OREGON DEPARTMENT OF CORRECTIONS

July 25, 2025

Falcon Correctional and Community Service, Inc.
Dr. Elizabeth M. Falcon
155 North Wacker Drive, Suite 4250
Chicago, IL 60606

Re: Oregon Department of Corrections Healthcare Delivery System Assessment

Dear Dr. Falcon,

On behalf of the Oregon Department of Corrections (DOC), we wish to extend our sincere thanks for producing the Health Services Delivery Assessment Report. We appreciate the time, expertise, and thoughtful care that went into developing this comprehensive review of our health care delivery systems.

The Falcon team's thorough approach, including research into the Health Services Division's history, site visits to our facilities and institutions, stakeholder input and interviews with current and former staff, has resulted in a report we believe will serve as a valuable roadmap for the division's new leadership.

As part of our commitment to improving the quality, accessibility, and efficacy of care for adults in custody, this report will serve as a strategic guide for prioritizing actions within the implementation plan being developed by our incoming Health Services Assistant Director. We are committed to ensuring that the implementation plan will be completed within 120 days, and we value your team's willingness to assist in prioritizing and refining the report's recommendations.

Falcon's understanding of DOC's operational realities, paired with your knowledge of national best practices, gives us confidence that the resulting strategy will be both practical and impactful.

Ensuring safe, effective, and equitable health care in a correctional environment is a complex task. Your team's contributions have already advanced our efforts in meaningful ways. Thank you again for your professionalism and commitment to this important work. We look forward to continued collaboration in the months ahead.

Sincerely,

Michael Reese
Director

Heidi Steward
Deputy Director

State of Oregon
Department of Corrections

Healthcare Delivery System Assessment

Independent Report Commissioned by the
Oregon Department of Corrections
Contract #DASOBO-00043880

SUBMITTED TO:

Director Mike Reese
3723 Fairview Industrial Drive SE
Suite 200
Salem, OR 97302
Michael.W.REESE@doc.oregon.gov

July 15, 2025

Falcon Correctional & Community Services, Inc.
155 North Wacker Drive, Suite 4250, Chicago, IL 60606
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COVER LETTER

Dr. Elizabeth M. Falcon
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July 15, 2025

State of Oregon Department of Corrections
Director Mike Reese
3723 Fairview Industrial Drive SE, Suite 200
Salem, OR 97302

Re: Oregon Department of Corrections Healthcare Delivery System Assessment

Dear Director Reese,

On behalf of Falcon Correctional and Community Services, Inc., thank you for the opportunity to assess the Oregon Department of Corrections' healthcare delivery system. Our attached report includes observations, key findings, and recommendations—all intended to support your ongoing efforts to elevate the quality of care provided in Oregon's correctional facilities.

Dr. Robin Timme, Falcon's Principal and Senior Expert for Integrated Healthcare Operations, led a team of national experts for this project. The Falcon team included Dr. Marina Cadreche, Dr. Raymond Herr, Stephanie Patrick, Rick Raemisch, Bernie Warner, and Dr. Corey Brawner. The team engaged with hundreds of stakeholders and groups to collaboratively assess healthcare quality, operational efficiency, and the well-being of healthcare staff. While each facility was considered, the assessment took a systemwide perspective, prioritizing systemic issues that affect all adults in custody throughout Oregon's correctional facilities.

The Department of Corrections initiated this assessment following a whistleblower report and fact-finding effort that was publicly released last year. That investigation brought to light chronic difficulties—particularly with access to specialty care—and led to the removal of Health Services leadership. Since December, under the guidance of an experienced Chief of Medicine and the

agency's Deputy Director, swift and targeted reforms have begun, procedures have been revised, case management has improved, and innovative facility-based strategies have expanded specialty care access for adults in custody. Our assessment coincided with these ongoing improvements, and our final report is intended to capture the systemwide healthcare delivery's current state.

The assessment included visits to correctional facilities, pharmacies, and administrative offices across Oregon. The Falcon team, accustomed to examining prisons nationwide and abroad, was struck by the engagement from staff and collaborative atmosphere within the state's institutions—even where infrastructure was literally crumbling, a tone of hope and resilience was evident across facilities. As an example, facilities were consistently described by the team as clean and orderly, and the presence of murals painted by adults in custody provides color and a welcoming tone. Many of those murals were photographed and included in this report.

Although the report puts forth several recommendations, the next step lies with the incoming Assistant Director of Health Services and the Department's leadership team to assess each recommendation for feasibility and impact, then determine a course for meaningful implementation.

Thank you for entrusting us to contribute to the evolution of Oregon's correctional healthcare system. We look forward to continued collaboration with the agency as you work to improve conditions for those living and working in Oregon's correctional facilities.

Please reach out to me or Dr. Timme with any questions.

Sincerely,

Elizabeth M. Falcon
Psy.D., CCHP-MH, MBA
Tel: 312.803.5666
E-mail: efalcon@falconinc.com

EXECUTIVE SUMMARY

This Executive Summary serves as a high-level overview of the 2025 Healthcare Delivery System Assessment report commissioned by the Oregon Department of Corrections (ODOC). While this summary briefly introduces each section and presents important background, observations, and findings, the comprehensive report provides fuller analysis, supporting data and details, and complete context necessary to understand the scope, methodology, findings, and recommendations from the study. This Executive Summary and comprehensive assessment process have been part of a systemwide Continuous Quality Improvement (CQI) process, and the documents are intended to establish a baseline for performance improvement going forward.

Acknowledgement

The Falcon team would like to acknowledge the cooperation and collaboration from so many impacted individuals and groups. The team is incredibly grateful to the hundreds of staff members who took the time to reach out directly or to complete the staff survey. Similarly, the team is eternally grateful to the many adults in custody (AICs) and their families who also took the time to contact the study team and contribute invaluable information. In a study of this nature, data takes many forms, and some of the most valuable data are qualitative and relational rather than numerical. This was the case in this assessment, and the experiences of those who live and work within Oregon's prisons were afforded tremendous weight throughout the study.

Background

In December of 2024, Falcon Correctional and Community Services, Inc. (Falcon) was engaged to identify priority areas in need of immediate attention as ODOC separated from its clinical and administrative leaders within the Health Services Division. On the heels of an independent whistleblower and fact-finding investigation, the agency recognized that rapid action was required and worked with Falcon to address priority needs at that time. In February of 2025, ODOC engaged Falcon in a comprehensive assessment of the healthcare delivery system, while simultaneously taking action to address the priority needs discovered in the pre-assessment phase. This report is the culmination of more than six months of work assessing ODOC's healthcare delivery system.

Approach and Methodology

Falcon's team included seven professionals who have worked in various roles within systems of care and custody throughout their careers. Expertise included correctional healthcare administration, physical health, behavioral health, correctional practice, and research design.

The Falcon team requested and reviewed extensive data and documents, assessing the quantity and reliability of current data infrastructure in addition to the material provided. The team held a preliminary workshop series with ODOC leaders, and met with community-based

partners, AICs, facility-based staff, and many other stakeholder groups. In all, the team held more than **80 meetings** and workshops, including over **85 AICs** and more than **260 staff members**.

Additionally, Falcon developed and deployed a staff survey throughout the Health Services Division, receiving **250 responses** or **57.6%** of the distribution list. The team also received input from more than **35 families of AICs**, in addition to several other impacted groups.

Falcon visited **11 prisons**, **two correctional pharmacies**, and **ODOC administrative offices**, across three site visits. The team visited Coffee Creek Intake Center (CCIC), Coffee Creek Correctional Facility (CCCF), and Oregon State Penitentiary (OSP) three times each, viewing these as particularly relevant sites due to specific missions, prior public reports, and their proximity to Portland.

Data Quality and Validation

Data infrastructure is a key component when assessing a healthcare system. Whether conducting a comprehensive study like this or looking at monthly utilization statistics to inform decision-making, the ability to produce, collect, analyze, and report using reliable data is critical.

Consistent with previous reports on healthcare for AICs, ODOC Health Services was fully transparent with the Falcon team about the data limitations within the division and requested that this assessment become a tool to improve that area of practice. It was clear that at one point Health Services did have a more robust statewide CQI program, but the positions fell victim to funding cuts during the COVID-19 pandemic in 2020.

Although data specific to Medical Services was notably sparse, the Falcon team was able to collect reliable data from additional sources to inform the study. The following sources of information proved particularly helpful in capturing an empirical understanding of healthcare needs and services in ODOC facilities:

- ODOC Research Department's Inmate Profile Data Sets
- Dental Services Reports
- Pharmacy Reports from Correctional Institution Pharmacy Software (CIPS)
- Utilization Management Data from Correctional Health Partners (CHP)
- Unique Facility-Specific Data Sets

Key Population Data Points

- Since 2015, the number of AICs in Oregon's prisons has declined by 17.3%. While the male population of AICs has declined by 16.5%, the female population has seen a 27% reduction in numbers. The population is significantly reduced from ten years ago.

- Population demographics reflect a predominantly male population (92%), with the majority identifying as White (71.96%). AICs also identified as Hispanic (13.49%), Black (9.39%), American Indian (3.08%), Asian (1.68%), and Pacific Islander (0.33%).
- Since 2015, the average age of AICs has increased significantly. While all age groups of AICs between 18 and 60 have seen substantial declines, the population of AIC ages 61 and older has increased by 41%. This trend toward an older population is consistent across the country, but the rapid increase of the geriatric population in Oregon is unique.
- Within the population of AICs, 76.7% are prescribed at least one medication by an ODOC prescribing provider, including 94.6% of women and 75.2% of men. These numbers are high relative to benchmarks across the country, reflecting a combination of clinical complexity and lack of controls for pharmaceutical prescribing in the current system.
- Within the population prescribed at least one medication, the average number of prescriptions per patient was 6.02, which included over-the-counter medications in the data set. This number is also high relative to benchmarks across the country, and it is a good baseline for comparison as the Electronic Health Record (EHR) and statewide CQI program roll out in the future.
- In the data set, more than 3,000 AICs were prescribed seven or more medications, with over 200 AICs prescribed 20 or more medications. This is an indicator of "polypharmacy," which can be required in certain complex patients, but also presents risks for interactions and side effects, and cases should be triaged to clinical pharmacists for review.
- Across the system, there are an average of 82 emergency department trips per week. This number is high compared to benchmarks across the country. While emergency department services are critically important to a correctional health system, many in the sample appeared to be the result of delayed care or inability to access routine services like imaging studies (i.e., X-ray).
- Utilization of inpatient hospitalization revealed two hospital systems servicing the great majority of AICs: Salem Health on the west side of the state, and Saint Alphonsus on the east side of the state, with significant opportunities to explore efficiencies.
- For emergency department trips and hospital stays, at least two correctional officers are required to escort the patient, resulting in a significant impact to an already short-staffed system, and impacting normal operations of prisons.

- Since 2015, the percentage of the population with an identified mental health need has increased approximately 15%, while those AICs with the highest level of mental health treatment need now represent nearly one-third of the entire population. Behavioral Health Services screens all AICs at intake and access to Behavioral Health Services is excellent but casting a wider net results in detecting a greater number of AICs with mental health needs. Although this number is relatively high, it is likely an accurate reflection of true needs.
- Statewide, 64% of the AICs population is identified with some level of substance use disorder (SUD) treatment need, with 51% of all AICs identified with moderate to severe SUDs. These numbers are consistent with estimates across the country, and again, Behavioral Health Services screening is exemplary in this way.
- Within the female population, 76% of AICs are identified with some level of SUD treatment need, with 69% meeting criteria for moderate to severe SUDs. These numbers are also consistent with estimates across the country and contribute to a conceptualization of CCCF as a treatment facility.
- In recent years, Medications for Opioid Use Disorder (MOUD) have been implemented and access to care expanded. On November 14, 2024, 10.6% of the AICs population was prescribed MOUD, ranging from 38.9% at CCIC, to 0.0% at South Fork Forest Camp (SFFC). On May 31, 2025, more than 14% of the AICs population was prescribed MOUD.

Workforce Insights

Early and often, the Falcon team was contacted by current and former employees who wanted to share their experiences working in Health Services. While those qualitative discussions occurred throughout the study period, the team developed and deployed a staff survey to current Health Services personnel. With 250 responses (57.6% response rate), the Falcon team was able to present quantitative and qualitative analyses. All prisons were represented in the sample, along with both pharmacies and CTRS (Health Services headquarters). The sample included physicians, nurses, pharmacists, dentists, qualified mental health professionals (QMHPs), qualified mental health associates (QMHAs), clinical support staff, and managers.

Respondents identified the following eight areas as most concerning:

1. Staffing adequacy, medical, and nursing
2. Staff health and wellness
3. Staffing adequacy, operations, and transportation
4. Process for referral to specialty care (Therapeutic Levels of Care (TLC) Committee)

5. Access to care, medical specialty care
6. Continuity of care, medical
7. Medical treatment space
8. Feedback and communication processes from line staff to administrators (bottom-up)

Respondents identified the following five areas as least concerning, or functioning well:

1. Use of clinical restraints
2. Telehealth
3. Issues with on-call providers
4. Suicide prevention
5. Pharmacy

Stakeholder Workshops

The alignment of various stakeholder groups was unprecedented in the experience of the Falcon team, with clear themes emerging among staff, AICs, their families, and those who advocate for them in the community.

The primary area of concern included inconsistent and delayed access to care, specifically identifying barriers in timely and equitable access across prisons and populations.

Additionally, a theme emerged around the ability to create and sustain improvements in healthcare within ODOC, advocating for legislation, external support from subject matter experts, and restructuring of governance.

The EHR was consistently described as a priority intervention that will help immensely, but also concerns that if workflows are broken, the problems will be built into the EHR and institutionalized.

Other consistent themes included gaps between policy documents and actual on-site care, along with a strained workforce experiencing burnout and compassion fatigue.

There was a clear need to standardize administrative meetings, implement systemwide CQI programs, and generally create a better system of healthcare utilization management.

Other themes included the need to improve community connectivity and discharge planning, specifically at CCCF, along with gender-responsive healthcare services.

Stakeholders described challenges surrounding current investigatory processes and lack of oversight of investigations into Health Services personnel, which can last for months or years.

In general, all stakeholders described wanting better communication within the agency, including between AICs and their treatment providers, between custody and clinical staff, and among facility leaders of various disciplines.

Facility Studies

The team visited prisons across the state and studied the environments of care, including infirmaries, clinics, residential mental health units, SUD treatment programs, dental clinics, administration areas, and other treatment spaces. While limitations exist in all facilities, none were more pronounced than those observed at OSP. Crumbling infrastructure makes care delivery extremely challenging, and yet the clinical teams have developed detailed and intensive programs to expand access to care. The quality of care achieved at OSP despite these conditions is incredible, but AICs and the dedicated staff deserve a more humane and functional environment.

The team reviewed National Commission on Correctional Health Care (NCCHC) accreditation reports from each of the prisons and analyzed them for statewide implications. While NCCHC accreditation has clearly driven improvements across ODOC's institutions, the findings from their reports underscore a critical need for investment in healthcare infrastructure, workforce development, and standardized practices.

Several of the themes consistently identified by NCCHC converged with stakeholder input and the Falcon team's observations, include the following areas of focus:

- Adequate responses to NCCHC recommendations with resulting improvements and granting of accreditation.
- Deficiencies in medical autonomy, CQI processes, access to care, and inter-departmental coordination within prisons.
- Strengths, including improvement in chronic disease management, enhanced documentation practices, reliable pharmacy operations, dental services, timely emergency response protocols, and increased provider involvement in administrative oversight.
- Nursing assessment protocols have been identified as problematic, but significant systemwide improvement has been demonstrated in recent months.
- CQI activities are inconsistent or absent at many facilities and there is no systemwide CQI program currently.

Sample Findings and Observations

The Falcon team arrived at 67 findings and key observations reflecting convergence among sources of information and stakeholders that were unprecedented in Falcon's experience.

The following is a sample of key findings and observations:

- ODOC impressed as authentically committed to studying and improving healthcare for those who live and work within the prison system.
- Despite this energy and engagement, high levels of burnout and compassion fatigue among staff are widespread. Current and ongoing efforts to improve processes, workflows, and staff value are likely to have a positive impact going forward.
- Although the population of AICs is getting smaller, the population is aging, becoming more acute, and growing more clinically complex. Prison closures result in greater concentrations of complex patients in a smaller number of facilities.
- The healthcare system generally functions reactively, rather than proactively or preventatively, resulting in increased utilization of emergency departments, inefficient resource utilization, and fragmented care for AICs.
- Too many AICs move through the intake process and transfer to other prisons without completing their healthcare assessments. This leads to subsequent problems with intra-system transfer, continuity of care, treatment delays, and misalignment between the patient's needs and the capabilities of the receiving facility.
- Specialty care consults have represented the greatest area of concern, but recent policy changes, improved case management, and facility-based solutions have resulted in significant improvements, which must be continued and supported indefinitely.
- There is a sense of hope and optimism among stakeholders, led by the Health Services workforce in facilities, that this assessment process will lead to improved healthcare delivery.
- Staffing concerns permeated the study, with a focus on the number of staff available, the type and mix of staff, staff supervisory roles, and the transient nature of contracted and agency staff.
- The blending of administrative and clinical roles across the state has led to dilution of medical autonomy and an overloaded workforce, particularly pronounced for facility-based managers and statewide administrators.
- Staff consistently requested additional training opportunities, improved new employee orientation, and access to continuing education.

- Like many prison systems, COVID-19 decimated operations in Oregon, reduced programming and services, and has had a long-term impact on the ability to staff and operate facilities safely.
- The lack of a systemwide CQI program is concerning and has led to care that is fragmented, disorganized, and inefficient, despite a workforce that is highly professional and deeply committed to the health and wellness of AICs.
- There is no standardized Health Services Report (HSR) across prisons to track access to care and healthcare utilization, which is the foundation of a good CQI program, and a back-of-house function included in the EHR currently being implemented.
- The existing Clinical Education and Audits department could be expanded to encompass a systemwide CQI program but would require significantly more resources and elevation within the organization.
- Paper health records are impacting safety and quality of care, and the EHR implementation is a clear priority.
- Health Services data sets are sparse, fragmented, and in need of organization. While the EHR will provide some of these functions, there is currently no department responsible for organizing CQI studies using the data.
- Behavioral Health Services has many best-practice approaches, including the mental health classification coding system, early screening and intervention, and a passionate and dedicated workforce.
- Dental Services emerged as a best practice model, providing exemplary care relative to other prison systems.
- Pharmacy Services also emerged as a best practice model, operating fully licensed pharmacies that function analogously to their community counterparts.
- The addition of clinical pharmacists to the workforce is a best practice and will help target polypharmacy, increasing safety and efficacy of care, and reducing costs.

Recommendations

The Falcon team arrived at a series of recommendations, ranging from no-cost process changes to full replacement of a prison. The team fully recognizes critical dependencies between branches of government and understands that ODOC as an agency within the Executive branch is dependent on collaboration with members of the Legislative branch for several of the

recommendations. It is strongly recommended that a collaborative approach between branches of government work to support moving these recommendations forward.

The recommendations were grouped into areas of focus, which include the following:

- **Commit to implementation and change management:** ODOC must own the process of change management, but partner with external subject matter experts to expand knowledge base and capacity. The agency will be hiring a new Assistant Director of Health Services, who should be given the time and opportunity to orient to the system and develop a plan for implementing recommendations and moving the division forward.
- **Develop and deploy a plan for internal and external communication**: Prioritize communication with the workforce and AICs and continue conveying intention and progress toward improvement throughout the agency. Share this report publicly and provide updates to legislative, media, and community-based stakeholders.
- **Continue with improvements in the TLC process and specialty care consults**: Allocate case managers and care coordinators to track and manage consults and continue to show improvements in access to specialty care that have been demonstrated in recent months.
- **Continue to prioritize implementation of the EHR**: The improvements to the TLC and specialty care processes and the implementation of the EHR are the two most important initiatives in the agency currently.
- **Enhance interdisciplinary communication and care coordination through standardized administrative meetings**: At least weekly, bring together leaders from corrections, medical, behavioral health, and other departments to discuss challenging cases and coordinate care.
- **Establish a Department of Innovation and CQI**: This is a suggested title. This department would oversee data collection, analysis, routine audits, and performance improvement within Health Services. Alternatively, these functions could reside within an expanded and elevated version of the Clinical Education and Audits department currently housed in Business Operations.
- **Create an interdisciplinary working group to support implementation, increase transparency, and enhance accountability**: This working group should be chaired by the new Assistant Director of Health Services, and it should incorporate healthcare professionals and stakeholders from outside of ODOC.

- **Distinguish CCIC from CCCF to promote gender-responsive approaches and prioritize the intake process for all AICs**: In a best practice model, these functions would occur in separate institutions. Given the current facility configuration, however, that is likely impossible. However, both functions will benefit from conceptualizing them as separate. Improved workflows and additional infrastructure at intake can increase efficiency, and no AIC ought to be released from CCIC without completing the healthcare assessments.
- **Conduct a comprehensive Health Services staffing analysis once the EHR is fully implemented, update the analysis regularly, and address immediate staffing needs at specific prisons**: The EHR will result in substantial changes to workloads and processes, but a staffing analysis is required once it is implemented. Specific prisons in need of immediate staffing attention include Oregon State Correctional Institution (OSCI) and Two Rivers Correctional Institution (TRCI), while Deer Ridge Correctional Institution (DRCI) is addressed in a separate recommendation.
- **Reconsider the staffing levels and complements specifically at DRCI**: DRCI is designated as a minimum security facility, but the population needs are acute and complex. Specifically, the clinical area and planned infirmary require additional staffing to operate safely and effectively. The team was particularly impressed with the operations at DRCI, where a shared mission that prioritizes healthcare is clear.
- **Provide clinical supervision toward licensure for eligible QMHAs and QMHPs looking to advance in their professions**: The Behavioral Health Services team is clearly passionate and dedicated, but those looking to achieve licensure are often required to obtain that clinical supervision outside of their facilities and at their own personal cost. Navigating collective bargaining agreements to achieve this goal should be a priority to support professional development and to recruit and retain staff who seek to become licensed professionals.
- **Prioritize hiring of psychologists to fill existing vacancies and expand access to doctoral-level assessment, treatment, supervision and consultation services**: Psychologists are in high demand and can be hard to recruit in prison systems, but their scope of practice has long been seen as invaluable in prisons. Prioritizing hiring into those positions is likely to have a force multiplying impact.
- **Revisit governing statutes, administrative rules, and policy structure to improve governance, oversight, direction, and accountability**: Revise the policy structure to incorporate more detail into statewide policies and create site-specific procedures that detail post orders and daily expectations within each prison.

