional facilities have been hit particularly hard because they are often unable to keep pace with higher salaries available in other medical facilities. The JHCSAC discussed how, even if Oregon jails *have* the resources to hire or contract for more medical staff, more staff are often not available.

Second, limited jail resources, by way of county budgets, often do not leave jails with the funds to hire or contract for more staff, particularly in Oregon's rural or frontier counties, many of which are already considered medically underserved for persons who are *not* incarcerated, let alone those who are.[55]

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[52] ORS 169.076(1).
[53] ORS 169.076(5)(c).
[54] *See, e.g.,* Oregon Health Authority, Primary Care Office. "Health Care Professional Shortage Area Designation," available at https://www.oregon.gov/oha/HPA/HP-PCO/Pages/HPSA-Designation.aspx (last accessed September 12, 2022); Oregon Health Authority, "What's the Deal With Designations?" available at https://www.oregon.gov/oha/HPA/HP-PCO/Documents/Designations%20Overview.pdf (last accessed September 12, 2022); Oregon Health Authority, "Oregon's Health Care Workforce," 2021, available at https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2021-Health-Care-Workforce-Needs-Assessment.pdf (last accessed September 9, 2022) (describing challenges within Oregon's health care workforce); Amelia Templeton, "*With too many patients and too few colleagues, Oregon nurses say: 'We're drowning,'*" Oregon Public Broadcasting (September 6, 2022), available at https://www.opb.org/article/2022/09/06/oregon-nurses-drowning-too-many-patients-staff-shortage/ (last accessed September 13, 2022); Jonie Auden Land and Amelia Templeton, "*Severely short on nurses, Central Oregon hospital system quietly declares crisis*," Oregon Public Broadcasting (July 27, 2022), available at https://www.opb.org/article/2022/07/27/central-oregon-st-charles-hospital-system-declares-crisis-amid-nurse-shortage/ (last accessed September 5, 2022); Ben Botkin, "*Behavioral Health Slammed by Worker Shortage in Oregon*," The Lund Report (August 10, 2021), available at https://www.thelundreport.org/content/behavioral-health-slammed-worker-shortage%C2%A0-oregon (last accessed August 15, 2022), Whitney M. Woodworth, "*Marion County jail faces nurse shortage*," The Salem Statesman Journal (March 2, 2017), available at https://www.statesmanjournal.com/story/news/2017/03/02/marion-county-jail-faces-nurse-shortage/98601484/ (last accessed August 9, 2022).
[55] The Oregon Health Sciences University (OHSU) defines, for the purpose of health geography, "rural" as "any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more." OHSU defines "frontier" as any county with six or fewer people per square mile, of which there are 10 in Oregon;

As a result of those issues, the JHCSAC discussed how mandating minimum staffing levels or provisions for on-call medical services in statute would create little change given the real and persistent resource challenges that exist in medical staffing today. However, several proposals came out of these discussions aimed at leveraging pooled resources more effectively, increasing telehealth opportunities when medically appropriate, and incentivizing new medical professionals to seek out working with incarcerated populations more often.

These include creating regional provider teams, potentially through OHA or DOC, that would have dedicated staff available to serve jails in parts of the state that are unable to hire or retain medical staffing to better serve AICs. An apt comparison may be the Oregon Department of Justice's resource prosecutors, who manage special caseloads for counties that do not have the resources to employ a dedicated prosecutor, such as elder abuse or animal abuse. Regional jail health care teams could support medically underserved jails through routine telehealth appointments and in-person visits, as-needed, to be determined by qualified medical professionals. A related proposal is to expand and support telehealth services to the greatest extent possible for all jails for appointments where telehealth is an appropriate alternative to in-person care. Privacy and confidentiality should be provided to AICs who receive telehealth services, as well as in-person services.

Additionally, making employment as a health care professional in Oregon's jails more competitive or incentivized is another angle through which the JHCSAC discussed improving staffing levels. Suggestions include providing internships or apprenticeships for students in medical fields in jail settings as part of their required training, providing additional student loan assistance for persons who choose to work in jail medical roles, and, when available, hiring incentives, such as hiring bonuses or subsidized housing, which some rural counties do for other county jobs, such as prosecutors.