- **Revise the AIC Communication Form (i.e., "kyte") and medical grievance procedures to distinguish between Health Services requests and promote rapid informal resolution of grievances**: It is important to separate Health Services requests and grievances and to triage them differently, ensuring confidentiality is available and clinicians respond to clinical issues. Studying the feasibility and impact of revising these forms, including consideration for impacts to security and other ODOC divisions, is a crucial next step.
- **Invest in community partnerships with hospitals, healthcare clinics, and providers to create a more effective continuum of care**: This recommendation includes exploring the feasibility of creating secure treatment units in off-site hospitals; establishing a neurocognitive unit or skilled nursing facility (SNF) inside the prison system; incorporating community-based partners in care coordination; studying the feasibility of a university-based model of care delivery; replacing OSP with a purpose-built healthcare facility; studying existing facilities for opportunities to expand environments of care; and revisiting legislation pertaining to expanded compassionate release or medical parole.
- **Maintain NCCHC accreditation and performance improvement**: Accreditation by NCCHC has been incredibly helpful for ODOC, and the required improvements to meet the standards have ensured some systemwide CQI functions exist. The new standards will be released in the coming months, and it is recommended that the mental health standards be incorporated into ODOC policy and practice.
- **Prioritize confidentiality of patient contact**: Except in exigent circumstances, all clinical contacts should be offered outside of the cell in a confidential setting to promote trust and allow for sharing of protected health information between patient and provider.
- **Move suicide watch and close observation out of segregation areas**: There is a growing movement away from using segregation areas to house those on suicide watch or with other behavioral health statuses. Except in exigent circumstances with documented rationale, these patients should be housed in therapeutic settings until the crisis is resolved.
- **Consider revising the administrative-organizational structure to increase medical autonomy, relieve overburdened managers and administrators, and integrate healthcare disciplines across the state**: This is a suggestion to consider models of organizational structure that create more distinct clinical and administrative lines of reporting, both at the statewide level and in facilities, and better integrating healthcare disciplines within prisons.

Recognizing that a new Assistant Director of Health Services is currently in the process of recruitment and given the importance of that individual in leading the required change, the team is recommending a **120-day planning period** from the onboarding of the new Assistant Director of Health Services. The new Assistant Director will need a period of orientation and training, at least some of which must come from external resources. This assessment report should serve as a helpful foundation for onboarding and training.

Bringing on the Assistant Director of Health Services will also align with the early implementation of the EHR, which should be ODOC's immediate priority in addition to continuing with the improvements in specialty care consults. Should ODOC decide to adopt the recommendations in this report, an implementation plan must be developed in collaboration with various stakeholders, to determine a timeline for implementation. The Falcon team estimates that several recommendations can be implemented immediately, while others requiring more complex administrative support, funding, or restructuring could require significantly more time to implement. ODOC must develop internal resources and partner with external subject matter experts to implement these changes, as the current workforce cannot withstand the added responsibilities required to achieve these recommendations.

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Section 1

Introduction

SECTION 1: INTRODUCTION

Falcon was retained by the State of Oregon to assess the healthcare[1] delivery system within ODOC. Falcon was initially engaged to assess the immediate needs of the agency following a growing number of complaints about access to healthcare made by AICs, their families and advocates, ODOC Health Services staff, and as reported in the media. After ODOC's Chief of Medicine and Assistant Director of Health Services were placed on paid administrative leave, Falcon quickly assessed the priority needs of the organization and collaboratively developed a plan of action to expediently address the most urgent issues facing healthcare delivery for AICs. In the initial phase of the study, it became clear that while the priorities identified were critical, they revealed underlying systemic concerns that warranted broader assessment. This report provides a detailed record of the Falcon team's assessment process, methodology, observations, and recommendations for improving healthcare delivery in ODOC's prisons.

People experiencing incarceration across the country and around the world are far more likely than others to meet criteria for complex health conditions, and today's prisons have a significant healthcare mission. In recent years, state and county jurisdictions have sought to actively evolve their care delivery models to meet that growing need, and mature systems of healthcare in correctional settings recognize the critical role of professionalizing their models of healthcare delivery. Correctional healthcare systems are seen as large healthcare organizations, led by healthcare executives and strong clinician-administrators who ensure access to care and see AICs as their patients. This process of professionalizing a healthcare agency begins with an assessment of the current state.

This assessment was requested by the State of Oregon and the Office of ODOC Director Mike Reese as part of a broader commitment to transparency and the health and wellness of the people who live and work inside Oregon's prisons. Compiled as a systemwide CQI project, the report reflects the significant contributions of Health Services leadership, facility-based staff, AICs, community-based stakeholders, and many other people impacted by incarceration. The Falcon team's goal was to apply a multi-method, inclusive, and comprehensive approach to assessing the healthcare delivery system, and to arrive at observations and recommendations to elevate AICs care delivery.

A. Falcon Correctional and Community Services, Inc.

Launched in 2017, Falcon is a nationwide consulting and management firm that brings together the most distinguished and credentialed leaders in healthcare, justice, and public safety.

[1] Healthcare is an umbrella term intended to encompass physical health, behavioral health, dental health, Pharmacy Services, and ancillary care.

With dozens of specialized experts, Falcon exists to ensure that justice-involved programs effectively address the unique challenges facing communities across the country.

Falcon's subject matter experts are current and former operators, steeped in evidence-based practices for healthcare and prison operations, and deeply committed to equity and access to justice and healthcare. Each has been selected from across the nation to work collaboratively as agents of change. All have spent their careers at the intersections of public health and public safety. Subject matter experts bring their experience to bear on a wide range of projects, including expert consulting services; systemwide healthcare assessments; imbedded support for implementation and change; and architectural and engineering expertise striving to elevate correctional facilities. For more information on Falcon, please visit www.falconinc.com.

Subject Matter Experts

Robin Timme, Psy.D., ABPP (Forensic), CCHP-MH, CCHP-A, Principal and Senior Expert for Integrated Healthcare Operations.[2] Dr. Timme is a clinical psychologist, board-certified in forensic psychology, and a Fellow of the American Academy of Forensic Psychology (AAFP). He is a Certified Correctional Health Professional with a Mental Health specialty (CCHP-MH) and holds an Advanced certification (CCHP-A) from the NCCHC. Dr. Timme has delivered, supervised, or consulted on healthcare matters in a wide array of community-based, forensic, and correctional settings, including more than 150 correctional facilities.

Marina Cadreche, Psy.D., LP, HSP, Senior Project Manager and Senior Expert for Behavioral Health.[3] Dr. Cadreche is an experienced healthcare administrator who has dedicated her career to leading local, state, and international healthcare teams in correctional settings. A licensed psychologist, she has chaired the Behavioral Health Committee of the American Correctional Association (ACA) and has served as ACA's Health Commissioner of Accreditation, on the Board of Governors, and on the Performance Standards Committee.

Raymond Herr, MD, CCHP, Chief Medical Expert. Dr. Herr is a physician, board-certified in general preventive medicine, public health, and addiction medicine. He has served as Chief Medical Officer for two national healthcare companies and has provided on-site care in community-based clinics, city jails, county jails, and state prison facilities. He has specialized interest and expertise in patient safety in correctional settings, as well as managing care for incarcerated individuals with SUDs.

Stephanie Patrick, MSN, MHNP-BC, CCHP, Senior Medical Expert. Ms. Patrick is a Nurse Practitioner (NP) who has delivered and supervised care in emergency departments, county jails,

[2] Correspondence should be directed to Dr. Robin Timme at rtimme@falconinc.com

[3] Behavioral Health is an umbrella term to integrate mental health, psychiatric care, substance use disorder treatment, and co-occurring disorders.

and prison settings. With a focus on executive healthcare, Ms. Patrick brings a keen awareness of the challenges facing correctional healthcare providers and the critical importance of systemwide CQI programs and policy development and implementation.

Rick Raemisch, JD, Chief Expert for Correctional Practice and Administration. Mr. Raemisch is an internationally recognized leader in correctional practice, having served as Executive Director for the Colorado Department of Corrections and Secretary for the Wisconsin Department of Corrections. Prior to his work in corrections, Mr. Raemisch served as Sheriff of Dane County, WI, as an Assistant United States Attorney, and as a narcotics detective. Mr. Raemisch has been recognized internationally for his work on creating more humane prisons, specifically reducing reliance on solitary confinement. He was a member of the U.S. delegation to the United Nations to revise the Standard Minimum Rules for the Treatment of Prisoners (*The Mandela Rules*).

Bernie Warner, Senior Expert for Correctional Practice and Administration. Mr. Warner is an internationally recognized leader in correctional practice. He began his career as a Correctional Officer in the Washington State Department of Corrections, and after serving as Chief Deputy Secretary for the California Division of Juvenile Justice, he returned to the Washington State Department of Corrections and retired as Secretary. Mr. Warner's expertise lies in management of class action litigation around healthcare, safety, security, and accommodations under the Americans with Disabilities Act (ADA). Mr. Warner was also a member of the 2015 U.S. delegation to the United Nations to revise *The Mandela Rules.*

Corey Brawner, Ph.D., CCHP, Senior Expert for Research, Data, and Analytics. Dr. Brawner is a clinical psychologist whose expertise lies in research and data analytics. Specializing in research design and statistics, Dr. Brawner has been integral to developing and implementing Falcon's proprietary methodologies, which aim to ground assessments in quantitative data and assess the quality of data within agencies. Prior to joining Falcon, Dr. Brawner worked with family courts and jails in Mississippi and served as a regional clinician-administrator for the U.S. Department of Veterans Affairs.

Section 2

Assessment Approach and Methodology

SECTION 2: ASSESSMENT APPROACH AND METHODOLOGY

To complete this assessment, the Falcon team's methodology included a systematic, phased approach. Focused on the standard of care for people experiencing incarceration in the United States, the team followed a sequential process of reviewing data and documents, including statewide leadership from ODOC early and often, visiting prisons, and conducting interviews with staff and AICs, deploying a survey to Health Services staff, and gathering experiences from community-based partners and impacted people. Over the course of approximately five months and building on the work of the Falcon team in the two previous months, the following tasks were accomplished.

A. Project Overview and Kickoff

The Falcon team engaged with ODOC leaders to confirm tasks, timelines, and expectations for the project. Director Reese was designated as the Executive Sponsor for the assessment, while the Deputy Director and Chief of Medicine were designated as the Project Sponsors, tasked with interfacing with the Falcon team throughout the study. The Falcon team was introduced to the Health Services Administrative Team (HSAT) immediately, representing leaders from Medical Services, Behavioral Health Services, Dental Services, Pharmacy Operations, and Business Operations. Employee Services, Public Affairs, and counsel from the Oregon Department of Justice (ODOJ) were also included in the initial phase. The Executive Sponsor and the Project Sponsors reiterated their ongoing commitment to objectivity and transparency, and directives were repeatedly issued throughout the study period to allow the Falcon team unfettered access to data, documents, personnel, outside organizations, ODOC facilities, or any other sources of information requested.[4]

B. Data Collection and Review

i. Data Request

The Falcon team issued a request for data and documents to begin assessing the current state of healthcare delivery, quality assurance, utilization management, and orientation to the broader context of living and working in Oregon's prisons. The team received responses to every requested item, fulfilling the request with the specified documents or data where available, and transparently indicating where the requested items were not available. Further demonstrating the commitment to transparency and quality improvement, the agency openly described its limitations in data collection, analysis, and CQI activities, and clearly stated a hope that this report

[4] Throughout the study period, all participants in this assessment were informed that while comments and themes would be compiled and included in this report, specific individual or organizational names would not be attributed.

would aid in expanding those capabilities. The agency described losing CQI resources in 2020 due to pandemic-related budget cuts and the desire to rebuild those capabilities.

Additionally, several internal subject matter experts from the HSAT and their managers contacted the team directly for clarification and further discussion. In this early phase of the project, it was established that statewide and facility-based personnel could contact the Falcon team through the project principal with questions, concerns, or to share information.

Requested data and documents fell into one or more of the following categories of information:

1. NCCHC accreditation reports
2. Prior ODOC healthcare-related reports
3. AICs population demographic data
4. AICs healthcare data
5. Health Services utilization data
6. Staffing information
7. Facility-specific missions across all prisons
8. Budgetary information
9. Policies and procedures
10. Other data and documents, as requested

ii. Data Quality

The team assessed the data infrastructure within ODOC, including demographic information and healthcare utilization data. The population health approach used by the Falcon team aimed to create a research design to study the entire population of AICs, the health and wellness of incarcerated individuals, and the operational response from Health Services.

Basic demographic information, such as daily population, was requested and received from ODOC's research office, including underlying raw data in most cases. These data sets allowed cross-sectional (snapshot) measurements, as well as some time series measurements by requesting the same snapshot data sets for different points in time. The research office's data sets titled "Inmate Profile" held daily population demographics, statewide and by facility, including gender, age, race, custody level, time to release, sentencing guidelines, and basic offense information.

The Inmate Profile also presented information on AICs educational needs, mental health needs, substance use needs, and developmental disability status. While the Behavioral Health Services data included in the Inmate Profile was well-organized and useful, the Inmate Profile does not include the same type of indicators for Medical Services, Dental Services, Pharmacy

Services, specialty care (Out of Facility (OOF)), or ancillary care. The well-organized data from the research office was presented in a useful format, and these data sets established baseline information on AICs.

Clinical data sets were far more difficult to obtain in the current DOC environment. They were not available and/or were not standardized across the system. The agency does not maintain a standardized HSR across all prisons, nor does it currently have a systemwide CQI program that creates and deploys routine audits and surveillance studies that would create useful data sets for analysis.

ODOC has committed to developing its systemwide CQI program, and the EHR will significantly help consolidate data compared to the current paper health record, which presents barriers to data collection, obtaining representative samples, and conducting valuable studies to inform care delivery and improve performance. ODOC plans to expand its systemwide CQI program and incorporate data from the EHR into a standardized HSR in the calendar year 2025, but the current state required extensive investigation of existing data sets through interviews, site visits, and coordination with various healthcare leaders across the state, as well as reliance on qualitative data, workshop discussions, and individual meetings with clinical staff in facilities.

Ultimately, little information was available about the population's clinical needs, and the team was forced to rely more on data describing the services provided by Health Services. Relative to other healthcare systems this team has studied, the quality of available healthcare data across ODOC is poor, but there is a plan and commitment in place to significantly improve the reliability and utility of data in the immediate future.

C. Stakeholder Engagement

Falcon held an initial series of group workshops designed to fully understand ODOC and its operations. While the Falcon team has collectively worked with dozens of agencies and visited hundreds of prisons, each system is unique in important ways. Understanding the interrelated components of the prison system's operations was critical to conceptualizing the role, priority, and effectiveness of the Health Services Division. Detailed agendas were created for each workshop conducted by Falcon, who facilitated the meetings to elicit required information. Given the nature of implementing systemwide improvements, the initial workshops also served to establish working relationships between the Falcon team and Health Services leaders.

The initial series included the following workshops, each attended by Project Sponsors, members of the HSAT, leaders from other ODOC divisions, as appropriate, and facility-based or other local subject matter experts:

1. Systemwide Orientation
2. Intake and Classification
3. Healthcare Administration, Accreditation, and CQI

4. Behavioral Health Services
5. Dental Services
6. Pharmacy Operations
7. Specialty Consults and TLC Processes

A supplemental series of workshops was held throughout the study period, which included additional ODOC personnel and topics. External or outside organizations were also invited into the assessment process. For collaborating stakeholders, the agenda was standardized to encourage engagement and to function more as listening sessions for the Falcon team. Agendas included a) introduction of roles and relationships with ODOC; b) discussion of healthcare-related issues in ODOC; and c) ideas, suggestions, or solutions to common problems. Workshops and meetings with outside organizations were attended only by the Falcon team and the collaborating entity.

Additional workshops included the following topics and partners in the study:

1. Health Services Medical Services Managers (MSMs)
2. ODOC Facility Superintendents
3. Health Services Behavioral Health Managers
4. Health Services Dental Managers
5. Health Services Immediate Staffing Needs
6. Health Services Staffing Priorities
7. Disability Rights Oregon
8. Oregon Citizens United for Rehabilitation of Errants (CURE)

   While not a formal workshop, contact information for Falcon's principal was shared with families and friends of AICs, resulting in approximately 35 contacts with the Falcon team, provision of AICs letters, and telephone calls from family members. The Falcon team also received a compilation of letters from AICs and family members describing their healthcare experiences in ODOC prisons.
9. Gender-Responsive Policy (Governor's Office)
10. EHR Implementation
11. Office of the Corrections Ombudsman
12. Organized Labor Concerns
13. Oregon Justice Resource Center (OJRC)
14. HEAL-R Program at Oregon Health Sciences University

D. Workforce Insights

Early in the process of this assessment, several current and former ODOC employees contacted the Falcon team. The Health Services Division quickly emerged eager to share their experience of delivering care inside institutions and their passion for quality improvement. Their insights proved invaluable. Although not included in the scope of services for this assessment, the Falcon team felt inspired to collect these insights from peers and colleagues who deliver care inside prisons.

i. Survey Construction

The team utilized a Rapid Qualitative Analysis (RQA) framework to design the study domains, staff survey tool, and analytic plan. RQA, a systematic approach to collecting and analyzing qualitative data, uses predetermined domains and matrices to determine themes and actionable information. RQA requires predetermined domains (e.g., pertinent categories like Access to Care) to streamline data collection and later to guide analysis. RQA is ideal for applied settings, where timely decision-making is key, and well-suited for use in large healthcare systems.[5, 6]

To determine the most appropriate domains for this study, the team incorporated pre-assessment work from December 2024 and January 2025, a scan of recent media and public policy statements, the initial workshop series that had occurred in February and March, interviews with AICs and staff during Site Visit #1, and early contacts with the families of AICs and current ODOC employees. These sources of information identified areas of significant concern across Health Services within ODOC, providing the Falcon team with a nuanced understanding of priorities from people living the experience of daily care delivery – the ultimate goal of the survey.

Figure 1. Survey Domains (16)

SURVEY DOMAINS (16)
Administrative Communication
Access to Care
Continuity of Care
CQI
Gender-related Issues

[5] Watkins, D. C. (2017). Rapid and rigorous qualitative data analysis: The "RADaR" technique for applied research. International Journal of Qualitative Methods, 16(1), 1–9. https://doi.org/10.1177/1609406917712131

[6] Hamilton, A. B., & Finley, E. P. (2019). Qualitative methods in implementation research: An introduction. Psychiatry Research, 280, 112516. https://doi.org/10.1016/j.psychres.2019.112516

SURVEY DOMAINS (16)
Housing Issues
Interdisciplinary Collaboration
Nursing and Medication
Onboarding Training and Continuing Education
On-call Issues
Pharmacy
Programming and Treatment Space
Referrals/Consults
Suicide Prevention
Staffing
Telehealth

ii. Survey Instrument

The team used a dual-method approach to data collection in which quantitative ratings and qualitative responses were collected for every domain. The inclusion of Likert-type responses to survey items for specific issues within each domain ensured that critical topics were covered by every respondent. By providing broad free-text questions, respondents could include their personal observations, concerns, ideas, and potential solutions.

The final survey instrument consisted of three primary segments. The first section included respondent profile (e.g., roles and credentials) and organizational items (e.g., department and facility). These questions were limited, and almost all items were optional, to provide staff with a sense of confidentiality and anonymity, if desired. The survey was constructed to be anonymous to the extent possible, and identifying information was intended to be entirely optional. Staff were also able to provide contact information and to indicate whether they were open to follow-up contact, all optional. While results are available later in this report, in the final response set, 56.4% of the staff answered every identifying question, and 64.8% stated they were willing to participate in follow-up contacts, indicating strong engagement with the survey and its content.

The second section asked staff members to rate their level of concern regarding 58 specific issues within the 16 domains. The quantitative items were intended to take no more than ten minutes to complete if no additional free text was entered. For each item, a four-point, Likert-type scale was used, along with an option for “prefer not to answer.”

Figure 2. Survey Response Options on Likert-Type Scale

Not at All Concerned/ Functions Well	Slightly Concerned	Moderately Concerned	Very Concerned/ Significant Changes Needed
1	2	3	4

The third section was designed to provide staff with an open format to provide details, observations, and concerns, and to create the opportunity for staff to discuss their ideas and potential solutions for the department. This section of the survey ensured that potentially meaningful concerns were not lost in the quantitative averages or completely outweighed by more commonly reported concerns, even if concerns were reported less frequently.

These responses were voluntary, and respondents indicated which domains – if any – they wanted to contribute additional information. Two questions were asked for every domain that was selected. For example:

1. ***What are your primary concerns related to Intake Screening and Access to Care? Please describe any specific challenges or issues you believe need attention.***
2. ***What ideas, improvements, or solutions do you think could address the concerns you've identified in Intake Screening and Access to Care?***

iii. Distribution

The survey was distributed on April 11, 2025, using the Health Services Distribution List, an email collector used specifically to communicate with Health Services employees. The invitation and link to the survey came directly from Falcon's principal for the project and included contact information for the Falcon team in addition to the link. The email collector included 424 Health Services employees. Prior to distribution, the ODOC's Deputy Director (Project Sponsor) informed the entire division that Falcon would be distributing the survey, that only Falcon had access to responses, that it would be anonymous, and that it could be completed as part of normal duties at work. Falcon's principal sent a follow-up reminder on April 29, 2025, and data collection was closed on May 2, 2025. Full Staff Survey Results are included later in this report.

E. Facility Studies

Site Visit #1 occurred during the week of March 10, 2025. Falcon deployed two teams simultaneously, each team including experts from medical, behavioral health, correctional practice, and administration. Facilities visited included: Snake River Correctional Institution (SRCI) (with Ontario Pharmacy included), OSP, Powder River Correctional Facility (PRCF), OSCI, Santiam Correctional Institution (SCI), DRCI, CCCF (Intake, Women's Medium, and Women's Minimum), TRCI (Medium and Minimum), Eastern Oregon Correctional Institution (EOCI), SFFC, and Columbia River Correctional Facility (CRCF). Falcon team members toured facilities, interviewed AICs and

staff, and held on-site workshops with interdisciplinary facility administration at in-briefs and closeouts.