Recommendations:

- Create statewide or regional provider teams to support jails when AICs need medical care. Medical professionals employed through the state could provide jails with much-needed staffing support when local resources are unable to meet the medical attention needs within a given facility. The independent commission described in Section II should be tasked with developing guidelines for when a facility will call upon the state's jail provider teams.
- Support the expansion of telehealth opportunities to the greatest extent possible, when medically appropriate.
- Provide training opportunities for new medical professionals with jail populations and incentivize jail-setting medical employment with student loan assistance or hiring bonuses or housing subsidies, whenever possible.

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see also, "Oregon's Health Care Workforce," 2021, page 3 (describing that the capacity for primary care providers to meet community health care services demands is 23 percent lower in rural and frontier areas of Oregon compared with urban areas, and the behavioral health provider full-time equivalent per capita is 65 percent lower in rural and frontier areas of Oregon compared to urban areas).

4. Protocols to ensure timely transfer and continuity of care for adults in custody to and from a hospital following a determination by a health care professional that treatment at a hospital is medically necessary

The JHCSAC discussed timely transfer and continuity of care as two related but distinct issues. Timely transfer of an AIC to receive health care in a hospital when medically necessary concerns when an AIC is taken to a hospital as directed by the facility's medical director or in other circumstances when jail staff observe an emergency situation. ORS 169.076(5) requires jails to have written policies for emergency medical and dental health, including review of medical and dental plans by a qualified medical professional. ORS 169.076(5) also requires that jails have a records system to include AIC requests for medical and dental attention, treatment prescribed, prescriptions, special diets, and other services provided.

a. Timely Transfer

The JHCSAC discussion regarding timely transfer has included the urgency with which AICs who need medical care beyond the scope of medical practice available at a given jail are taken to the closest emergency room. This poses greater challenges for jails in rural or frontier areas where the nearest medical center may be a considerable distance away. Previous report discussions about minimum staffing, on-call health care services, and telehealth options are responsive to improvements to timely transfer of AICs.

It should be noted that the list of JHCSAC membership in HB 3229 did not include any persons with lived experience receiving health care in a jail setting as appointed members. In conversations with persons with lived experience receiving health care in Oregon jails, some voiced concerns about there being few, if any, channels, for AICs or their families who do not feel as though their medical needs are being attended to as needed, due to myriad factors such as jail staffing levels or available resources, beliefs from facility staff that AIC health concerns are being overstated, or other barriers. No Oregon statute contains provisions for how AICs should seek to have their health care needs reviewed if they, or their families, feel that the facility in which they are incarcerated is not addressing them. Ideas for providing avenues to raise questions or concerns have been discussed regarding the scope of the independent commission described in Section II.

b. Continuity of Care

The JHCSAC discussed ways in which continuity of care could be improved when AICs transition from a jail facility to another state facility, such as the Oregon State Hospital (state hospital), to a community-based service provider, or back into the community. Three areas for improvement were primarily contemplated: (1) expanded access to OHP, including improved reinstatement processes, (2) more community-based options for mental health care and treatment as alternatives to the state hospital, and (3) increased transition planning when AICs are released.

The greatest single policy change that would improve continuity of care is to change federal law and allow incarcerated persons to maintain their Medicaid/OHP coverage while in Oregon jails. The JHCSAC is aware that this federal policy is not within the Oregon Legislature's control to

change. However, the JHCSAC has been following OHA's request to amend the existing 1115 Medicaid Waiver to include making some limited services that would otherwise be covered by OHP but-for incarceration available to Oregon AICs and urges the state to continue seeking any opportunity to expand OHP coverage to all AICs.