Wall Mural 1. Two Rivers Correctional Institution

Site Visit #2 occurred during the week of April 14, 2025. Falcon deployed a team of experts from medical, behavioral health, correctional practice, and administration. This team was intentionally blended between the two teams from Site Visit #1, and the focus was on OSP and CCCF, two facilities highlighted as requiring additional attention and depth of study. Falcon teams interviewed AICs and staff, observed healthcare practiced in real time, reviewed health records on-site, and attended an AIC town hall meeting. The team also spent a full day on-site at CTRS (Health Services Headquarters), conducting interviews with ODOC staff from divisions related to Health Services (i.e., transportation, disciplinary hearings, classification, etc.).

Site Visit #3 occurred during the week of June 9, 2025, with a team of interdisciplinary experts visiting CTRS for a final series of supplemental meetings and workshops. The site visit included meetings with the Executive Sponsor, Project Sponsors, and Public Affairs leadership, in addition to a workshop with approximately 60 statewide Health Services managers. In addition,

the site visit included another trip to CCCF to observe intake operations at the CCIC and the women's facility, as well as another visit to OSP.

Prison visits included a semi-structured agenda that included:

- Assessment of the continuum of available healthcare services (including medical, behavioral health, dental, pharmacy, and specialty care).
- Visits to specialized housing units, such as infirmaries and restrictive housing areas, including segregation, clinical alternatives to segregation (i.e., behavioral health unit (BHU)), mental health infirmaries, mental health day treatment units (DTUs), mental health housing units, co-occurring disorder treatment programs, residential SUD treatment, and close observation and suicide watch monitoring areas.
- Review of healthcare staffing, intake screening, assessment, access to care, chronic care clinics, medication and Pharmacy Services, withdrawal management, Medication Assisted Treatment (MAT) and MOUD, suicide prevention, psychiatric emergencies, service backlogs, including chronic care appointments, diagnostics, referrals, and urgent care, quality improvement and information systems, discharge planning and reentry, and services for transgender and gender nonconforming (GNC) AICs.
- More than 100 discussions or interviews with staff across disciplines (medical, behavioral health, dental, pharmacy, custody, and administration), in varying degrees of confidential settings, in group and individual formats, often at the request of a staff person who knew the team was coming.
- More than 100 discussions or interviews with AICs, selected to reflect a range of health needs and housing statuses, in varying degrees of confidential settings, in group and individual formats, sometimes pre-selected by ODOC and other times selected at random by Falcon team members.
- Observations of clinical spaces and workflows, including intake, sick call, medication administration, emergency response, programing, mental health, SUD treatment, medical and mental health housing, restrictive housing, recreation spaces, and general population.

F. Supplemental Meetings

Following Site Visit #1, the Falcon team identified a series of individuals or groups as local subject matter experts with data, documents, or knowledge that would assist in refining the results of the study prior to formulation, analysis, and report writing. As with the workshop series, Falcon was granted full access to all requested staff. Supplemental meetings included the following topics with local subject matter experts:

1. Internal and external communications
2. Research and data
3. Transportation
4. Grievance Process
5. Policy Development
6. Classification and Custody Operations
7. Correctional Health Partners
8. Interviews with Director Reese
9. Release Planning and Reentry
10. Disciplinary Hearings
11. Community Corrections
12. Infrastructure and the Built Environment
13. Nursing Administration
14. Investigations
15. Pharmacy Operations and Data

G. Formulation and Analysis

Having completed data collection and refinement, and all sources of information reviewed and incorporated, the Falcon team worked to synthesize various data points, validate areas of strength, and identify opportunities for improvement. The team reviewed existing practices against the standard of care and nationwide best practices and data trends and arrived at opinions through the lens of intended and expected improvements to the healthcare delivery system. Specifically, the team recognized the massive impact that an EHR will have on this particular system, as well as the real-time impact of changes made to processes already identified as problematic, like the specialty care consult process. The Falcon team worked collaboratively with ODOC as the project came to an end, regularly providing updates, alerting leadership when urgent issues arose, and providing a series of presentations on the evolving work of the team.

i. Defining a Standard of Care

When assessing healthcare delivery in a correctional system, Falcon conceptualizes a standard of care against which to measure systemwide performance, beginning with legal foundations that establish the constitutional right to healthcare for incarcerated individuals. Landmark healthcare cases like *Estelle v. Gamble* (429 U.S.97 [1976]) and the extension to psychiatric care in *Bowring v. Godwin* (551 F.2d 44[1977]) created the legal foundations that guarantee access to care for incarcerated individuals. These legal foundations and affirmations of constitutional rights created a major paradigm shift in terms of the services that a prison must

provide to meet the clinical needs of incarcerated individuals. Today, prisons are required to provide access to adequate healthcare providers and services for serious medical and behavioral health needs, and to provide a level of care that is commensurate with a community standard of care.

Beyond the constitutional obligations – and deviating significantly from traditional roles of correctional staff – healthcare professionals approach AICs as their patients, introducing an additional set of guiding principles and requirements. Credentialed healthcare professionals have some version of a Hippocratic perspective, sworn to *first, do no harm,* or more generally to act in the best interests of the patient. This moral and ethical imperative to healing patients is critical to the operation of a healthcare delivery system in a correctional facility, and as such, standards in healthcare delivery like those promulgated by NCCHC are invaluable to guide practice.

ODOC's prisons are accredited by NCCHC, requiring periodic reviews, site visits, and surveys to maintain accreditation. These standards frequently form the framework for a correctional healthcare delivery system; in Oregon, Health Services policies and procedures align with the *NCCHC Standards for Health Services in Prisons (2018).* The Falcon team members for this project included frequent presenters at NCCHC conferences, members of the CCHP-MH and CCHP-A committees, and contributors to the broader NCCHC community. The presence of the NCCHC framework creates an excellent structure for efficiently assessing a facility or a system. As part of this project, the Falcon team obtained accreditation reports for each prison, covering the last two rounds of surveys. Those reports are incorporated into the Facility Studies section of this report, and the findings are incorporated into the observations and recommendations contained in the final sections of this report.

Creating standards for healthcare in correctional facilities provides a framework for a delivery model, but NCCHC accreditation is neither necessary nor sufficient to define constitutional adequacy. Rather, surveys and accreditation ensure that governing policies are comprehensive and inclusive of all components required in a care delivery system for AICs. The Falcon team has seen correctional facilities that are accredited by NCCHC but, in the team's opinion, do not meet the threshold for adequacy. Conversely, the team has seen facilities that are not accredited by NCCHC yet provide outstanding service that reflects the letter and spirit of NCCHC standards and best practices. The Falcon team views NCCHC standards as a starting point and accreditation as validation that the foundation exists. From there, each facility must build its own site-specific policies and practices that align with the standards.

The Federal court in *Balla, et al. v. Idaho State Board of Correction* (595 F. Supp. 1558, D. Idaho 1984) wrote of the helpful role NCCHC standards played in elevating patient care and ending a nearly 40-year-old class-action healthcare suit: "The NCCHC accreditation and [Modified Compliance Plan] compliance, while not determinative, constitute substantial evidence of adequate medical care." Further, the court wrote that compliance with the NCCHC standards

constitutes "powerful evidence" of constitutionally adequate healthcare, consistent with Eighth Amendment rights of incarcerated individuals.

Professional standards provide benchmarks in care delivery and promote CQI, but delivering clinical services inside a correctional facility creates an added layer of moral, ethical, and legal considerations that clinical professionals face every day. For example, the ethical concept of *dual loyalty* has been recognized as a constant and often unconscious influence on Clinical Practice in prisons. Clinical professionals in prisons are frequently reminded that they practice their trade in settings designed, intended, and operated primarily for security. When the environment of care delivery is governed not by a healthcare mission or healthcare standards, the influence on the practice of healthcare can be extreme. For these reasons, reliance on standards of accreditation to justify policy and practice decisions is wise, and it is critical to remind all leaders in ODOC of the legal, ethical, and moral imperative to support the healthcare mission.

Lastly, in addition to law, ethics, and professional standards, the Falcon team relies on the collective experience of subject matter experts. This particular Falcon team has collectively observed hundreds of correctional facilities, engaged with thousands of people who live and work inside prisons, and helped forge creative solutions to the unique challenges of healthcare delivery in correctional facilities. These firsthand experiences inform all aspects of an assessment, from engaging with peers working across systems, to conducting site visits, and to evaluating readiness for change within various correctional systems.

Falcon strongly believes in the power of policy as governing documents, synthesizing the standard of care into written directives for intended care delivery in correctional settings. Policies must adequately meet all legal requirements, grounded in federal and state regulations, and incorporate professional standards, ethics, and expected practices. The Oregon Administrative Rules (OARs) reflect ODOC's interpretation of statutory requirements for healthcare delivery in the prisons. The OARs are written by ODOC and create the regulatory framework within which policies are crafted. Relevant OARs for this study are primarily found in Chapter 291, Division 124, Health Services (AIC). Additional relevant OARs include *Suicide Prevention in Correctional Facilities* (291-076) and *Mental Health Special Housing* (291-048-0200). Obviously, all OARs can have an impact on the experience of incarceration for AICs, but Health Services policies, procedures, and Clinical Practices are primarily based on these OARs.

The OARs were observed to be fairly detailed and comprehensive in many cases, while the policies developed from the OARs were generally vague, brief, and less helpful than OARs in terms of directing patient care. For each policy, however, ODOC develops a corresponding statewide procedure, which is much more similar in detail to the OARs and explains how the policy is implemented statewide. Meanwhile, care provided by Behavioral Health Services is governed by

Oregon Revised Statutes → Oregon Administrative Rules → ODOC Health Service Policies → ODOC Health Service Procedures

Clinical Practices rather than policies, which are fairly detailed, often including best practices, but are buried in the governance documents of the agency.

In this way, the policy and governance structure of the agency can be cumbersome and difficult to navigate. People delivering care on-site at a specific prison experience ambiguity in their roles and a lack of clarity in their daily assignments and duties. This is particularly important because of the number of agency and contracted personnel on-site each day, rotating quickly, and requiring clear directives and post orders (i.e., site-specific procedures). Each prison ought to have a site-specific procedure that clearly defines how a policy (including a statewide procedure) is implemented in that specific facility, including measurable and quantifiable indicators for CQI.

H. Highlighted Relevant Assessments

In recent years, a series of studies and reports have assessed specific areas of healthcare delivery in ODOC facilities, arriving at similar observations and recommendations across various bodies. These specific reports were authored by a legislative Task Force, a nonprofit dedicated to justice for women, a private firm specializing in whistleblower investigations, and this Falcon team's pre-assessment work with ODOC. They offer a helpful foundation of targeted assessment in specific areas of healthcare delivery within ODOC facilities, which informed this comprehensive assessment, its observations, and its recommendations.

i. 2022 Report on Access to Health Care Services for Oregon AICs

In September 2022, a Joint Task Force on Corrections Medical Care issued a report prepared by the Legislative Policy and research office. The report was the result of a legislative mandate (*House Bill 3035*) directing the formation of a multidisciplinary Task Force to evaluate healthcare delivery within ODOC. The report reflected input from Oregon's correctional health leaders, state officials, and stakeholders across Oregon. The scope of the report was to review aspects of the healthcare services for AICs, specifically focused on ODOC's "grievance process, medical standards of care, and adoption of an EHR system."

The report addressed ODOC's grievance process and structure. Second to security concerns, healthcare concerns comprised the greatest number of grievances among AICs. The report also discussed the status of the Office of Corrections Ombudsman, delineating, "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.'" At the time of the report, the ombudsman position was in the process of being funded and filled. The report also described the status of the EHR adoption project that was under way at the time. The authors noted that efforts to modernize ODOC's healthcare technologies dated back more than 15 years at the time, but the Request for Proposals (RFP) had been disseminated at the time of the report's writing.

The authors of the Task Force report then described ODOC's Medical Standards of Care and Service Prioritization. They outlined the Health Services Division, its full-time staffing pattern,

and its accreditation by NCCHC. Beginning at intake, the report outlined the services afforded to AICs at the time of entry into the prison system, tracking the individual to the receiving facility and noting that although classification needs are prioritized when considering placement in a specific prison, "Medical needs also inform AIC facility placement since not all facilities have the infrastructure or staffing to meet all medical needs." Additionally, "Specific medical needs that are not offered at all DOC facilities include infirmary level of care and mental health services. 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."

The Task Force report also introduces the ways AICs can access care while in custody, including through Health Services requests ("kytes") or verbal requests to staff. The TLC[7] process was also described: "DOC is able to provide most routine services on-site, while others (e.g., advanced imaging, specialist visits, etc.) need to be coordinated with community providers." The four levels of care and treatment are defined: *medically mandatory* (Level 1), *presently medically necessary* (Level 2), *medically acceptable but not medically necessary* (Level 3), and *of limited medical value* (Level 4). The TLC process includes a TLC committee that conducts case reviews and makes treatment decisions, noting that, "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." The legislature was noted to set a Key Performance Measure (KPM) target of one percent or less for healthcare services being provided outside of ODOC facilities. Prior to the COVID-19 pandemic, "DOC generally met the KPM target," but due to staffing and service availability since the pandemic, DOC, "exceeded the target in 2020 (1.78 percent) and 2021 (1.39 percent)," according to the report.

The Task Force also discussed the challenges of comparing or adopting community-based (i.e., Medicaid-funded) models of correctional healthcare due in part to federal laws that preclude expenditures of federal funds on incarcerated individuals. While they did not exactly recommend adopting the Prioritized List of Health Care Services from the Oregon Health Plan (OHP), they noted that the TLC process serves, "a prioritization function, albeit one that is far more general than the Prioritized List." The Task Force found "general alignment" between the TLC levels and examples, and the Prioritized List from the OHP.

Lastly, the Task Force identified a series of recommendations for ODOC and for the Legislative Assembly. Those recommendations included:

[7] TLC processes are represented in *Health Services Procedure P-A-02.1 Level of Therapeutic Care Provided by the Oregon Department of Corrections, Health Services Division.*

For the ODOC:

1. **CQI**: Task Force recommended that ODOC develop a systemwide CQI program, implying that a robust program did not currently exist.
2. **EHR System Implementation:** Task Force recommended that ODOC should prioritize the procurement and rollout of an EHR.
3. **Workforce**: Task Force recommended that ODOC should explore creative ways of attracting, recruiting, and retaining Health Services staff.
4. **Access**: Task Force recommended that ODOC should expand access to technologies to support delivery of healthcare services, including use of telehealth.
5. **Reporting**: Task Force recommended regular updates on implementation of progress covering recommendations #1-4 above.

For the Legislative Assembly:

6. **Office of the Corrections Ombudsman**: Task Force recommended indefinite funding for this position and tasking the ombudsman with, "engaging with AICs, family of AICs, and DOC to learn from, inform, and support DOC's CQI efforts."
7. **Mental Health and SUD Funding**: Task Force recommended increased funding for Behavioral Health Services to ensure access, "to every AIC for the entire period of incarceration, including evidence-based MAT options."
8. **EHR System Implementation**: Task Force recommended additional funding based on the quality of the EHR selected.
9. **Early Medical Release**: Task Force recommended consideration of early medical release standards to address, "appropriate and timely care of AICs with terminal illnesses and complex medical needs, as well as free up DOC workforce and facility capacity to provide care to other AICs."

ii. 2023 Gender Informed Practices Assessment and Advisory Panel

Prior to Falcon's engagement with ODOC, there had been efforts to address some of the systemwide concerns, beginning with the Gender Informed Practices Assessment (GIPA), which was commissioned in 2022 as part of Oregon's broader initiative to improve outcomes for incarcerated women and develop a gender-responsive strategic plan for CCCF. While the scope of the GIPA included far more than healthcare delivery, the report and subsequent healthcare work group notes included important observations that are helpful beyond the women's facilities.

The Falcon team was provided with documentation from the Gender Responsive Advisory Panel (GRAP) Healthcare Workgroup, specifically information from AIC listening sessions, as well as recommendations. Themes extracted from the listening session notes included:

1. Unanswered or delayed care requests, complaints that medical "kytes" (Health Services requests using AIC Communication Forms) go unanswered, or that responses take too long.
2. Lack of continuity and access to specialists, like waiting 18 months to receive a Continuous Positive Airway Pressure (CPAP) machine for sleep apnea, while other women described no access to specialists for basic services like eye exams.
3. Disrespectful interactions, describing some medical staff as dismissive or demeaning.
4. Inadequate communication and follow-up about conditions and care plans, resulting in diminished trust in Medical Services.
5. Barriers related to disabilities, with reports of correctional staff lacking training in accommodating people with disabilities.
6. Logistical obstacles to care, such as requiring AICs to pack all belongings prior to medical transports, which leads to people declining care to avoid losing access to needed items for days.

The GRAP Health Services Workgroup produced a comprehensive list of policy and practice recommendations to improve healthcare delivery at CCCF. Some of the key themes included:

1. Improve access and timeliness:
    a. Activate an electronic AIC Communication Form system to track and respond to care requests.
    b. Establish benchmarks and audits for response time and follow-up care.
    c. Create shared data dashboards for performance tracking and transparency.
2. Improve care delivery and services oversight:
    a. Reevaluate or replace the TLC process using OHP clinical guidelines.
    b. Expand telehealth access, especially for specialty care.
    c. Create a patient advocate or boundary spanner role to mediate between staff and AICs.
3. Improve reproductive and gender-responsive care:
    a. Implement a structured reentry contraceptive plan for all AICs, including method of choice and refills.
    b. Ensure providers are trained in women's health.
4. Create a patient-centered healthcare process:
    a. Eliminate strip searches following off-site medical procedures.

b. Provide written after-visit summaries to patients.

c. Expand the formulary to align with OHP offerings and streamline access to low-cost adaptive needs (e.g., glasses, dentures, hearing aids).

5. Improve continuity of care and reentry services by assigning medical staff to coordinate reentry health plans, ensure 30-day supply of medications and supplies, and facilitate community-based follow-up.
6. Improve workforce and culture:
    a. Expand access to trauma-informed and gender-responsive training.
    b. Address staff burnout and compassion fatigue through regular engagement and structural improvements.
    c. Explore alternative work week models, like 4 x 10-hour days or 3 x 12-hour days.

As a result of the GIPA, a phased Implementation Plan was developed. As of May 22, 2025, 19 of the 185 projects defined in Phase 1 are in "Substantial Compliance," with 166 "In Progress." According to the GIPA Implementation Plan, Phase 1 is expected to be completed in late 2028 followed by Phase 2 initiatives.

iii. 2024 Whistleblowing and Retaliation Fact-Finding Report

In March of 2024, two ODOC-employed physicians alleged they were retaliated against after they raised concerns about patient care and leadership practices within the ODOC Health Services Division. Brought to the attention of Director Reese, an outside consultant was retained to investigate whether the physicians' complaints met the legal definition of whistleblowers under Oregon law; to assess whether retaliation occurred by ODOC leadership, specifically by the Chief of Medicine and Assistant Director of Health Services; and to examine related patterns of failures to provide clinical supervision of practices and processes, misuses of personnel and procedures, and ethical misconduct.

The two physicians who raised their concerns described delays or denials of medical care specifically related to the TLC process, gender-biased treatment policies and practices, improper documentation of performance evaluations, and systemic leadership failures in communication, transparency, and collaboration. Both physicians also alleged that after making these disclosures, they were subjected to punitive work assignments, removal from their clinical duties, and reputational harm.

The findings from the investigation report concluded that both physicians met the definition of whistleblowers; each acted in good faith and had a reasonable basis for their concerns. The report also found that the physicians were each subjected to retaliatory actions by leadership after they raised concerns. Although the report focused primarily on issues of

whistleblowing and retaliation, it highlighted the following additional findings relevant to the current assessment and methodology:

1. The TLC process was manipulated by clinical leadership, and dissenting clinical opinions were suppressed.
2. There was false documentation of performance meetings and delegation of supervisory duties without oversight.
3. Retaliatory reassignment of one physician to [redacted] post after [redacted] and expressing clinical disagreements.
4. Efforts to discredit the other physician were noted after the physician attempted to escalate concerns to Director Reese, including the selective use of peer reviews and misleading administrative records.

In addition, the report identified significant leadership deficits in ODOC Health Services, specifically failing to uphold standards of ethical management, collaboration, and clinical governance. The investigation concluded that the impact of these cultural, retaliatory, and leadership failures compromised the safety, dignity, and right to healthcare for incarcerated patients.

iv. 2025 Pre-Assessment Priority Needs Report

When both Health Services leaders were placed on administrative leave, the Falcon team began working with ODOC to quickly assess and triage the immediate needs of the system, and to identify areas for prioritization. This *pre-assessment* phase of work was motivated by the need to rapidly engage with ODOC, and to quickly join and support the agency as it made immediate changes to its organizational structure, managed internal and external communications, and addressed the clinical and administrative leadership vacuum at the top of the organization.

The Falcon team spent two months meeting with ODOC's administrative and clinical leadership on a near-daily basis, reviewing extensive documentation, and collaboratively engaging in an examination of the current ODOC healthcare delivery model. The team provided real-time advice and guidance on priority needs within the healthcare delivery system, working with decision-makers in an iterative process of quality improvement.

Key observations and findings from the pre-assessment phase:[8]

1. Director Reese and his executive team demonstrated a clear commitment to improving healthcare within the prison system, signaling a systemwide shift toward reform and accountability.

[8] For the full document, see Appendix B: Pre-Assessment Priority Needs Memo.

2. ODOC experienced an increase in complaints from both AICs and healthcare staff about access to care and system performance, prompting the work of the whistleblower investigation and high-level administrative changes, including the departure of the Chief of Medicine and Assistant Director for Health Services.
3. ODOC responded effectively to Falcon's data request and actively collaborated with the team to begin addressing short-term and long-term challenges concurrently.
4. ODOC prioritized the appointment of an Interim Chief of Medicine, and the agency's Deputy Director temporarily assumed the role of Acting Assistant Director of Health Services, quickly filling the clinical and administrative leadership roles for Health Services.
5. Areas in need of urgent attention included the following three domains:
    a. Access to Care and the TLC process
    b. Systemwide CQI
    c. Organizational Structure and Staffing

Recommendations from the pre-assessment phase included:

1. Access to Care and TLC process:
    a. While improving the underlying TLC process, simultaneously use a "blitz" approach to address the existing backlog of specialty care appointments.
    b. Revise *Procedure A-02.1* to clarify TLC criteria and remove non-clinical barriers to care.
    c. Remove non-formulary medication approvals from TLC and place under Pharmacy and Therapeutics (P&T) review process.
    d. Centralize TLC case management and referral tracking using a single standardized roster at each facility to prevent lost or delayed consults and ensure the TLC is kept abreast of delays.
    e. Ensure "medical holds" are placed on AICs with pending off-site appointments to prevent inadvertent transfers prior to consult completion.
2. Systemwide CQI:
    a. Establish a statewide CQI department in the Health Services Division with a defined charter, revised policy, and clear responsibilities.
    b. Appoint CQI liaisons at each facility responsible for coordinating audits, studies, and performance improvement plans (PIPs).

c. Create a standing CQI calendar with scheduled audits and review cycles to track policy compliance, outcomes, and standardized healthcare utilization tracking.

d. Require documentation of audits and PIPs, including meeting sign-ins, data sheets, action plans, and follow-through verification.

3. Organizational Structure and Staffing:

a. Clarify roles among Health Services leadership, including the separation of clinical and administrative responsibilities within different disciplines.

b. Hire or assign dedicated staff for recruitment, policy management, training, and CQI.

c. Develop a systemwide staffing model to project needs based on facility size, acuity, and program complexity.

d. Initiate a succession plan for the interim clinical and administrative leadership in Health Services.

e. Strengthen Human Resources and transportation coordination, including the consideration of dedicated Medical Transport Officers.

With the triaged pre-assessment phase completed and the immediate action plan under way, Falcon was able to begin a comprehensive assessment of the broader healthcare delivery system in Oregon's prisons. ODOC and ODOJ requested that Falcon consider the ODOC healthcare delivery system through a lens of *mature* systems of care. Committed to a best practice model of care delivery for AICs, ODOC aimed to understand the existing system; to identify those aspects of healthcare that are sound and operating capably; and requested recommendations for improvement. The scope of services was intended to begin as broadly and inclusively as possible, and to narrow the focus to target specific areas in need of improvement.

ODOC also committed to sharing these results publicly and to consider adoption and implementation of recommendations. In fact, ODOC leadership requested that Falcon recommend a model for implementing recommendations, including program governance and oversight, as well as subject matter expertise to implement sustainable change.

Consistent with the recommendations from the pre-assessment phase of the project, ODOC began implementing changes to priority areas in December of 2024. While those areas were studied further during this comprehensive assessment phase, Falcon was also able to provide advice, guidance, and coaching on implementing systemwide CQI initiatives proposed by ODOC, including:

1. Changes to the TLC process championed by the new Chief of Medicine to streamline the process of referral, triage, approval, scheduling, transportation, and follow-up.

2. Identification of immediate staffing needs to support TLC process improvements, specifically in the areas of scheduling and case management.
3. Identification of immediate resources needed to increase the capacity for off-site consults, specifically medical vans and transportation officers.
4. Development and revision of the position description, qualifications, and posting of the position for the Assistant Director of Health Services, the Responsible Health Authority for the agency.
5. Recruitment and hiring of a dedicated Health Services recruiter to improve ODOC's ability to hire staff more effectively.
6. Prioritization and preparation for implementing EHR resources, specifically defining the administrative and clinical support needed for rollout, back-filling providers for training and an expected learning curve, and planned personnel reallocation.
7. Incident review process, including a death review and psychological autopsy for a suicide that occurred during the assessment period.
8. Medical inquiries tracking for families of AICs and supporting improvements in information gathering and disseminating.
9. Provision of legislative testimony to the Senate Judiciary Committee.
10. Internal and external communication support, responding to media requests, and communicating with employees.
11. Implementation of medical town hall meetings at CCCF for AICs housed at the minimum custody facility, where designated Medical Services personnel are available and engaged directly with AICs to hear their medical concerns.

Section 3

Workforce Insights

SECTION 3: WORKFORCE INSIGHTS

When this assessment was announced publicly, the project principal's email address was included in the ODOC press release. Almost immediately, current and former staff from Health Services began sending messages and requesting to speak with the Falcon team. An estimated 15 contacts were received before the healthcare assessment began in earnest. Once the assessment kicked off and workshops began, it was common for individual staff members to follow-up with the project principal and convey additional information, ask questions, and almost always offer additional support to the project, if needed. Each contact was shared with the entire Falcon team, processed at internal meetings, and incorporated into formulation and analysis.

> The energy and engagement from Health Services staff were unprecedented in Falcon's experience. Staff were direct, collegial, and eager to share concerns about caring for patients in ODOC prisons.

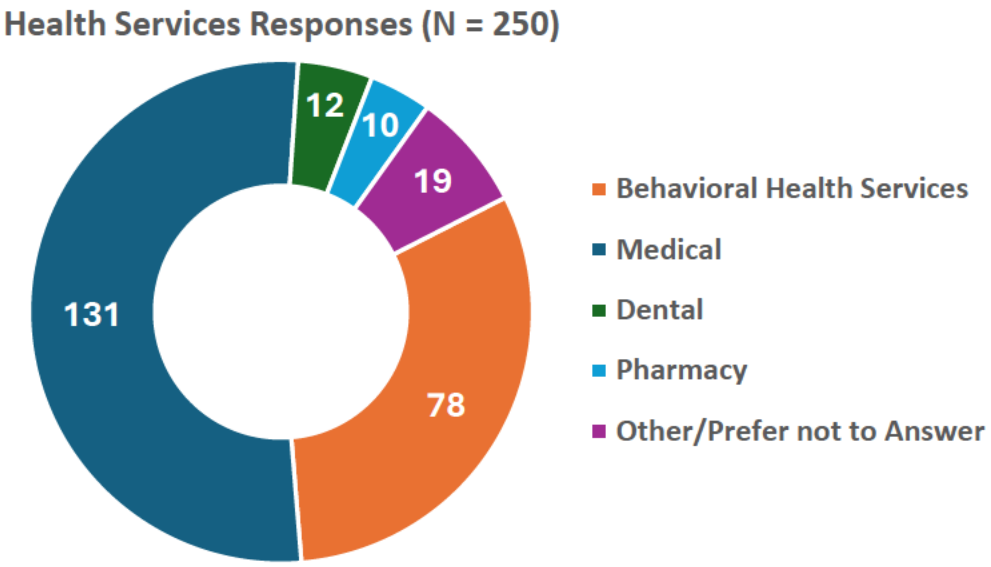
Similarly, the team communicated with the President and Executive Director of the Association of Oregon Corrections Employees (AOCE) by email and telephone and arranged for a supplemental meeting with the Executive Director and a staff member to discuss concerns. Although the Falcon team attempted to connect with additional organized labor groups, AOCE was the only group that contacted the team and provided input for the study. However, hundreds of staff members from facilities were included across the project.

A. Staff Survey Results

The Falcon team's survey was distributed by email on April 11, 2025, and responses were collected through May 2, 2025. The survey was emailed to 424 Health Services employees via the Health Services Distribution List. The dataset was cleaned of any duplicate responses, and responses were only retained if a respondent completed at least 80% of the Section 2 Likert questions. The team received a total of 250 usable responses, resulting in a response rate of 57.6%.

Staff submitted surveys across all departments within Health Services, including responses from physicians, nurses, pharmacists, dentists, QMHPs, [9] and QMHAs, [10] as well as clinical and administrative support staff and managers. Staff responses were received at all 12 prison facilities, CTRS, and the Four Rivers (Ontario) and Salem Pharmacies, including several respondents who reported providing clinical or administrative services to two or more facilities.

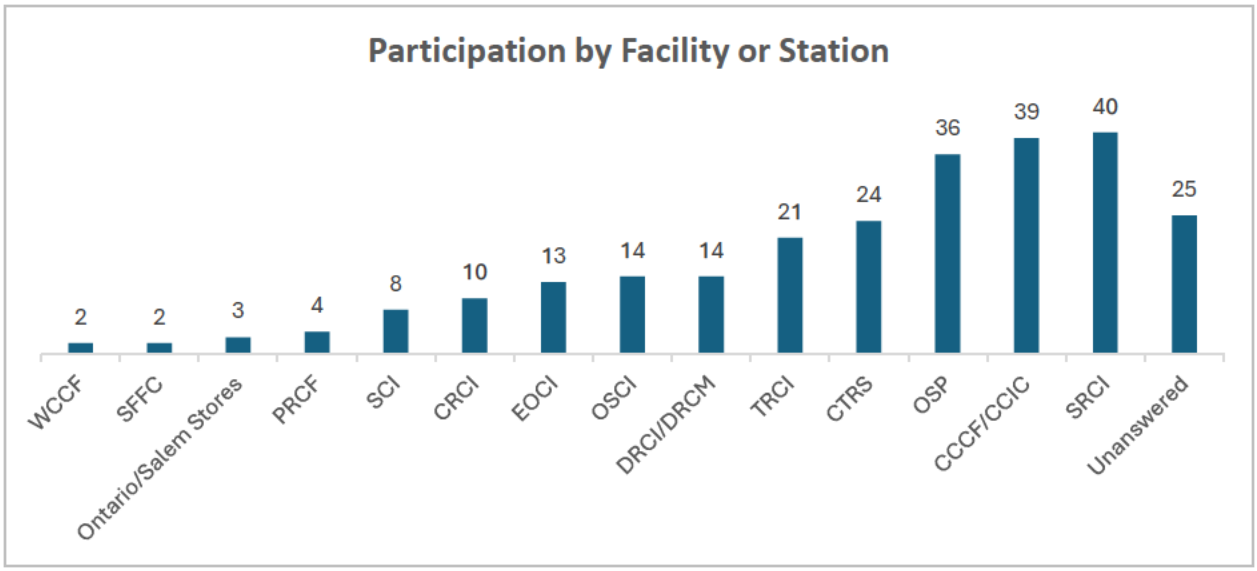
Figure 3. Responses by Discipline



[9] **Qualified Mental Health Professional (QMHP)**: Per OAR 291-124-1030, the credential of QMHP is applicable to any licensed medical practitioner, or to anyone who holds a graduate degree in psychology; bachelor's degree in nursing (and licensed by the state); graduate degree in social work; graduate degree in a behavioral science field; graduate degree in recreational, music, or art therapy; bachelor's degree in occupational therapy (and licensed by the state); and whose education and experience include competency in identifying precipitating events, gathering biopsychosocial histories, conducting mental status exams, diagnosing individuals, developing care plans, conducting mental health assessments, and conducting individual, family, or group therapy within their individual scope of training.

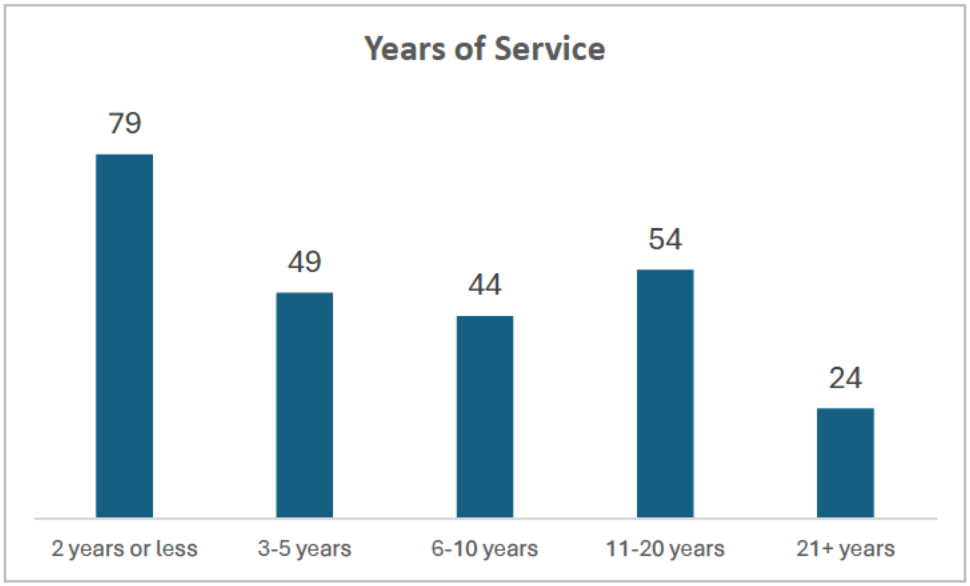
[10] **Qualified Mental Health Associate (QMHA)**: Per OAR 291-124-1030, the credential of QMHA is applicable to individuals who hold a bachelor's degree in a behavioral sciences field; or a combination of at least three years relevant work, education, training, or experience; and demonstrate competency necessary to communicate effectively; understand mental health assessment, treatment and service terminology and apply these concepts; provide psychosocial skills development; implement interventions as assigned on an individual care plan; and provide behavior management and case management duties.

Figure 4. Participation by Facility or Station



Respondent experience varied greatly across the sample. Many newer employees with 0-2 years of experience responded, representing the largest respondent demographic group at 31.6%. Employees with 11-20 years of experience were the second largest group at 21.6% of the sample, followed by employees with 3-5 years of experience (19.6%), 6-10 years of experience (17.6%), and 21+ years of experience (9.6%).

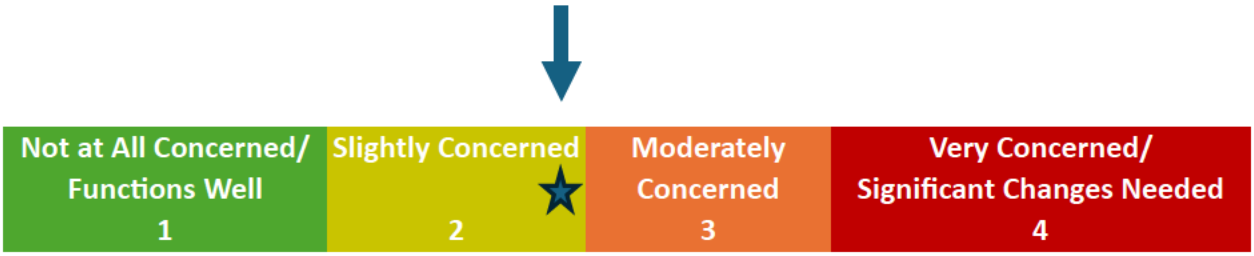
Figure 5. Years of Service



B. Quantitative

The average score for all staff on all survey rating items was 2.4 out of 4.0, indicating that staff reported generally between slightly and moderately concerned about the issues discussed in the survey. While most staff responded to one or more domains with significant concern or complaints, the overall sentiment of staff was more positive than not. The following sections report quantitative results at the system level, by department, and by facility. Results are reported at the domain level, followed by specific concerns.

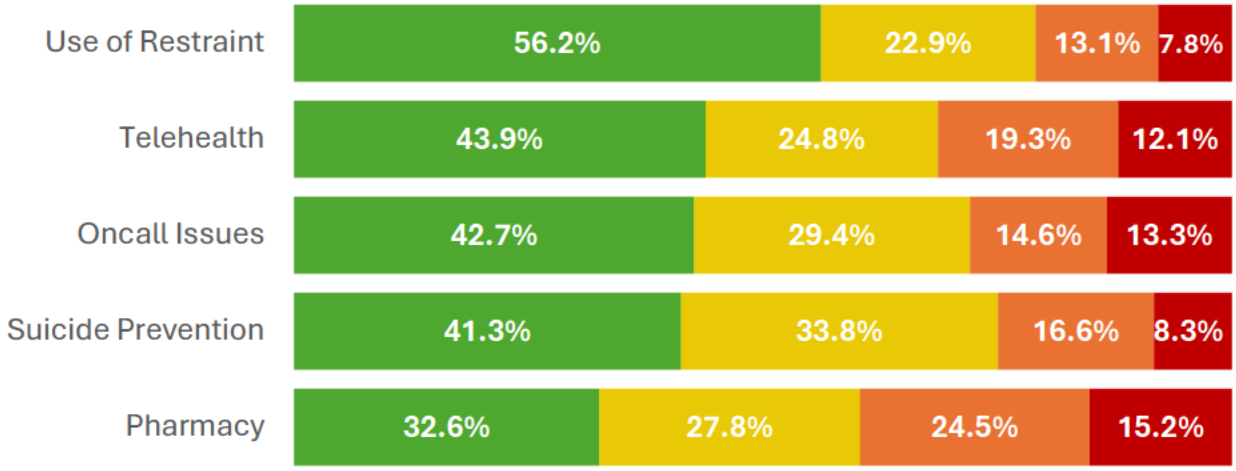
Figure 6. Average Survey Score between 2.4 and 4.0



i. Quantitative Results by Domain

At the system level, therapeutic restraint protocols were the lowest rated concern overall, with over half of staff responding that restraint protocols function well and less than 10% reporting significant concerns. Telehealth, on-call issues, and suicide prevention concerns ranked next lowest, followed by pharmacy issues as the least concerning domains.

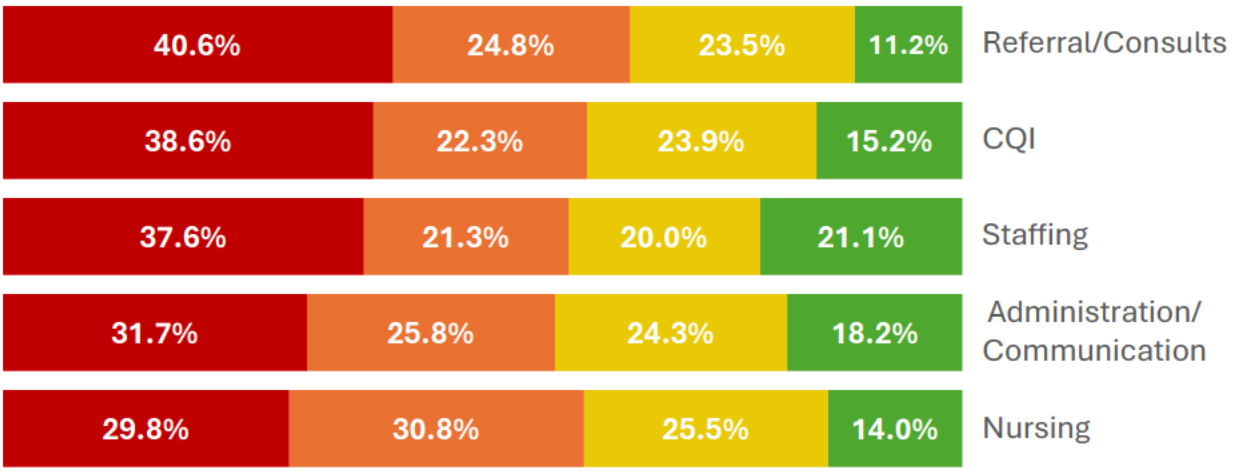
Figure 7. Five Lowest Rated Domains (Least Concerned)



Medical referrals and specialty consult issues (i.e., OOF consults) were the highest rated concern overall, with almost half of the staff reporting a need for significant changes, and only 11% reporting that these processes function well. CQI and staffing concerns followed closely, and

Administration/Communication and Nursing and Medication Administration concerns ranked as the fourth and fifth most concerning domains.

Figure 8. Five Highest and Lowest Rated Domains (Most Concerned)



Within the domains, analysis of specific issues provided a more nuanced perspective on staff concerns. Eight issues were rated as the highest specific concerns overall (three or higher out of four). The top three specific concerns reported by staff were all staffing-related, including staffing adequacy for medical and nursing positions and for operations and transportation. Notably, staff rated concerns about their personal health and wellness as being second highest out of the 58 issues surveyed. Three concerns about Medical Services (referrals to specialty care, access to specialty care, and medical treatment space) were also the top concerns, as well as processes for line staff to communicate feedback up the chain to administrators.

Figure 9. Highest Rated Issues

#	HIGHEST RATED ISSUES
1	Staffing Adequacy, Medical, and Nursing
2	Staff Health and Wellness
3	Staffing Adequacy, Operations, and Transportation
4	Process for Referral to Specialty Care (TLC committee)
5	Access to Care, Medical Specialty Care
6	Continuity of Care, Medical
7	Treatment Space
8	Feedback and Communication Processes from Line Staff to Administrators (Bottom-Up)

ii. Quantitative Results by Department

Overall, Behavioral Health Services responded with above average concern ratings (2.6). Medical and Pharmacy were just lower and equal to the overall average (2.4), and Administration staff and Dentistry reported lower levels of concern overall (2.0).

Departments rated most concerns similarly. Most differences occurred primarily due to dentistry and administration respondents generally rating concerns lower than behavioral health, medical, nursing, and pharmacy respondents. A filtered analysis including only Behavioral Health Services, medical and nursing, and pharmacy data demonstrated full consensus on all the Top Five and Bottom Five rated concerns, though rank orders differed, with only two exceptions.

Behavioral Health Services rated concerns with continuity of care substantially higher than other departments on average and specifically rated concerns with continuity of medical care and at time of release. Other departments shared these concerns but rated them relatively lower. Medical and nursing staff rated concerns with onboarding and continuing education and training higher than other departments. Again, other departments also reported this concern but rated it somewhat lower, except dentistry which rated onboarding and education concerns only a 1.7 out of 4.0. Notably, though onboarding and training did not rank at the top of overall staff concerns in the quantitative data, they were frequently discussed in the qualitative responses, indicating their significance to staff.

Figure 10. Highest and Lowest Rated Domains per Department

Department	Highest Three Concerns	Lowest Three Concerns
BHS	Staffing Nursing & Medication Administration CQI	Telehealth On-Call Suicide Prevention
Medical/ Nursing	Staffing Medical Referrals/Specialty Consults Administration/Communication	Telehealth Therapeutic Restraint Suicide Prevention
Pharmacy	Space Medical Referrals/Specialty Consults CQI	On-Call Suicide Prevention Therapeutic Restraint
Dentistry	Staffing Nursing & Medication Administration Interdisciplinary Collaboration	Therapeutic Restraint Telehealth Pharmacy
Admin/ Other	Staffing Medical Referrals/Specialty Consults Space	On-Call Suicide Prevention Pharmacy

Figure 11. Three Highest and Lowest Rated Domains per Facility

	Three Highest Ratings of Concern	Three Lowest Ratings of Concern
CCCF/CCIC	Staffing CQI Administration/Communication	On-Call Suicide Prevention Therapeutic Restraint
CRCI	Staffing CQI Train	Telehealth Suicide Prevention Therapeutic Restraint
CTRS	Staffing CQI Space	On-Call Suicide Prevention Therapeutic Restraint
DRCI/DRCM	Staffing CQI Referrals/Consults	On-Call Telehealth Therapeutic Restraint
EOCI	Administration/Communication Space Referrals/Consults	Telehealth Suicide Prevention Therapeutic Restraint
OSCI	Staffing Administration/Communication Nursing	On-Call Suicide Prevention Therapeutic Restraint
OSP	Referrals/Consults CQI Nursing	On-Call Telehealth Therapeutic Restraint
SCI	Staffing Administration/Communication Referrals/Consults	On-Call Suicide Prevention Therapeutic Restraint
SRCI	Staffing Housing Referrals/Consults	Telehealth Suicide Prevention Medical Referrals/Specialty Consults
TRCI	Staffing Nursing Referrals/Consults	Gender Nonconforming Issues Telehealth Therapeutic Restraint

Note: Data is presented for all facilities with at least five respondents.