A policy change that *is* within the Oregon Legislature's control is the way in which persons on OHP are suspended from, and reinstated to, OHP upon entrance to, and release from, Oregon's jails. Presently, when an AIC is released from an Oregon jail, the burden of reinstating their OHP medical coverage is on the individual being released. Myriad barriers make this reinstatement process unduly difficult for criminal justice system-involved persons, particularly those who are managing other major, immediate needs, such as obtaining food and water, finding safe housing, managing future court appearances, reconnecting with children, and so forth. This is particularly true for persons with acute health care needs, with disabilities, with behavioral health issues, or any combination of those and other circumstances. The JHCSAC recommends putting the burden of reinstating OHP coverage on the state rather than the individual when releasing from jails, through the processes shared by OHA and ODHS.[56]

Additionally, a persistent issue affecting AICs, Oregon jails, and the state hospital, is the cyclical nature of persons awaiting transition from one institution to the next while criminal charges are pending. The JHCSAC recommends the state focus on making more community-based facilities available to persons as alternatives to jails and the state hospital, which would allow persons to maintain OHP coverage, avoid the impacts of being incarcerated, and decrease the likelihood of decompensating in an Oregon jail not designed for intensive behavioral health care.

Lastly, supporting transition planning between the state hospital, Oregon jails, and community-based providers would also increase the success with which continuity of care is maintained. At present, it is not always apparent which institution is responsible for given elements of transition planning, leading to inconsistent results and lack of clarity that does not support continuity of care for AICs. Improving transition planning between state and local facilities or in preparation for an AIC's release back to the community, would support continuity of care outcomes, such as avoiding interruptions in medication access and maintaining existing relationships with health care professionals or establishing new relationships for care needed.

Transition planning out of a jail is, however, complicated by the fact that many AICs are in jail for a matter of days, and for some, even shorter periods of time. This means that jail staff or other community-based organizations often have little time to spend with AICs preparing for their potentially imminent release, even if the length of incarceration has led to suspension of OHP benefits. For jails that do have any transition planning staff capacity, not much time is available to assist AICs with these transitions. Training additional community-based transition planning staff (or volunteers) to assist AICs releasing from jails would help reduce the impacts of incarceration and improve continuity of care outcomes considerably.

Recommendations:

[56] Though the scope of this report is limited to Oregon jails, alleviating the burden of seeking OHP reinstatement from persons releasing from Oregon's *prisons*, as well, may also be of interest to the Legislature.

- Expand OHP coverage to AICs in Oregon at every opportunity
- Place the burden of reinstatement of OHP duties on the state rather than on the individual
- Support expansion of non-jail, non-state hospital settings for behavioral health treatment
- Support increased transition planning between institutions from which individuals are releasing and to the community to the greatest extent possible

While outside the scope of this jail health care project, the JHCSAC also received comments regarding the importance of using every available jail diversion opportunity to ensure that persons who would be best served *in* the community may maintain their community-based health care options (and avoid losing their OHP coverage) rather than being incarcerated in a jail.

5. Screening health care needs of adults in custody

ORS 169.076 does not contain a provision specific to screenings in jails, though ORS 169.076(2)(d) requires that jails must have a comprehensive written policy with respect to admission medical procedures. Presently, the non-statutory, non-binding OSSA Jail Standards require initial medical screenings, suicide risk screenings, mental health screenings, a general health assessment, and an intake follow-up process.[57] The medical, suicide risk, and mental health screenings described have specific factors that screening forms should include.

The JHCSAC discussed how, given the nature of how the efficacy and preferred contents of medical screenings change over time, mandating screenings in statute would not allow for screening policies and procedures to be updated as necessary. Rather, what screening are appropriate and what they should cover should be better left up to the independent commission to provide ongoing guidance.

Recommendations:

- Medical screenings, including intake medical, suicide-risk, and behavioral health screenings, should be administered by jails upon the admission of an AIC, but the precise contents of these screenings would be best left to the independent commission to manage with Oregon's jails through administrative rules or policies.