C. Qualitative

In addition to quantitative ratings, the Falcon team received qualitative free-text responses from 173 respondents (69.2%), which included observations, concerns, ideas, and potential solutions. Responses to each question were first categorized by the domain(s) that were most relevant. Within each domain, data were further organized into statements of expressed

concerns and proposed solutions. The team then reviewed the domain-level summaries to identify key statements and recurring themes across respondents, providing a structured synthesis of the qualitative input.

The team found that when staff were provided with the opportunity to respond without forced choices, they tended to gravitate toward several key themes, some of which directly aligned with quantitative data and others that had not come out as strongly. The following section incorporates responses from all respondents and summarizes findings for key issues that emerged.

i. Key Issues

Staffing

Summary of Key Concerns:

Aligning with the quantitative data results, almost all respondents discussed significant issues with staffing shortages across most disciplines. Staff discussed a reciprocal relationship in which the consequences of understaffing (e.g., burnout, feeling unsupported, unsustainable and/or unpaid overtime) lead to higher turnover rates (i.e., further reduced staffing), constant need for training new staff, and over-reliance on short-term agency staff who are not experienced in the system. Medical and Nursing staff from several facilities also reported additional strain and tension between co-workers caused by excessive unplanned leave ("call-ins").

Staff discussed other factors that contribute to the workload, including issues with paper medical records (e.g., untimely refiling when charts are pulled), unorganized medical scheduling and overbooking, and delays caused by inefficient communication and direction from middle and upper managers, especially when new initiatives or procedures are rolled out.

> "A system needs to be in place for a tighter and more efficient schedule. We need more nurses and providers, but I also think if we focused on how we schedule and **WHEN** we schedule that would make a huge difference."

Suggestions for Improvement:

Ideas to improve staffing levels included more targeted recruitment of university students and interns in tandem with incentives to encourage retention, including improved continuing education and opportunities for career development. One respondent recommended a study of community hospitals to identify effective strategies and incentives.

All staff who raised concerns about excessive call-ins suggested that stricter policies on unplanned absences would help address these issues.

Ideas to improve current staff wellness included increased training for support staff (e.g., schedulers) and improved scheduling rules. One respondent also recommended providing

outside break areas or designated space inside for staff to walk and take a moment of respite, "to improve mental health and resilience."

Treatment and Program Space

Summary of Key Concerns:

Staff raised ongoing concerns about insufficient space for both Medical Services and therapeutic programming, emphasizing two primary themes. Regarding medical examination space, respondents described extreme limitations in waiting and exam areas, which compromise privacy and make it difficult to meet treatment demands. They also cited a lack of space for specialty evaluations, such as sleep studies, leading to prolonged wait times and untreated suspected conditions. Additionally, staff noted inadequate facilities to house and care for the aging incarcerated population and those requiring long-term care.

> "There is almost no space for the amount of AICs that we have coming in. Our 'waiting room' in medical is in the hallway in front of everyone and in the way of people and charts coming through. It is very cramped. It just seems like we are overflowing."

For addiction and mental health programming, staff highlighted the lack of confidential space within housing units. This limitation necessitates transportation to other locations, placing added demands on operations staff and introducing delays. Inadequate formal meeting spaces and logistical challenges with transportation further contribute to missed group sessions and disrupted care.

Suggestions for Improvement:

Respondents proposed conducting facility space studies to identify under-utilized areas that could be reconfigured or repurposed more flexibly. Several staff specifically discussed prioritizing usable meeting spaces over office spaces, especially on or near housing units, and recommended converting single-occupancy offices into shared spaces to better accommodate individual sessions. Most suggestions pertaining to medical evaluation and treatment spaces focused on the need for new builds and modernization. Other suggestions included constructing additional dedicated treatment areas, such as "treatment trailers," to provide confidential meeting spaces.

Training

Potentially overshadowed in the quantitative analysis, staff onboarding, initial training, and continuing education were themes discussed as frequently, or more frequently, than any other topics in Section Three of the survey.

Summary of Key Concerns:

Onboarding

Respondents reported inconsistent and inadequate initial training for new hires, with working before completing the required training courses, for years in some cases. The absence of structured onboarding programs causes confusion and inconsistent performance, which negatively impacts patients and staff alike. Staff specifically acknowledged that online onboarding training courses are not a substitute for job-specific and institution-specific training materials and standardized procedures. Inequitable access to ongoing training and continuing education opportunities was also noted.

> "Onboarding employees properly makes them feel supported, respected, competent, and ready to do their jobs. Throwing them onto the floor, especially if it's their first time in corrections, feels like we are setting up everyone to fail."

Respondents also discussed the relationship between disorganized or absent onboarding training with ongoing staffing challenges, emphasizing that untrained new employees are often unable to contribute meaningfully to service capacity. They also discussed the negative impact that confusion and feeling insecure in one's position can have on retention.

Agency/Contract Staff Training

Respondents acknowledged the realistic need for agency nurses but emphasized this issue as particularly challenging, given frequent inability to meet required performance standards due to minimal pre-assignment training. Staff also discussed the additional burden placed on regular staff to train agency nurses or to compensate for their transience—without allocating time for these efforts. Staff also reported insufficient preparation for specialized units or populations, such as mental health housing.

Ongoing Training

Respondents frequently reported insufficient ongoing training and continuing education. Behavioral health and nursing clinical staff specifically discussed the need for formalized training when assigned to different duty stations or assigned new responsibilities. Staff also perceived that security staff received inadequate training on mental health and trauma-informed approaches, and respondents highlighted a lack of regular refresher training or updates on Clinical Practices.

Suggestions for Improvement:

In this domain, almost all respondents who presented complaints also presented ideas for possible improvements, and there was a strong consensus among some of the suggestions, namely:

- New structured discipline-specific training programs with manuals to support consistent initial training statewide.
- Structured facility-specific training to occur on-the-ground after onboarding.
- A feedback loop that includes frontline staff input to monitor and continuously improve training content and delivery

Suggestions also included creating a centralized onboarding consultant role for each discipline with dedicated full-time equivalent (FTE) to support new hires. This role would also formalize and organize some of the training tasks that currently fall on managers.

Staff emphasized the need for more regularly scheduled skills-based training by trainers with hands-on correctional healthcare experience, including formalized training when assigned to a new unit. Some nursing respondents specifically suggested additional behavioral health training, particularly for those who work nights or weekends and who "function as Behavioral Health Services" during off-hours.

Administration and Communication

Summary of Key Concerns:

Staff at all position levels emphasized the need for clearer, more consistent communication when introducing new policies or procedures. Inconsistent messaging without clear implementation plans was seen as a driver of confusion and inconsistent implementation, which could lead to increased grievances filed. Clinical staff noted that dense email communication without context was difficult to process amid daily demands, reducing the likelihood that important information was understood or retained.

Staff expressed broader concerns about a disconnect between frontline personnel, facility-level management, and department administration. Frontline staff frequently cite limited communication with managers and a lack of managerial presence in clinical areas, which they felt contributed to leadership being out of touch with the realities of service delivery. Local managers described challenges balancing administrative responsibilities, onboarding new staff, and responding to frontline concerns. Upper-level administrators noted difficulty in gaining buy-in from managers and staff when implementing broad initiatives. Overall, each level of the system reports feeling isolated from those above or below them.

> "When deciding new process or policy changes, there should be clear and concise communication across the state to ensure that everyone will complete the change correctly. It is important to prioritize the fact that each facility does the same thing. When there is consistency across the state, it minimizes the opportunity for grievances and additional complications."

Suggestions for Improvement:

Staff suggestions included a standardized process for rolling out new policies that include concise summaries and clear facility-level implementation steps. Information should be shared through multiple formats, such as emails followed by scheduled brief discipline-specific huddles, to improve accessibility amid daily demands. Staff also requested easy-access comprehensive service procedure manuals.

Staff proposed strategies to strengthen managerial awareness of day-to-day operations and improve communication across organizational levels. Frontline staff suggested scheduling regular floor time for local managers to participate in patient care and understand the context of staff performance and services delivered. Frontline staff also recommended a standardized process for submitting issues or concerns to local management, with a required documented response. Suggestions also included establishing formal introductions between new local managers and Health Services administrators to improve these lines of communication, as well as training, coaching, and feedback for managers, akin to what would be expected for early career clinical training.

Section 4

Stakeholder Workshops

SECTION 4: STAKEHOLDER WORKSHOPS

Based on a series of meetings and workshops, consistent themes emerged across stakeholder groups. With strong alignment among stakeholders, many individuals and groups described similar experiences and observations. Most important, there was a sense of cautious optimism among stakeholders that priority issues are being named and addressed, yet some skepticism at ODOC's ability to make the needed changes.

The primary area of concern included inconsistent and delayed access to care, specifically identifying barriers in timely and equitable access across prisons and populations. Similarly, stakeholders consistently expressed frustration with the TLC process, which was described as requiring burdensome logistics that discouraged AICs engagement in healthcare. Stakeholders expressed frustration around a culture within ODOC that prioritized "safety and security" over access to healthcare, while also describing a deep sense of mistrust and doubt that ODOC could implement lasting change without external support and accountability.

The team heard from AICs, their families, advocacy organizations, and ODOC staff that the governance, oversight, and accountability functions need to be re-examined. Several groups and individuals suggested that legislation is needed to effect and sustain any true reforms, and that outside oversight by the Oregon Health Authority (OHA) or the state legislature is required to make change that is lasting.

Additionally, internal and external partners described viewing the planned EHR rollout in terms of both hope and risk. Stakeholders described optimism that the EHR implementation will help with documentation, workflows, continuity of care, scheduling, and patient safety. However, there was concern that if the existing workflows are broken, then those systemic problems may be built into the EHR, requiring thoughtful design and implementation. Stakeholders also agreed on the need for user-informed design and post-launch evaluation.

Another consistent theme identified among stakeholders was described as a persistent gap between written policies and how care is delivered in practice at each individual facility. Specific examples were raised surrounding medication prescribing, medication distribution, release planning, and appointment scheduling. Facility-based staff described a lack of clarity around how statewide policies are to be carried out inside their specific prisons.

Stakeholders consistently described a strained workforce and structural challenges, indicating that staffing levels – especially for healthcare and transportation roles – were inadequate to meet the population's health needs. Much of the workforce described burnout and compassion fatigue. Across facilities, there was a clear need to standardize administrative meetings, create and implement actual systemwide CQI activities, and in general deploy a much better system of healthcare utilization management and surveillance.

With respect to reproductive health and gender-responsive healthcare services, stakeholders described the need for improved access to care specifically at CCCF. Community

connectivity was highlighted as an area in need of attention, with referrals to counseling prioritized along with access to preferred contraception and other gender-responsive approaches.

The need for improved communication was also a consistent theme. Widely reported were problems with communication between AICs and providers, between custody and clinical staff, and among facility leaders of various disciplines. Groups suggested implementing after-visit summaries from healthcare encounters, enhancing patient advocacy roles, and developing shared governance opportunities among leaders of various disciplines.

All stakeholder groups described the lack of accountability and systemwide CQI infrastructure to varying degrees. In one meeting, a provider said, “It seems like nobody is watching anything,” referring to utilization management, system surveillance and study, and systemwide CQI functions more broadly. Mortality reviews, incident tracking, and outcome-based metrics are inconsistently applied or are not yet standardized. Identified areas of strength in this domain included Pharmacy Operations, Behavioral Health Services, and CHP, the third-party firm that manages specialty care consults and off-site healthcare utilization.

Lastly, stakeholder groups consistently described the challenges surrounding the existing investigatory processes and lack of oversight of investigations. These processes were noted to lack transparency and procedural rigor, yet last for months or even years.

Section 5

Healthcare System Overview

SECTION 5: HEALTHCARE SYSTEM OVERVIEW

A. Model of Care Delivery

ODOC self-operates its healthcare delivery system through its Health Services Division. Self-operation refers to the agency serving as Responsible Health Authority, overseeing and delivering healthcare services to AICs. In the self-operated model, services within prisons are optimally provided by employees of the state, although most systems also augment staffing with agency, temporary, or contracted staff. Most often, the healthcare staff is employed by the DOC, but in some models, they work for other state entities (i.e., health departments or state university teaching hospitals). Off-site and specialty care is provided by community-based partners through procurement mechanisms, contracting, or memoranda of understanding. The state manages all ancillary, risk management, variable, pharmaceutical, and staffing costs, while also conducting and overseeing utilization reviews and systemwide CQI activities. In Oregon, the self-operation model is supplemented by contracting specialty care services through a third-party. Other examples of self-operated systems include the Washington State Department of Corrections, the California Department of Corrections and Rehabilitation, the Louisiana Department of Corrections, and the New York State Department of Corrections and Community Supervision.

Wall Mural 2. Two Rivers Correctional Institution

i. Organizational Structure

In the existing organizational structure, the Assistant Director reports to the Deputy Director of ODOC and serves as a Division Director and the Responsible Health Authority for the agency. The Assistant Director supervises all the various departments within Health Services, including Medical Services, Behavioral Health Services (mental health and SUD treatment), Dental Services, Pharmacy and medical stores, and Business Operations.

Business Operations within Health Services reports directly to the Assistant Director. Relative to other systems Falcon has collaborated with, ODOC's Business Operations team is exemplary. Their scope of work includes all administrative aspects of Health Services, including contracts, payroll, clinical education, training, and the EHR project. Despite impressing as competent and engaged, the growing mission of Health Services in correctional systems demands greater resources to support administrative functions. If the quality and efficiency of care is to elevate, so too must the administrative resources allocated to the system.

As the organizational chart depicts, the current model has both *clinical* and *administrative* functions reporting to a single administrator, rather than distinguishing between those functions and placing all clinical decision-making in its own reporting structure. The risk is that clinical decisions (i.e., medically necessary treatment) may appear to become diluted or secondary to administrative decisions (i.e., cost of care or political impact). In the ODOC model, the Chief of Medicine is the "Responsible Physician," the counterpart to the Assistant Director of Health Services, who is the Responsible Health Authority, meaning that all final clinical decisions should ultimately be the responsibility of the Chief of Medicine.

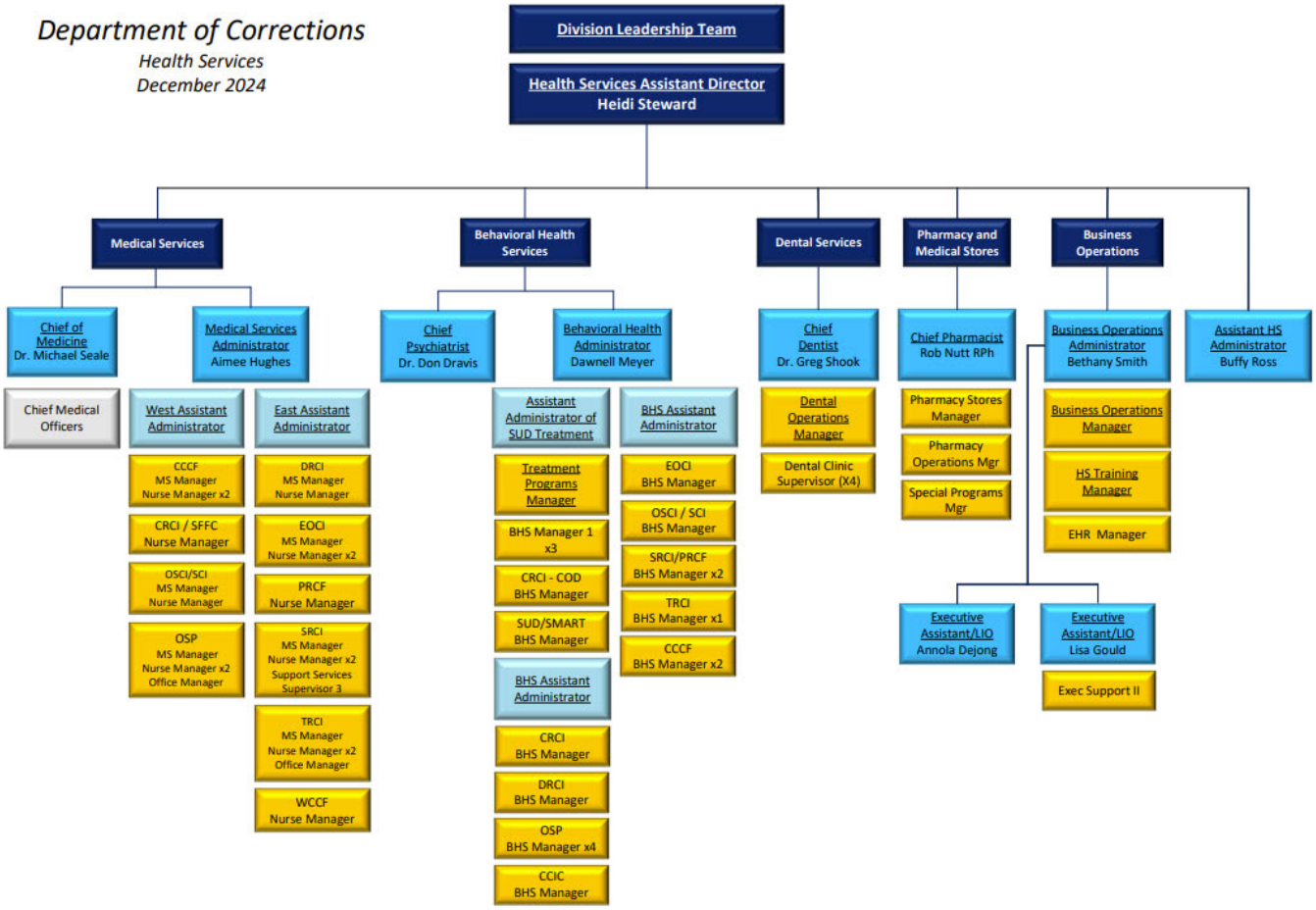
All clinical and administrative nursing functions also fall under a single individual in the current model. Rather than creating a clinical chain of reporting that prioritizes patient care and nursing services delivery, separate from the administrative requirements of healthcare management and administration, the two roles are blended into one. This is a common theme throughout the organization, where administrative and clinical roles are blended into one position. In many systems, for example, the administrative nursing functions would be separated from the clinical functions, in the form of statewide and regional Medical Services Administrators and statewide and regional Directors of Nursing. The issue is observed in facilities, as well, where there are no Directors of Nursing, for example, and the MSMs and Nurse Managers are responsible for both clinical and administrative roles.

The current organizational chart also creates silos between Medical Services, Dental Services, and Behavioral Health Services, which all have distinct reporting chains at the facility level. Just as the Chief of Medicine and the Assistant Director are the statewide Responsible Physician and Responsible Health Authority, respectively, so too are the Chief Medical Officers and MSMs at each prison. These are the final authorities for clinical and administrative decisions within the prison – certainly subject to appeal at the regional or statewide level – but they are responsible for *all* healthcare inside the facility, including medical, dental, behavioral health,

pharmacy, and ancillary care. This role requires routine and structured communication between disciplines within each prison such that the MSM has access to all healthcare information as the Responsible Health Authority.

Notably absent from the current organizational chart is a systemwide CQI department. There is no designated individual or team responsible for policy audits, standardized data collection, utilization review, process or outcome studies, or performance improvement. As a result, there is no surveillance system to identify problems before they become acute. There is no routine process of reviewing utilization in a way that identifies variances month-to-month, captures trends, or identifies waste. This is an issue that has been identified at least since 2022, but one the Falcon team prioritized in the pre-assessment phase of this project.

Figure 12. ODOC Organizational Chart as of December 2024



ii. Continuous Quality Improvement

A consistent theme across the study was the need for a systemwide CQI program. CQI programs, which are often called or include utilization review, utilization management, performance improvement, or quality assurance activities, are fundamental to the success of mature healthcare delivery systems. They work to ensure policy compliance, detect systemic deficiencies, improve the quality of care, and reduce the costs associated with healthcare delivery. Without a strong systemwide CQI program, a system as large and as complex as ODOC is left without the needed framework for early detection and performance improvement.

Although a CQI policy exists, it is limited in scope and vague in its requirements. During this assessment, the Falcon team reviewed several CQI studies that have been performed in recent years. Each study was completed to comply with NCCHC audit surveys prior to the audit. Studies examined specific policies and procedures, like medication administration or completion of initial physical examinations. Each study included a review of approximately 15 AIC charts, identification of trends or patterns in the charts, and a report on findings. In systems with paper charts, these types of studies are not unusual; and yet, they reflect just a single point in time, completed to comply with NCCHC expectations, and the sample selected does not represent the AICs population to any degree of statistical significance. In other words, any policy or broad training action taken in response to these CQI studies may not reflect the state of the general practice.

ODOC currently has a small group of clinicians within Business Operations called Clinical Education and Audits. This team of mental health clinicians and nurses are tasked with creating and providing a wide array of clinical training for Health Services staff. The team is responsible for new employee orientation, as well as initial and refresher training on topics like suicide prevention, medical emergencies, responding to mental health concerns, and other Health Services related material. The team holds in-person trainings along with virtual and on-line content and work to introduce external subject matter experts in specialized areas. Recent efforts have focused on creating educational materials for AICs, such as flyers on common medical concerns. While some of the activities are aimed at compliance with laws or NCCHC standards, generally they occur at the request of the executive team or Health Services administrators. This small team of Clinical Educators research and work with content experts to develop curriculum, create graphic designs for online content, enroll participants, assign curricula, and track completions as needed. Clinical Education and Audits would be a logical department to expand its role to include a systemwide CQI program.

iii. Inquiries

Throughout the course of this study, the Falcon team received inquiries from family members of AICs, asking about healthcare-related issues specific to their loved ones. This process of inquiry is a critical function of the system, obtaining information and sharing it as appropriate with various stakeholders. Over the life of the project, the Chief of Medicine became the point of

contact for the Falcon team's inquiries. Early in the process, the inquiries would result in no response from prisons at times, lengthy delays in responding, and poorly compiled responses that were written in shorthand notes and difficult to understand. More recent inquiries have been responded to very quickly, providing clear updates and professional overviews of treatment and related issues, and reflective of a far more professional standard of care. This is an improvement that should be celebrated, and which reflects an energized workforce eager to communicate.

The Falcon team recognizes NCCHC as an important component of a CQI program in and of itself. The process of accreditation and re-accreditation forces the agency to ensure that policies align with standards of care; to review and revise those policies annually; to have all the basic elements of an adequate healthcare delivery system; and to prepare and pass survey audits on a rotating basis. Reviewing NCCHC reports, the team found that NCCHC has identified several sites with deficiencies, has placed sites on probation with remedial plans, and has required improvements prior to approving full accreditation. The survey reports are thorough, thoughtful, and comprehensively written with a serious approach to the safety and quality of healthcare delivery. The role of NCCHC in the system is critical.

iv. Demographics of Adults in Custody

ODOC operates 12 prison facilities housing approximately 12,000 AICs. Prison facilities are spread across the state, organized into east and west regions, each with six facilities. Prisons are classified as minimum security or medium security, with medium security facilities capable of housing AICs who are classified at the maximum security custody level. Custody levels include five classifications, ranging from 1 (lowest – minimum custody) to 5 (highest – maximum custody), along with a small number of AICs awaiting classification after being committed to ODOC. Minimum custody refers to those AICs who have been assigned to Custody Levels 1 or 2, while medium custody refers to those AICs who have been assigned Custody Levels 3 or 4. Level 5 Custody is reserved for AICs at the maximum security level, housed in intensive management units (IMUs) in designated facilities.

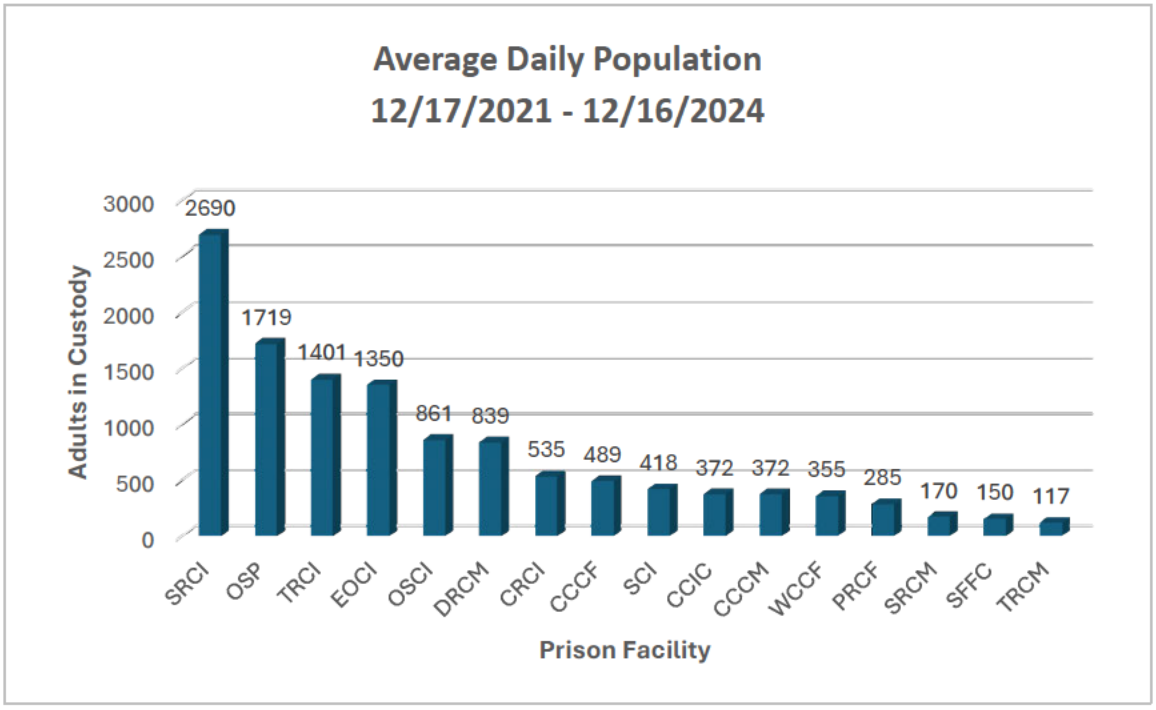
Figures 13 and 14 depict the Average Daily Population (ADP) of AICs across Oregon's prisons over a three-year period between December 17, 2021 and December 16, 2024. For the three-year period, the ADP was 12,123 AICs statewide, distributed across Oregon's 12 prison complexes.

Figure 13. Average Daily Population Across Institutions (Alphabetical)

PRISON	AVERAGE DAILY POPULATION
Coffee Creek Correctional Facility	489
Coffee Creek Minimum	372
Coffee Creek Intake Center	372
Columbia River Correctional Institution	535
Deer Ridge Correctional Institution	839

PRISON	AVERAGE DAILY POPULATION
Eastern Oregon Correctional Institution	1,350
Oregon State Correctional Institution	861
Oregon State Penitentiary	1,719
Powder River Correctional Facility	285
Santiam Correctional Institution	418
South Fork Forest Camp	150
Snake River Correctional Institution	2,690
Snake River Minimum	170
Two Rivers Correctional Institution	1,401
Two Rivers Minimum	117
Warner Creek Correctional Facility	355
Total	**12,123**

Figure 14. Average Daily Population Across Institutions (by Size)



Interviews and workshops with statewide clinician-administrators and facility-based healthcare staff indicated that significant population changes have occurred in recent years. Although the total population may have been reduced over the last five or ten years, the age, acuity, and clinical complexity of the population seems to have increased, according to ODOC staff. The Falcon team heard this impression across the organization and in all prisons and, as a result, analyzed data points from 2015 through 2025. Available ODOC data indicated that the total

number of AICs in ODOC custody has declined substantially since 2015, with a precipitous population decline since 2020.

Figure 15 shows changes in total numbers of AICs across ODOC facilities in that time. Since 2015, the total population of AICs has declined 17.3%, resulting in the closure of two prison facilities and shifting the population into its current configuration of prisons.

Figure 15. Total Population Year-Over-Year (2015 – 2025)

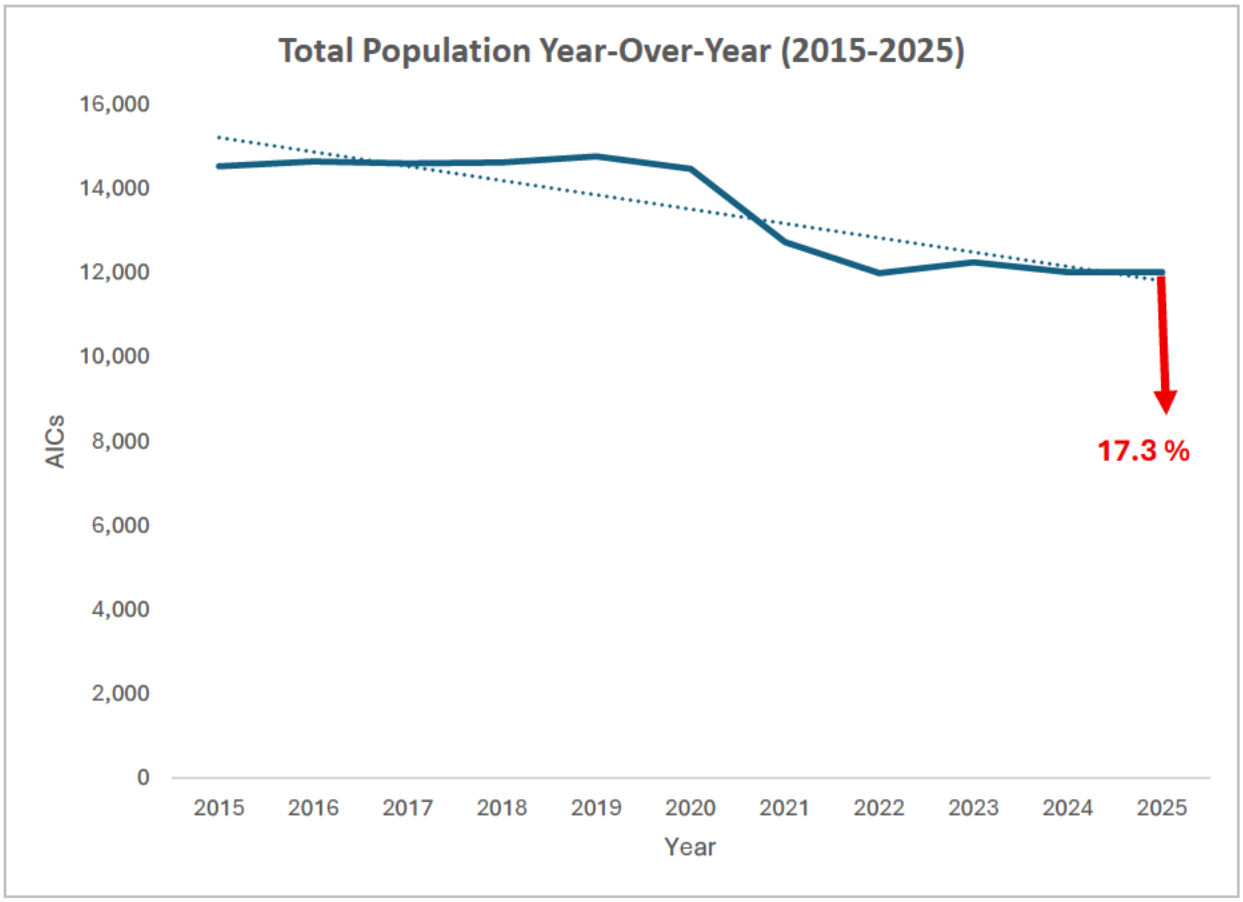
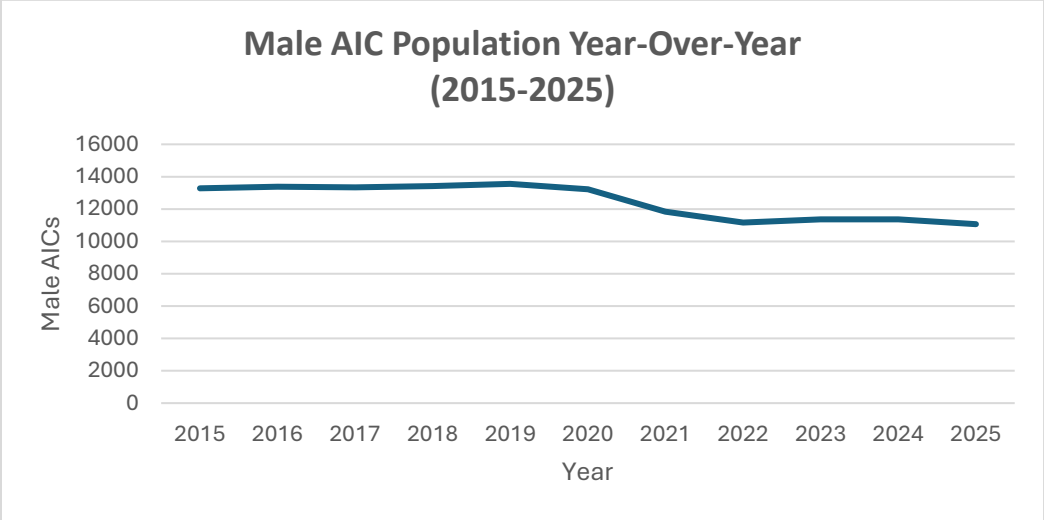
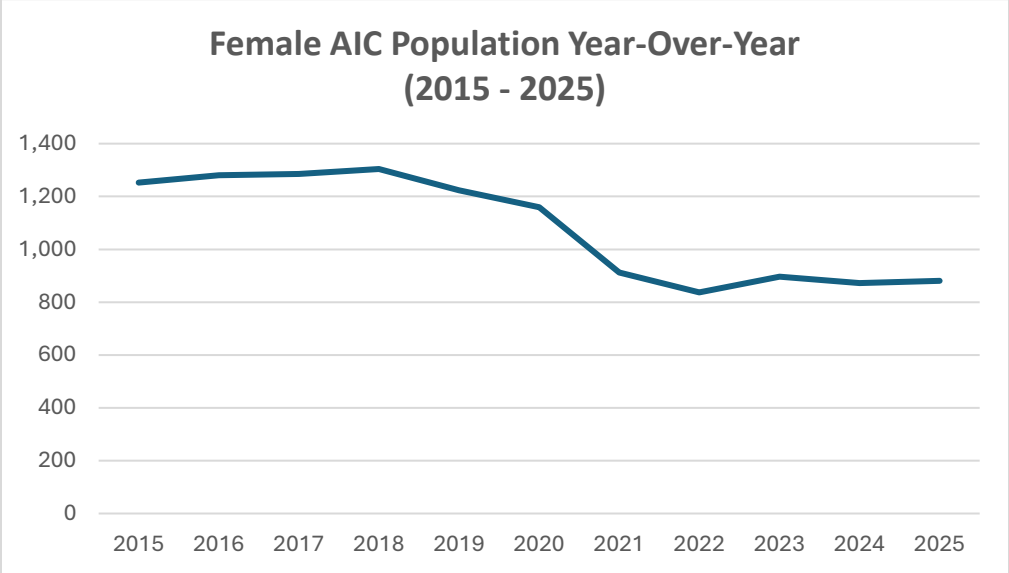


Figure 16. Male AIC Population Year-Over-Year (2015-2025)[11]



While the male AIC population has declined 16.5% since 2015, the female AIC population has declined by 27%, from 1,253 female AICs in 2015 to 920 female AICs in the current data sample.

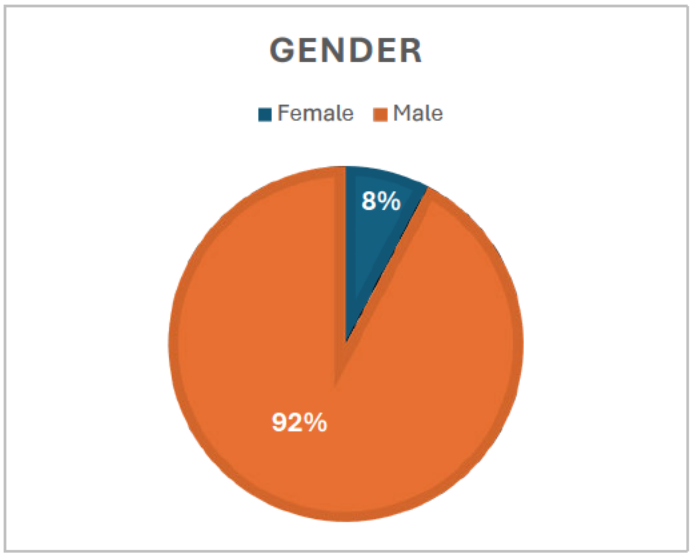
Figure 17. Female AIC Population Year-Over-Year (2015 – 2025)



[11] Each data point for population over time was January 1st of the corresponding year.

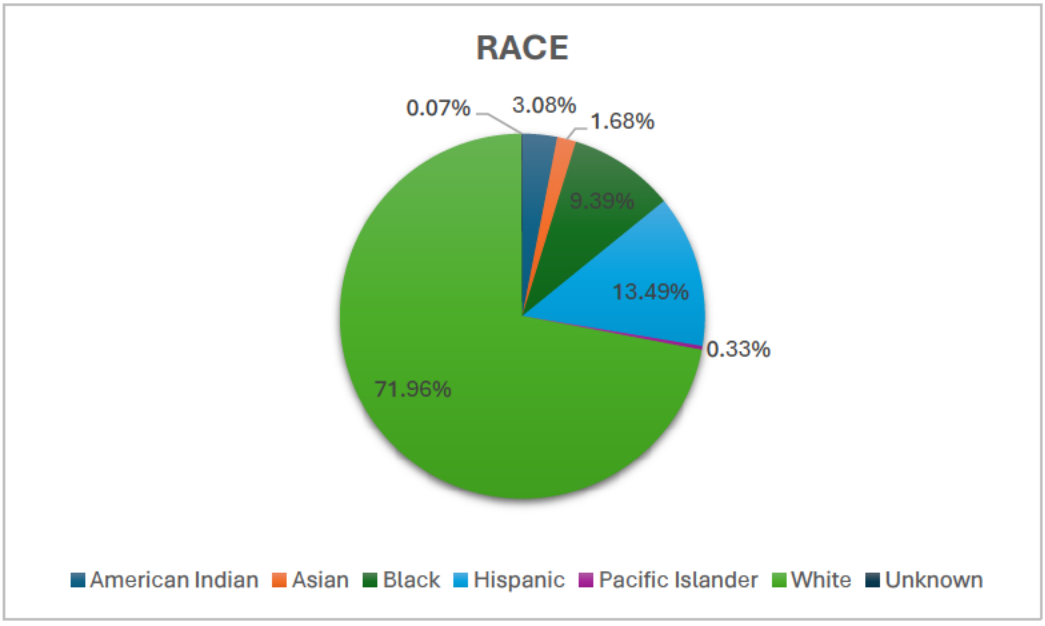
For the purposes of this demographic study and clinical analysis, a representative cross-sectional snapshot was used as a sample of AICs across facilities on a single day.[12] On the selected date, 12,020 AICs were in the care and custody of ODOC, housed across the 12 prison complexes.

Figure 18. Population by Gender



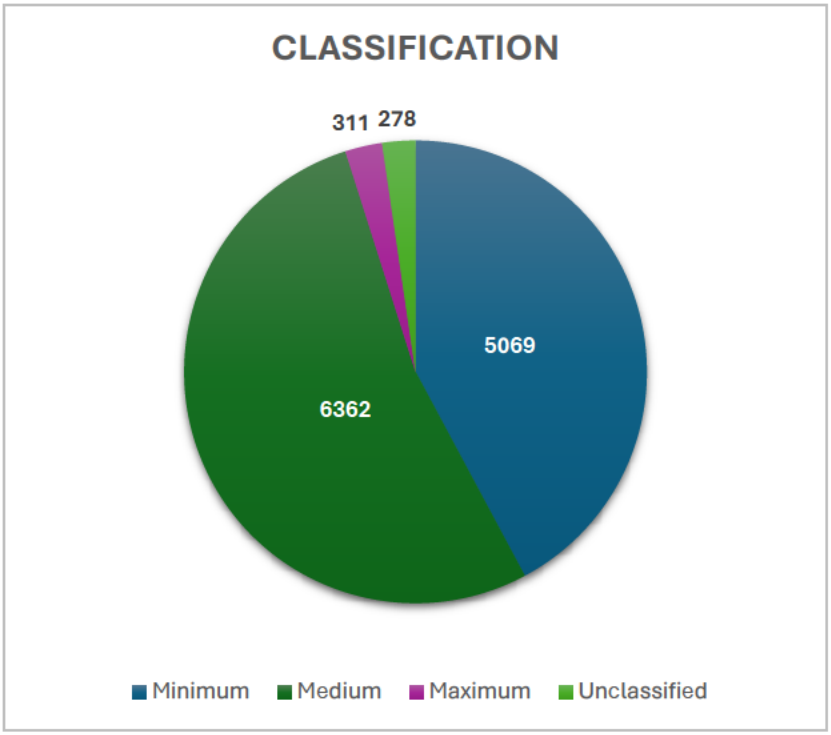
Of those 12,020 AICs, 11,100 (92.3%) were identified as male, while 920 (7.7%) were identified as female. With respect to racial identity, 8,649 (71.96%) identified as White, while 1,621 (13.49%) identified as Hispanic, 1,129 (9.39%) identified as Black, 370 (3.08%) identified as American Indian, 202 (1.68%) identified as Asian, and 40 (0.33%) identified as Pacific Islander. Nine AICs (0.07%) were designated as Unknown.

Figure 19. Population by Race



[12] December 17, 2024.

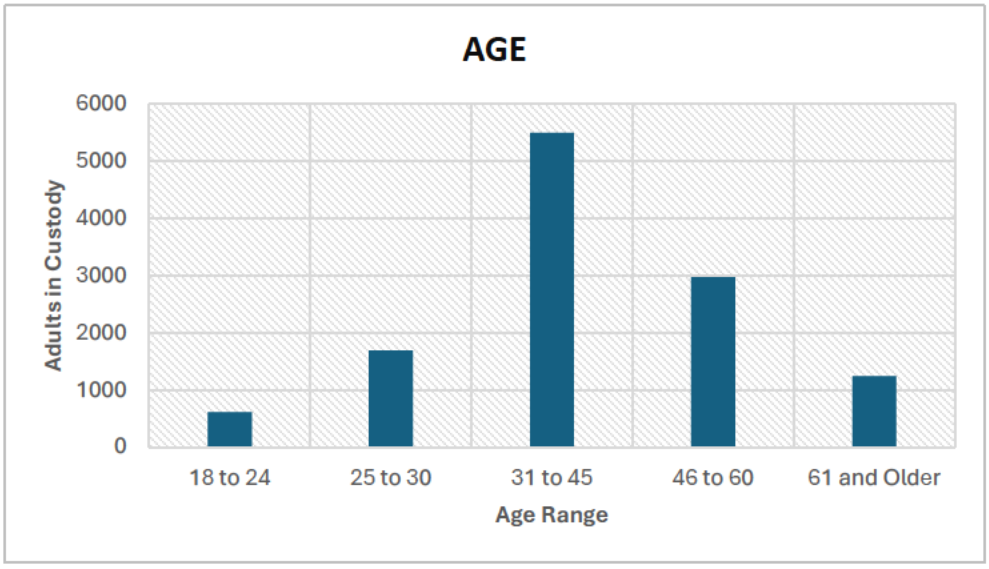
Figure 20. Population by Classification Level



In terms of custody levels, including minimum (levels 1-2), medium (3-4), and maximum (5) custody levels, the ODOC profile for the sample date reflected 4,530 (36.69%) at Custody Level 1; 539 (4.48%) at Custody Level 2; 2,289 (19.04%) at Custody Level 3; 4,073 (33.89%) at Custody Level 4; and 311 (2.59%) at Custody Level 5. There were 278 AICs, or 2.31% of the population, designated as Unclassified, awaiting classification at CCCF. Consolidating Levels 1 and 2 as minimum custody, and Levels 3 and 4 as medium custody, data revealed that 42.17% of the population were at minimum security levels, 52.39% were at medium security levels, and 2.59% were at maximum security levels, with 2.31% unclassified.