6. Scheduling and administering appointments, including follow-up appointments, with health care professionals

ORS 169.076(5)(c) requires jails to have a medical and dental records system that covers requests for medical and dental attention, treatment prescribed, prescriptions, and other services provided. The JHCSAC discussed ways in which scheduling and administering appointments works presently. There is no standardized means by which a person in custody is to request appointments across Oregon's jails, and appointment requests are namely made through the kite

[57] OSSA Jail Standards, Medical Screenings, B-208, 33-34; Suicide Risk Screenings, B-209, 34-35); Mental Health Screenings, B-210, 36; Health Assessment, G-202, 147-148; Intake Screening Follow-Up, G-201, 147.

system or by making a request of a staff member in person.[58] JHCSAC discussions centered on issues of wait times between appointments due to a lack of available providers as the primary barrier to getting appointments or follow-up appointments administered as quickly as desired.

Additionally, questions arose about whether fees to see a medical professional imposed on persons in custody in Oregon jails pose additional barriers to AICs seeking medical attention in Oregon's jails. ORS 169.150 ("[p]ayment of expenses of keeping prisoners; health care fees") allows cities and counties to charge persons incarcerated (pre- or post-conviction) in local jails "a reasonable health care fee for any health care services, medications and equipment provided" to the person if the city or county "(a) [p]rovides necessary medical care regardless of the person's ability to pay; (b) [p]rovides equal treatment to all persons committed to the local correctional facility regardless of a person's ability to pay; (c) [e]stablishes a system that notifies the person of the fees and what services are covered; and (d) [e]stablishes a grievance system that allows a person to challenge the deduction of a fee from the person's account." Thus, Oregon jails may charge, but are not required to charge, fees for medical appointments.[59] According to a survey administered by CJC in 2019, 14 jails of the 33 responding noted requiring some amount of a co-pay for health care services administered while in custody.

The JHCSAC discussed how these fees both provide AICs with some accountability for the services requested but may also pose barriers for persons who might request services but-for the imposition of even the most modest fees.

Recommendations:

- Addressing workforce shortages, as described in other report recommendations, would be the most effective means of improving the efficiency with which appointments are scheduled and administered.

7. Establishing an appropriate, confidential space for the provision of health care services to adults in custody

Nothing in Oregon statute covers the confidentiality of spaces for provision of health care in Oregon's jails.[60] The JHCSAC discussed how jail architecture presents challenges to the availability of confidential spaces and how facilities seek to provide the most confidential spaces available during any given circumstances. Challenges arise in making interactions confidential particularly during the booking process, during which initial screenings take place. The JHCSAC

[58] The non-binding OSSA Jail Standards provides guidance for having policies and procedures in place for AICs or staff to bring health care needs to the attention of a medical professional within a timely manner. The guidance includes provisions for putting AIC medical requests in writing and management of follow-up appointments. *See* OSSA Jail Standards, Requests for Health Care, G-205, 149-150.

[59] Additionally, ORS 169.151 ("[e]xpenses of keeping prisoners; reimbursement from prisoners; amounts; procedures") allows cities or counties to seek reimbursement at "at rate of $60 per day or its actual daily cost of safekeeping and maintain the person, whichever is less, multiplied by the total number of days the person was confined" in a given jail, including but not limited to "any period of pretrial detention." As such, Oregon jails may charge, but are not required to charge, what is known as "room and board" fees for any amount of time persons are incarcerated.

[60] OSSA Jail Standards also do not specifically cover confidential spaces in their provisions.

also received input regarding the need for gender-appropriate confidential spaces within Oregon's jails so that persons of all gender identities feel safe.

Recommendations:

- The JHCSAC recommends that the independent commission develop recommendations, in consultation with Oregon jails, on how to assess the availability of confidential spaces and create greater availability of confidential spaces in facilities in which these are lacking.

Section IV: Implementation Costs, Timelines, and Funding Sources

Additional work is ongoing to fully analyze resource needs for implementation of these recommendations. The CJC is working with state and local entities to gather specific resource and process details concerning implementation of the recommendations contained in this report. A follow-up addendum will be issued describing these results before the end of this year.