Figure 21. Population by Age Range

Age distributions of the snapshot sample included 617 (5.13%) of the population between the ages of 18 to 24; 1,691 (14.07%) between the ages of 25 to 30; 5,502 (45.77%) between the ages of 31 to 45; 2,969 (24.70%) between the ages of 46 to 60; and 1,241 (10.32%) aged 61 and older.



v. Intake and Assessment

Intake and assessment are arguably the most important opportunities for the entire correctional healthcare system and the most critical in the AIC's experience of incarceration – literally and figuratively the *front door* to the system. This is where the initial nursing assessments occur, where initial physical examinations, medication continuation, chronic care clinic enrollment, identification of serious mental illness (SMI), and many other critical functions (all in the context of security investigations and classification) determine the appropriate prison and housing conditions for each AIC.

Healthcare systems in correctional facilities must prioritize this key function, front-loading clinical assessment and triage services to increase the health and wellness of the AICs, but also to prevent subsequent placement in facilities that are incapable of meeting the healthcare needs of the AICs. Systems are moving to ensure full healthcare assessments are completed, including a first chronic care visit and behavioral health assessments, prior to classification being finalized and the AIC being discharged from the intake facility.

ODOC expects AICs to spend approximately 30 days at CCIC completing the intake, assessment, and classification process. AICs of all genders enter the system through CCIC, which is collocated with CCCF in the same facility. For transgender and GNC individuals, ODOC processes them through intake and places them in the appropriate facility based on an interdisciplinary appraisal. Gender care can be provided at all facilities, and an individualized approach is used to determine appropriate placement.

Prior to transfer of custody to ODOC, most AICs were held at the county jails until sentenced by their court of jurisdiction. [redacted] are the busiest times for CCIC, as a shuttle bus transports larger numbers of AICs to CCIC for intake. ODOC estimates an average of approximately 120 intakes at CCIC per week. In general, most AICs arrive with the information provided by the county sheriff's department, which usually only includes a brief history of the AIC, the AIC's charges, the sentencing order from the court, and any active safety or security concerns, if applicable. Clinically, there is wide variation in the quantity and quality of information provided to CCIC staff from the counties. Usually, CCIC staff can expect a brief summary of medical history, verification of current medications, and a vaccination history. Sometimes the county jail does not send any information, and the nurses will have to contact jails to obtain it. Given the extreme acuity and complexity of the population, ODOC's intake and assessment process can be hobbled by a dearth of clinical information provided by county jails in certain cases, so staff at CCIC must duplicate services that may have already been provided to obtain a comprehensive assessment of the AIC before classification and transfer to another prison.

AICs arriving at CCIC enter the facility and are placed in a holding cell until processing is complete. In addition to searches of person and property, the AIC takes a shower and is seen by medical staff. ODOC staffs two full-time registered nurses at CCIC five days per week, scheduled intentionally to match the highest periods of demand from arriving AICs. Intake assessments are

expected to be completed within three hours of arrival, and the registered nurses are trained to triage AICs based on medical needs. If an AIC requires infirmary level care, the AIC can be transferred to that unit and have intake and assessments completed while in treatment at that level of care. Similarly, if a registered nurse determines that an AIC needs to see a provider *immediately*, that service is also available for those emergencies or urgent care needs. Medications are verified and continued by an on-site or on-call provider. Once assessed by the registered nurse, the AIC is cleared for housing and assigned a bed on the intake housing unit.

The Falcon team toured the designated Intake and Reception (I&R) areas at CCIC on three occasions. The walk-throughs and discussions with the healthcare teams, who are responsible for the system's first initial contacts, offered valuable insight into the operational structure. The healthcare space assigned to I&R serves multiple functions, ranging from initial assessments and chart reviews to the management of emergent mental health issues.

The team observed that the medical staff assigned to I&R are experienced correctional professionals who demonstrate a clear passion for correctional health. Their long-standing commitment to ODOC brings stability and knowledge to one of the most critical functions in the facility. The Falcon team engaged in productive conversations with members of the medical team and custody staff to better understand current I&R operations, challenges posed, and potential solutions.

The staff shared candid reflections about existing challenges, including limitations in physical space, lack of adequate information provided by county jails, and lack of clear operational directives that can impact consistency of care delivery. One notable theme throughout the study was the mixed-mission nature of CCCF. The same built environment houses all AIC intake functions and also houses the only medium security women's facility in the state.

Staffing shortages mean that providers are required to cover male and female intakes, while also providing care for the women at CCCF. Staff expressed that a previous model of care, where a dedicated intake provider team managed new admissions, provided more seamless and consistent assessments and better continuity of care for both patients and clinicians. Its loss has resulted in healthcare delivery fragmentation and treatment planning delays. A need for formalized post orders, accountability structures, and regular leadership updates in the form of weekly or bi-weekly newsletters, can improve communications about departmental changes.

Staff also advocated for a return to a triage-style, in-person sign-up process ("line-up, sign-up"), which enabled next day encounters and more timely access to care than the current "kyte" system (AIC Communication Forms).

Intake is also the point at which the AIC's health record is created. Currently, the health record is a paper chart, an antiquated model by all accounts and certainly one of the most concerning issues for patients and staff alike. Charts tend to be voluminous, disorganized, and difficult to locate. Some providers estimate they spend three or more hours per day searching for

charts. Continuity of care is jeopardized as a result, and clinicians frequently see patients without the chart present. This has resulted in poor clinical documentation and inefficiencies in utilization management.

ODOC is currently in the final stages of implementing the EHR. Super-user training has already begun, and statewide rollout will start at CCCF in August. Full implementation is expected by the end of 2025. The Falcon team was able to meet with the EHR team and review the capabilities of the EHR, which was reassuring and exciting to see.

While efficiency, convenience, clarity, and coordination of care are obvious advantages to an EHR, this department will benefit tremendously from scheduling features, medication ordering features, workflows, and data reporting functions, all built into the EHR.

Mental Health Assessment and Classification

Every staff member described an increase in the number and acuity of AICs with SMI. During the intake process at CCIC, all AICs undergo mental health screening with a QMHP within 24 hours of arrival. The current Behavioral Health Services team creatively moved this function to the intake housing unit, freeing up space in I&R for initial medical functions. This is considered a best practice to recognize the extreme prevalence of mental illness among people experiencing incarceration. Those who screen positive are referred for additional assessment, psychological testing, or psychiatric evaluation.

All AICs are administered a Personality Assessment Inventory (PAI), but not by Behavioral Health Services. Rather, the PAI is administered by classification professionals to inform the classification process and sometimes reviewed by Behavioral Health Services staff. It is not clear why the PAI is used in the process, and it is not used under the supervision of a psychologist, administered in a standard fashion, and is likely invalid as a result. According to the manufacturer of the PAI, the 344-item self-report psychological test requires, “a high level of expertise in test interpretation,” and can only be purchased by individuals meeting one of the following criteria:

- A doctorate degree in psychology, education, or a closely related field with formal training in the ethical administration, scoring, and interpretation of clinical assessments related to the intended use of the assessment.
- Licensure or certification to practice in your state in a field related to personality assessment.
- Certification by a full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in personality assessment.

The Falcon team had the opportunity to observe a QMHP conducting initial mental health screenings for newly admitted AICs. The QMHP personally escorted each individual to a private office, establishing a safe and respectful environment from the moment the QMHP clinically engaged with them. The QMHP demonstrated strong ethical standards and clinical interview skills. The approach was structured yet compassionate, balancing rapport building while gathering essential clinical data. The use of motivational interviewing techniques, such as reflective listening and open-ended questions, helped to form accurate clinical impressions during this critical and initial point of contact. Effective initial mental health screenings require a blend of interpersonal skills and adherence to professional boundaries. This QMHP exhibited all these skills, contributing to a successful and appropriate triage process for further assessment or intervention. Notably, the QMHP would be responsible for covering the cost of clinical supervision if the QMHP pursues licensure.

Clinically, Mental Health (MH) Codes are assigned and further informed by Levels of Functioning (LOF) within those codes. This model reflects the nuance of mental illness, representing current clinical functioning in domains of Activities of Daily Living (ADLs); thinking, concentration and judgment; and adaptation to stress. Each patient is assigned a LOF in addition to the MH Code, using a rating tool that indicates the number, frequency, persistence, intensity, and impact of symptoms, arriving at a LOF of 1-5. Figure 22 presents the MH Codes articulated in *Clinical Practice MH-G-01.1 Mental Health Codes and Levels of Service*. The nuance afforded to clinicians using LOFs is a best practice that can accommodate unique cases individually, representing the relapsing-remitting nature of mental illness and a recovery orientation.

Figure 22. Mental Health Codes and Brief Descriptions

Mental Health Code	Brief Description
MH-0	AIC has been assessed by a mental health treatment provider and does not meet criteria for a diagnosis that requires Behavioral Health Services.
MH-1	AIC has been assessed by a mental health treatment provider and, based on current diagnosis and LOF, does not meet criteria for Behavioral Health Services.
MH-R	AIC is designated MH-1 and is prescribed psychotropic medications by a prescribing practitioner; or the client's LOF is assessed as a LOF4 or LOF5; or who has a Deferred for Evaluation – 799.9 entry until a Mental Health Evaluation Summary is completed and a diagnosis is determined; or who has a 7001 Code based on a suicide attempt within three years.
MH-2	AIC has been assessed by a mental health treatment provider and, based on specified diagnoses, meets criteria for Behavioral Health Services.

Mental Health Code	Brief Description
MH-3	AIC has been assessed by a mental health treatment provider and, based on a more chronic and severe diagnosis, meets criteria for Behavioral Health Services.

For psychiatric emergencies, close observation is available in individual cells designated for suicide watch or psychiatric decompensation. In many prisons, however, these cells are in segregation areas or other non-clinical spaces. At CCIC, acute patients are housed in the segregation area where they are afforded limited time out of cell awaiting classification and transport to the appropriate mental health housing. Uniformed staff conduct wellness checks and observations, but mental health staff are also rounding to engage with those patients. If a psychiatric issue cannot be adequately addressed at CCIC, the AIC can be moved to a facility with a mental health unit where intake processes can be completed.

Dental Assessment

Wall Mural 3. Powder River Correctional Facility – Dental Suite

Dental services are provided to all AICs during their stay at CCIC. There is a dental suite where an intake exam is conducted, X-rays are taken, and teeth are charted. Because of the short stay at CCIC, combined with the stress of initial incarceration, a formal treatment plan for dental care is developed at the subsequent institution upon AIC request, but the baseline examination, X-rays, and charting are all available at the receiving facility.

The Falcon team toured the dental clinics designated for male intakes. The space allocated to dental services was clean, orderly, and well-organized. Its location, adjacent to the intake unit, supported access to services and appeared efficient for dental reception screenings. The complement of dental staff was notably professional, engaged, and experienced.

Classification

Healthcare functions occur in the context of classification and designation of a home facility. Other activities that occur include orientation to ODOC, sentence calculation, assignment of an intake counselor, criminogenic risk-need assessment, determination of placement, and ultimately classification to a custody level and a home facility. ODOC uses the Level of Service/Case Management Inventory (LS/CMI) for all male AICs in determining risk and need, and they use the Women's Risk and Needs Assessment (WRNS) for female AICs. AICs are classified to medium security institutions (Custody Levels 3 and 4) or minimum security institutions (Custody Levels 1 and 2). Custody Level 5 (intensive management) is rarely applied to an AIC at intake and is much more likely to be a designation applied after an incident while in custody.

vi. Healthcare Housing and Special Populations

Infirmary Level of Care

Throughout the state, five infirmaries exist to meet the sub-acute medical needs of AICs. Like almost all prison systems, acute care is provided at off-site hospitals, using emergency departments or hospital admissions for care beyond the capabilities of the prison infirmary. Infirmaries are staffed with a registered nurse 24/7, and providers round daily, consistent with NCCHC requirements. Infirmaries exist at OSCI, CCCF, TRCI, SRCI, and EOCI. One additional infirmary at DRCI is planned to open this year to serve as the only infirmary for the minimum custody population. All five infirmaries have similar capabilities, although the infirmary at OSP does not have negative or positive pressure. The infirmary at OSP presents extreme operational challenges due to its location on the third floor. This creates access difficulties, specifically when the aging elevator is out of service.

Long-Term Medical Housing

One gap identified in the study is the absence of housing units for AICs who, due to their medical needs, require separation from the general population but do not require infirmary level care. Often referred to as sheltered medical housing or long-term medical housing in other systems, the level of care available in these units approximates a SNF in the community. Daily nursing rounds, support with ADLs, and more frequent access to providers are generally the level of support available. As the system is currently designed, AICs in the prisons are either in outpatient or infirmary level care for medical conditions. Infirmary level of care tends to be more staff and cost intensive than long-term medical housing.

Residential Treatment for Mental Health

All AICs have access to outpatient mental health services commensurate with their MH Code and LOF, or in response to requests for services. Those who have more significant mental health challenges also have access to residential treatment units for psychiatric emergencies and treatment of severe and persistent mental illness requiring removal from the general population.

Individuals may be referred to residential mental health treatment at intake or at any time during their incarceration, reflecting the relapsing-remitting nature of the condition. Admission and discharge are driven entirely by clinical need, as assessed by QMHPs or psychiatric providers, and the clinical need is matched to the level of care. Available sheltered or dedicated mental health housing units include the following (in ascending order of treatment intensity and security):

- Mental Health Unit
- Day Treatment Unit
- Intermediate Care Housing
- Mental Health Infirmary
- Behavioral Health Unit[13]

Transgender and Gender Nonconforming Care

Relative to other systems the Falcon team has studied, ODOC has a progressive policy on transgender and GNC care. The agency is committed to providing gender affirming care to AICs, and a TLC meets via telehealth to review cases and requests for treatment. The TLC is available to all facilities as needed. The TLC is chaired by the statewide Behavioral Health Services Administrator with the Chief of Medicine and Chief of Psychiatry serving as voting members. QMHPs present cases and requests for items that cannot be purchased on the statewide commissary list, such as breast forms or minoxidil. Additionally, initial consultation for Hormone Replacement Therapy (HRT) is conducted by an outside specialist through the TLC. The specialist places the initial orders for HRT, which are then continued by an ODOC provider. By all accounts, it would be helpful to care delivery and management to have a dedicated individual to manage the population of transgender and GNC AICs, ensuring adequate access to care. This model is consistent with best practices in the treatment of transgender and GNC populations, although the agency describes challenges with case management and ensuring appropriate tracking of cases.

Prenatal and Postpartum Care

At intake, an AIC may tell the registered nurse that she is pregnant if she knows at that time. All female intakes are provided with pregnancy tests. If positive, the AIC will be scheduled with the OBGYN at Coffee Creek and will have access to prenatal care. Additionally, a doula program is available for women beginning in pregnancy through 13 months postpartum. The doulas discuss birth plans, breast feeding, and postpartum issues, meet the patient at the hospital for birth, and provide patients with options.

[13] The Behavioral Health Unit is specifically designated for those AICs whose symptom acuity precludes placement in general segregation units, offering a clinical diversion from restrictive housing.

Care for the Aging Population

ODOC described challenges with an aging population, specifically citing limitations in the built environment that make care challenging. Limited space and accessible housing, as well as finite numbers of lower bunks, make it difficult to meet the requirements of an aging population. Security concerns exist around assistive devices like walkers, canes, or wheelchairs. Departments were described as siloed regarding elder care, with nursing, security, and Behavioral Health Services approaching cases differently. Many stakeholders described the need for a dedicated unit or units to care for the aging population, centralize the services, and create tailored policies and procedures around access to care.

Hospice services are available at all facilities, but ODOC is seeking to improve care delivery. Entering hospice care requires consent on the part of the patient, which is not always easily obtained. If the patient consents, the full hospice program is available. However, if the patient does not consent, ODOC can still provide an informal version of wraparound support for end-of-life care. ODOC has worked hard to improve end-of-life care, and family members can be approved to come and sit with AICs who will pass away in custody.

Wall Mural 4. Snake River Correctional Institution – Hospice Suite

vii. Pharmacy Operations

ODOC operates two licensed pharmacies, one in Salem (west side) and one in Four Rivers (east side), often called the Ontario pharmacy. The pharmacies receive orders from facilities, dispense and package medications primarily in patient-specific blister packs, and deliver to all 12 facilities. Stock orders for medication rooms inside prisons are also filled, and Health Services Pharmacy is also responsible for operating a medical store for durable medical equipment and devices. The two pharmacies operate similarly, and each service six institutions.

On average, the two pharmacies process approximately 10,000 orders per week, or about 500,000 orders annually. Health Services is responsible for all operations, and nothing is contracted. In recent years, the operation has incorporated emerging technologies, including the use of a blister pack machine and an automated medication dispensing system on the east side.

Each prison maintains agreements with local pharmacies for emergency medications, and each institution has a 10-14 day supply of emergency medications on-site.

Health Services uses CIPS to track and organize process flows. Medical orders are entered at the facility and then printed at the pharmacy. Nurses use Medication Administration Records (MARs) to document medication orders and distribution. Discontinued or wasted medications are returned to the pharmacy for destruction or reuse.

Logistics are noted to be an incredible challenge across the state, focusing on medication lines in institutions, along with the logistics of transporting across the state. Medication lines are reportedly disruptive to facility operations, with patients sometimes waiting one-to-two hours to receive their medications. With the introduction of MOUD, a second medication line now occurs in institutions, which is a source of frustration across the state. With intake functions occurring at CCIC and the quantity of orders being placed at that facility, it would be helpful to have a small, dedicated pharmacy on-site at that facility.

> Of all the operational complaints the Falcon team heard, medication lines for MOUD and frustrations around diversion were undoubtedly the loudest. There was a sense of optimism around ODOC's intention to move to the extended-release form of buprenorphine to reduce these challenges.

Discharge Planning and Reentry

All ODOC facilities are equipped to release AICs directly from the prison to the community. The agency tries to transport AICs closer to their home counties in advance of releases. For most AICs, the reentry process begins six months prior to the release date; four months prior to release, the reentry process should be well under way. When AICs are identified with special circumstances, the process often begins sooner. For medical discharge planning, two nurses are responsible for medical transition to the community. Nursing staff meets with patients 30-60 days before release and works to connect them with the next provider they will see in the community. AICs leave the facility with a 30-day supply of medications (with some important exceptions). With respect to complex care patients, two nurses assist with release planning, referred by QMHPs at the six-month mark before release.

It was frequently reported to the Falcon team that resource availability varies widely across counties, and some counties have more opportunities to support reentry than others. AICs and staff also described great variation in the quality of discharge and reentry planning across facilities and clinicians, with some describing helpful and effective services and others describing a total lack of services provided before release, including failure to obtain medications at discharge from ODOC facilities.

Staff consistently highlighted the need for improved case management, care coordination, and discharge planning across the state. The Falcon team also encountered community-based partners from organizations like Oregon Health & Science University (OHSU) who are eager to partner and access patients prior to release.

Reentry and discharge planning represent moments of great opportunity for the system to support public health and public safety, and to aid AICs in their rehabilitation and reintegration following incarceration. Because there is no systemwide CQI program in place, the Falcon team only had anecdotes from impacted persons and staff members to inform the process. It is expected that the new EHR will provide valuable information in this domain.

B. Review of Healthcare Delivery System

i. Population Health of Individuals Incarcerated in the United States

People who are incarcerated in the United States and around the world are far more likely than others to have higher rates of chronic illness, infectious disease, physical injuries, psychiatric illness, SUDs, and co-occurring disorders, and to present with complex comorbidities.[14, 15, 16 , 17, 18, 19] As a group, incarcerated individuals are less likely to be insured or to have a primary care provider, and less likely to have been adherent with treatment prior to detention and incarceration.

AICs as a group are entering the prison system with uniquely complicated medical and behavioral health conditions. Compounding this fact, prison life is also often unhealthy, with

[14] Baranyl, G., Scholl, C., Fazel, S., Patel, V., Priebe, S. & Mundt, A. (2019). Severe mental illness and substance use disorders in low-income and middle-income countries: A systematic review and meta-analysis of prevalence studies. *The Lancet: Global Health,* 7(4), 461-471.

[15] World Health Organization Health in Prisons Database (HIPED). Available: https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped)

[16] Cloud, D., Garcia-Grossman, I., Armstrong, A, & Williams, B. (2023). Public health and prisons: Priorities in the age of mass incarceration. Annual Review of Public Health, 44, 407-428. https://doi.org/10.1146/annurev-publhealth-071521-034016

[17] Cloud, D. (2014). On life support: Public health in the age of mass incarceration. Vera Institute of Justice. Available: http://www.vera.org/sites/default/files/resources/downloads/on-life-support-public-health-mass-incarceration-report.pdf.

[18] Kumar, V. & Daria, U. (2013). Psychiatric morbidity in prisoners. *Indian Journal of Psychiatry,* 55(4), 366-370.

[19] Ben Forry, J., Ashaba, S. & Zari Rukundo, G. (2019). Prevalence and associated factors of mental disorders among prisoners in Mbarara municipality, southwestern Uganda: A cross-sectional study. *BMC Psychiatry,* 19:178.

prisons and operations promoting a sedentary lifestyle, providing little in the way of healthful nutrition, exercise, or wellness activities that promote the health of incarcerated individuals.

ii. Physical Health of AICs in Oregon

The Falcon team found that some facilities were tracking metrics in HSRs, while others were not or could not provide those numbers to the team. As a result, quantitative analyses of clinical need and service utilization were often impossible in the current state. One area that emerged as particularly helpful and adept at maintaining data was the Health Services Pharmacy Operations department. While there are limitations on using pharmacy data, the quality and organization of the data sets were well-suited for the purpose of this population study. To be clear, however, this data set measures the treatment *response* by providers, rather than the treatment *need* of AICs, yet it is still helpful to assess how much treatment is being provided to the population.

The Falcon team requested daily snapshots of active pharmacy orders, presented quarterly, for calendar years 2023 to 2025. The data were requested in aggregate form, by facility, and with specific classes of medications highlighted. Using the underlying raw data provided by ODOC, the Falcon team began by examining the number of AICs who are receiving at least one prescribed medication. This population of patients was then used as a baseline for further investigations.

Of the 12,020 AICs in the sample, 9,215 (76.7%) were prescribed at least one medication by a provider. Of the 920 females AICs, 870 (94.6%) were prescribed at least one medication, while 8,344 (75.2%) of male AICs were receiving at least one medication ordered by a provider.

76.7% of AICs were prescribed at least one medication, including 94.6% of women and 75.2% of males.

Across all AICs in the sample, there was an average of 4.62 prescriptions per AIC, and of the identified patient population (N = 9,215), the average number of prescriptions per patient was 6.02. The data set did include over-the-counter (OTC) medications that could not be filtered out of the sample. For example, 4.7% of prescriptions were for vitamin D; 4% of prescriptions were for melatonin; and other OTC medications were fairly prevalent but less significant, such as aspirin, Benadryl, and others. In total, less than 10% of medications were OTC, but this is an important consideration in studying the current prescribing practices.

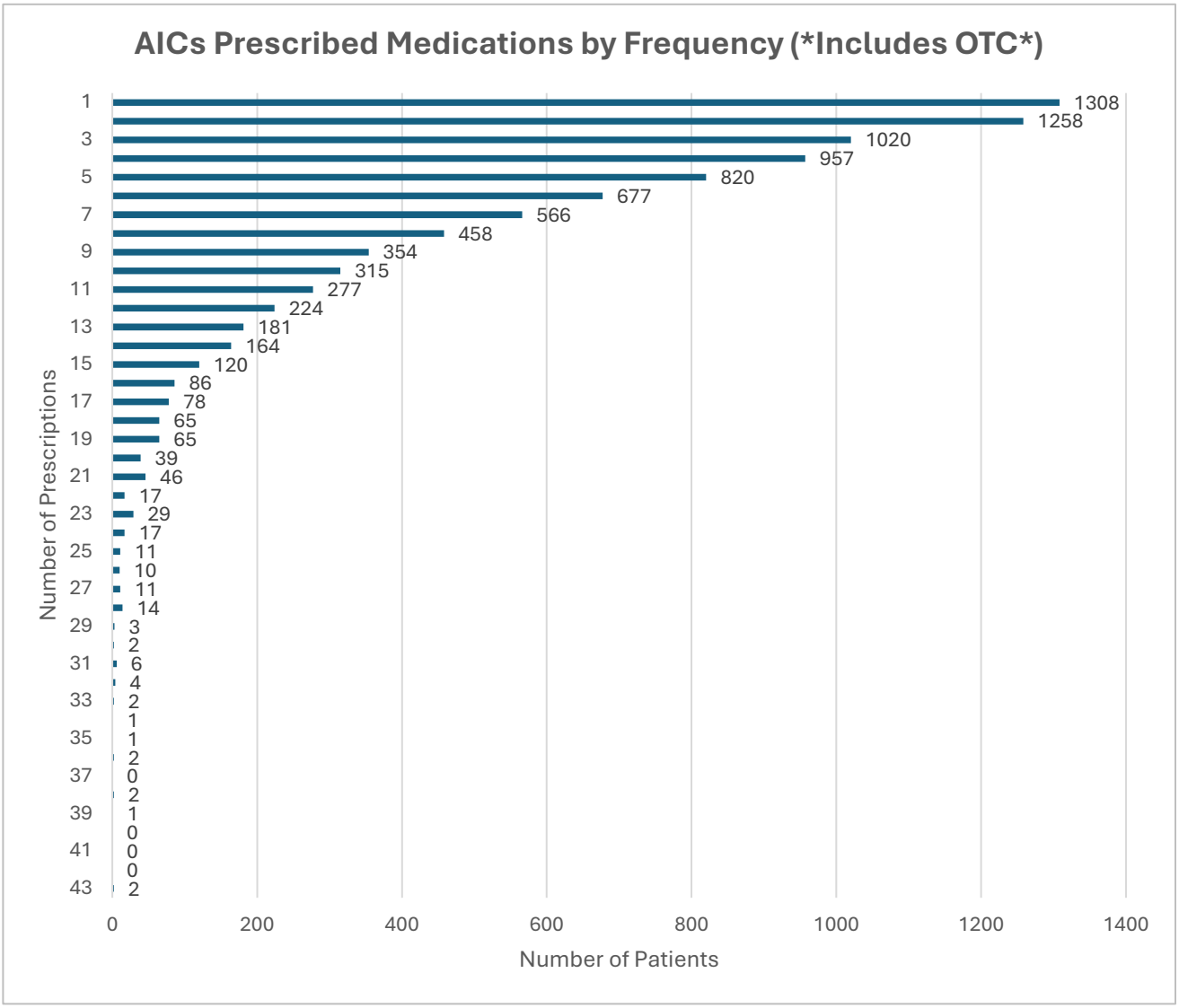
Best Practice Data Management: ODOC's Pharmacy Services emerged as an outstanding source of reliable data, reflecting a deeper commitment to best practices in pharmaceutical operations, and an area of clinical and administrative excellence within the organization.

According to Health Services, there is a struggle with polypharmacy – prescribing several medications each day to the same patient. While taking several medications per day may be needed to prevent or treat health issues, the interactions of medications can be harmful. It is critically important to review patient cases for polypharmacy. But using paper charts, and without a surveillance system or a systemwide CQI program, it is challenging to identify cases and respond with audits and care reviews. Before the COVID-19 pandemic, AICs prescribed more than 15 medications were flagged for review, but the process stopped during the pandemic and has not resumed. The implementation of the EHR is expected to have a positive effect on this practice, identifying drug-drug interactions at the point of care, and flagging cases for review by the new clinical pharmacists who will be on-site.

During the assessment process, ODOC hired a Clinical Pharmacist Manager, and began recruiting a group of clinical pharmacists, whose roles will include referrals for potential polypharmacy. Deploying these professionals in this capacity is a best practice, and combined with the EHR capabilities, Falcon expects a significant impact on the numbers and combinations of prescriptions for patients.

Analyzing the sample further, Figure 23 shows the frequency with which patients are prescribed one or more medications. For example, 1,308 patients were prescribed just one medication; 1,258 were prescribed two medications; and 1,020 were prescribed three medications.

Figure 23. AICs Prescribed Medications by Frequency



An Aging Population

As a group, the "greying" of the prison population has been observed across the country for several years, with the age of those experiencing incarceration reflecting that of the broader society (i.e., baby boomers). In 2014, for example, incarcerated individuals ages 55+ had increased 550% since 1992.[20] In short, healthcare providers face an overwhelming burden working to meet the healthcare needs of aging AICs, a challenge that is only expected to grow in

[20] Cloud, D. (2014). On life support: Public health in the age of mass incarceration. Vera Institute of Justice. Available: http://www.vera.org/sites/default/files/resources/downloads/on-life-support-public-health-mass-incarceration-report.pdf.

the years ahead without substantial policy changes. Consistent with what was heard in interviews and site visits, and using the same data sets provided by ODOC, the Falcon team assessed the age ranges of the AICs population since 2015.

Between January 2015 and January 2025, the number of incarcerated individuals ages 18 to 24 dropped from 1,499 to 617—a 58.8% decrease. This youngest age group now makes up just 5.1% of the prison population, down from 10.3%. The 25 to 30 age group also declined significantly by 39.1% since 2015.

While all age groups of AICs between **18 and 60 have seen significant declines**, the population of AICs **ages 61 and older has increased by 41%** since 2015, with more than 10% of the prison population now falling into that age group.

Declines among older age groups have been more modest. The 46 to 60 population decreased by 14.9%, and the 31 to 45 group by just 6.7%. Given the sharp declines in younger cohorts, these age groups make up a larger share of the total population now relative to 2015. The number of AICs age 61 and older increased by 41% and now account for more than 10% of the total incarcerated population.

Proportionally, the percentage of the incarcerated population between the ages of 18 to 30 has declined 34.7% since 2015. Meanwhile the percentage of the population between the age 31 to 45 and 46 and older has increased 12.8% and 16.7%, respectively.

Figure 24. AIC Population Proportions by Age Group (2015, 2020, 2025)

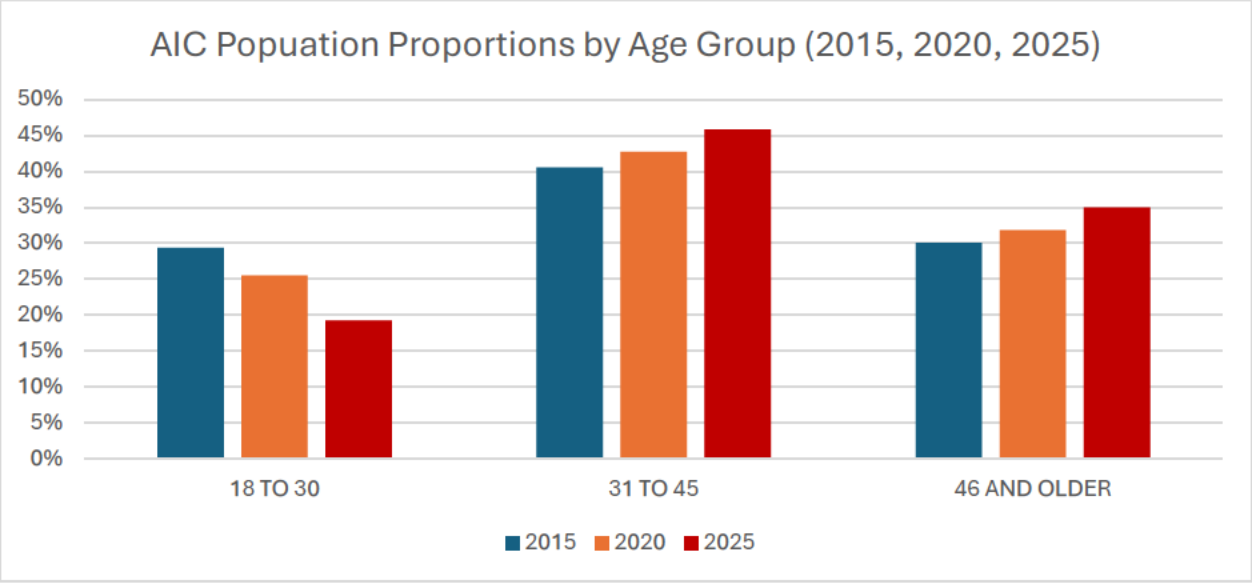


Figure 25. Two Rivers Correctional Institution – Dialysis Suite

Lingering Effects of a Global Pandemic

The global COVID pandemic revealed the medical vulnerabilities of the incarcerated population, as well as the vulnerabilities of staff, compounded by the congregate nature of prison environments and movement patterns. This combination of factors led to an estimated 2,800 deaths of incarcerated individuals during the pandemic, along with an estimated 275 deaths of correctional staff.[21] Incarcerated individuals demonstrated 3.3 times the incident rate for COVID-19 during the pandemic relative to others, and the population experienced a rate of death 2.5 times greater than community-based populations.

Across the country, the Falcon team has observed the devastating impacts of COVID-19 on the field of corrections. Many prisons and systems have never recovered from the operational impacts, loss of staff, modifications to operations, and a lingering malaise across prison systems. Furthermore, a realignment of the workforce over the past five years has brought a younger and

[21] Craig, M., Kim, M. & Beichner-Thomas, D. (2023). Incarcerated in a pandemic: How COVID-19 exacerbated the "pains of imprisonment." *Criminal Justice Review.* doi: 10.1177/07340168231190467

less experienced workforce into prisons, trained during times of relative inactivity across facilities. Most systems across the country are still struggling to "reopen" after the pandemic.

Specific Health Conditions and Specialty Care

With respect to specific health conditions, one in ten (1/10) people who experience incarceration in the United States are diagnosed with hepatitis C, versus 1 in 100 (1/100) in the general population. Sexually Transmitted Infections (STI) are twice as prevalent in carceral settings, and respiratory infections like tuberculosis are 12 times as common in prisons when compared to community-based populations.

Incarcerated individuals also have higher rates of asthma, hypertension, kidney disease, and cancer. For women, studies demonstrate higher rates of gender-specific health conditions like cervical dysplasia and cervical cancers, nearly ubiquitous experiences of physical or sexual trauma,[22, 23] and high-risk prenatal and perinatal care for women.

Best Practice Site: Snake River Correctional Institution has developed an electronic communication system for communication among the treatment team and schedulers, connecting the team with medical records, the TLC approval process, scheduled appointments, completion of specialty care visits, and follow-up needs. The model uses Microsoft Teams for improved coordination.

Access to care for incarcerated individuals must include access to specialty care that is not routinely available on-site in a prison setting. Specialty consults often include expertise by disciplines like podiatry, neurology, radiology/imaging, cardiology, and general surgery. Specialty care is a critical component of a constitutionally adequate correctional healthcare system, and one of the most challenging to achieve due to the substantial needs of the incarcerated population, operational and safety challenges, limitations of the prison's built environment, the lack of provider resources in areas around many rural prisons, and the resource demands of approval, scheduling, transportation, and follow-up.

Securing appointments with community providers can be difficult, as providers tend to prioritize community-based patients and may be hesitant to reserve time for AICs whose attendance is not guaranteed and who arrive restrained, in DOC attire, and with correctional

[22] DeHart, D., Lynch, S., Dass-Brailsford, P. & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly*, 38(1), 138-151.

[23] Reichert, J. & Bostwick, L. (2010). Post-traumatic stress disorder and victimization among female prisoners in Illinois. Illinois Criminal Justice Information Authority. Available: http://www.flintridge.org/wp-content/uploads/2021/08/Post-TraumaticStressDisorderandVictimizationAmongFemalePrisonersinIllinois-2010.pdf

officers. Institution schedules are often unpredictable, appointments can be delayed or canceled due to lockdowns, staffing shortages, or other emergency incidents. Moving AICs through public areas, such as doctor's offices or hospitals can also raise safety concerns for the public. The logistics of transporting AICs require significant resources, including escorting officers and secure transport vehicles. These trips come at a high cost, driven by staff overtime, security measures, and vehicle maintenance, along with the cost of care. Most importantly, they introduce public safety risks by increasing the potential for escapes, violence, and security breaches. These operations place added strain on facility staffing and contribute significantly to overall system costs. In Oregon's system, the combination of an aging population, high rates of chronic disease, complex medical conditions, rural settings for many prisons, and limited transportation resources make specialty care particularly challenging.

During the course of the study period, the Falcon team worked with ODOC to begin collecting backlog data from prisons. As the team observed the process improvements around pre-authorization, improved efficiency of the TLC process, and faster referral to schedulers to make appointments, backlogs were defined in terms of patients waiting to be scheduled and patients awaiting their specialty appointments. At the time of this report, ODOC had recently established a much-improved mechanism for tracking these numbers. Now managed by a strong and experienced clinician-administrator, a process has been established to track and triage referrals, TLC approvals, scheduling, completion, and follow-up. This was seen as a remarkable improvement over the course of just three months.

Best Practice Site: Deer Ridge Correctional Institution is strategically located for access to specialty care, just north of Redmond and Bend, with both cities offering strong specialty care resources and identified as willing and collaborative partners. Facilities with fewer resources in surrounding communities often rely on Deer Ridge for access to specialty care, due to these local resources, a strong clinical mission shared among facility staff and leadership, the single-level design of the facility (ADA accessibility), and its designation as a minimum security institution.

The Falcon team observed that ODOC has relied heavily on OOF transports to connect patients with specialists in community healthcare settings, such as hospital systems, clinics, or other community-based provider locations. However, many systems of correctional healthcare partner with providers to deliver these specialty care services on-site in the prison, reducing the need for OOF transport and increasing the expediency and efficiency with which specialty care can be provided for some patients. Similarly, the explosion of telehealth and asynchronous technologies has reduced the need for OOF transport for many specialties. By prioritizing on-site specialty care and expanding the capability of on-site resources, a smaller number of patients would require OOF transport for specialty care.

During the course of the study, the Falcon team observed strong interest from Health Services leaders in bringing services on-site and reducing reliance on OOF transports. Facilities expanded the use of on-site and telehealth contracted specialists in infectious disease, pulmonary medicine, neurology, optometry, pain management, physical therapy, general surgery, orthopedics, cardiology, and ultrasound. At the time of this report, ODOC was in the process of contracting on-site imaging (i.e., CT and MRI) and working with their third-party specialty care provider to expand on-site podiatry and occupational therapy. Lastly, the agency is developing an agreement with CHP for expanded telehealth for asynchronous and synchronous consultations with multiple specialties.

For OOF consults, the AIC is referred to a TLC for consideration of specialty medical care, non-formulary medication requests (for Medical Services and Behavioral Health Services), specialty dental procedures, and for transgender and GNC care. The process is similar between the TLCs, but more challenging when OOF consults are required. For OOF consults, which comprise the majority of medical TLC requests, the AIC must be transported to the community-based provider for the procedure and then transported back to the facility.

In recent years, the OOF process has been the focus of much attention, with many stakeholders and ODOC's internal staff calling attention to problems with the system. Prior to recent enhancements, the process was intended to work as follows:

- AIC sees a provider in the prison, who determines the AIC needs to consult with a specialist.
- The referral is submitted to the appropriate TLC.
- The TLC meets, discusses the case, and provides an expert opinion on the matter.
- If the referral is approved, the AIC moves on to scheduling with the specialist.
- If the referral is not approved, an alternative treatment plan is recommended.
- All decisions are documented, and the treating clinician signs off on the referral.
- The referral is sent to the specialist and the facility's scheduler.
- The scheduler enters the information into ODOC's database and documents what is needed.
- The scheduler also sends the referral to the specialist and obtains prior authorization from CHP, the third-party managing OOF consults.
- The scheduler coordinates the provider schedule and the transportation schedule and, depending on the priority level assigned by the TLC, determines when the patient is seen.
- The treating provider completes a "pink sheet," officially known as the Health Referral Outside Agency Form attached to *Procedure A-2.1*, which describes the

treatment issue and urgency. The treating provider then places the pink sheet in a "yellow envelope" with a transportation form and any other relevant information.

- The yellow envelope and the contents are provided to the Transport Office, which picks up the AIC from the facility and transports the AIC to the specialist office.
- The yellow envelope is then provided to the specialist, who completes the pink sheet with recommendations.
- The pink sheet comes back to the facility with the Transport team and the AIC gives the pink sheet to the nurse in receiving.
- The nurse contacts the on-call provider, reviews the specialist's recommendation, and obtains orders, if indicated.

Best Practice Site: Two Rivers Correctional Institution described strong relationships with local hospital systems, maintaining open lines of communication about developments in their specialties and availability of new or changing capacities among specialties. Healthcare leadership at Two Rivers does an excellent job of maintaining a working knowledge of these resources and coordinating closely with local partners.

During the assessment, the OOF process was the topic of frequent and protracted discussion and examination among various stakeholders. The process was described by all parties as fraught with problems. During workshops and interviews, the following potential pitfalls were identified and discussed:

- This is a paper process, so there are many opportunities for mistakes.
- The TLC process is dependent on expeditious referral, review, and disposition, but until recently it was not unusual to have TLC meetings canceled or with little time to review all requests, creating a bottleneck at the initial review point.
- Similarly, once approved, the scheduling process is dependent upon the existence of providers in the vicinity of the prison, and their schedules and availability.
- Once scheduled, the AIC's appointment is dependent upon transportation availability that day; in a prison system, however, demands on transportation are extensive. As a result, AICs may miss an appointment scheduled months earlier, with no notice to a specialist, and sometimes with no notice to the scheduler, the referring provider, or the TLC.
- Once transported to the appointment, the system is dependent upon the specialist completing the pink form, but this does not always happen; some requests are too vague so the specialist cannot interpret them, while some specialists might simply

not complete the paper form or might not give a clear recommendation or disposition.

- Sometimes the pink sheet is lost in transit and does not make it back to the prison.
- Sometimes the AIC does not go straight to the nurse at reception but goes back to the cell and does not provide the pink sheet to the nurse.
- At minimum security facilities, there is not always a nurse working 24/7, and so the AIC may not be able to provide the pink sheet to a nurse upon return.
- When the AIC does give the pink form to the nurse, the recommendations are sometimes urgent and the AIC needs medications or treatments immediately, but the on-call provider determines the urgency with the information available at that moment.
- The nurse also might not be able to reach the on-call provider immediately.
- The nurse might place the pink form in the chart, but the chart is not reviewed until the next day at the earliest.
- If the provider disagrees with the specialist's recommendations, the provider then needs to make a decision about the plan of care.

Best Practice Site: Oregon State Penitentiary provides access to several on-site specialty services, including Optometry, Surgery Consults, Infectious Disease, Cardiology, Electrolysis, Ultrasound, and X-Ray. These on-site services are particularly noteworthy given the security level of the institution.

Everyone agreed that the OOF system needed to improve, but like other areas of needed improvement, there has been little in the way of measurement to establish a baseline and measure change. It was reported that when specialists are willing and able to come on-site at a prison, the process works very smoothly. However, with no care managers or patient advocates tracking cases, there was no way to monitor the patient's access to specialty care beyond whether or not the person was scheduled, and the specialist was paid. There was no follow-up process to ensure that the AIC attended the appointment, that the specialist gave a recommendation, that the provider received the recommendation, or that paperwork was completed.

During the course of this assessment, significant progress was made under the new Chief of Medicine and the Acting Assistant Director of Health Services. Office Specialist 2 (OS2) schedulers were moved under the supervision of nursing professionals for care coordination and prioritization, and an experienced clinician-administrator began overseeing and tracking the process. Recent changes to the TLC included a series of procedures that do not require review, such as standard follow-ups, mammograms, colonoscopies, chest imaging for lung cancer screening, DEXA scans, hearing screening, oxygen, optometry, up to four visits with physical

therapy, wedge pillows, eye patches, and ankle braces. Further, the TLCs no longer get canceled, and designees can chair them when the Chief of Medicine is unavailable. Health Services has procured additional medical vans and increased staffing in the areas of OS2 schedulers, care managers, and administrative support to improve tracking and outcomes. The entire process of tracking and triaging consults was moved under an experienced clinician-administrator, although more resources are obviously needed to sustain this improvement. Lastly, it is clear that the EHR will address many of these issues, and significant process improvement has already been realized.

During workshops with ODOC staff and while visiting facilities, the Falcon team discussed these issues across the state. The team found wide variation among facilities and regions with respect to how specialty care was managed. Difference is collaboration with community partners, referral processes to the TLC for approval, consult coordination, scheduling, specialty care encounters, and follow-up, were all observed, with each facility demonstrating strengths and challenges.

The processes were not standardized statewide, although in recent months Health Services has worked to improve standardization and increase efficiency. This issue has clearly been prioritized, as it was this issue that led to the whistleblower report in 2024, which also concluded that the existing process had resulted in delays in care.

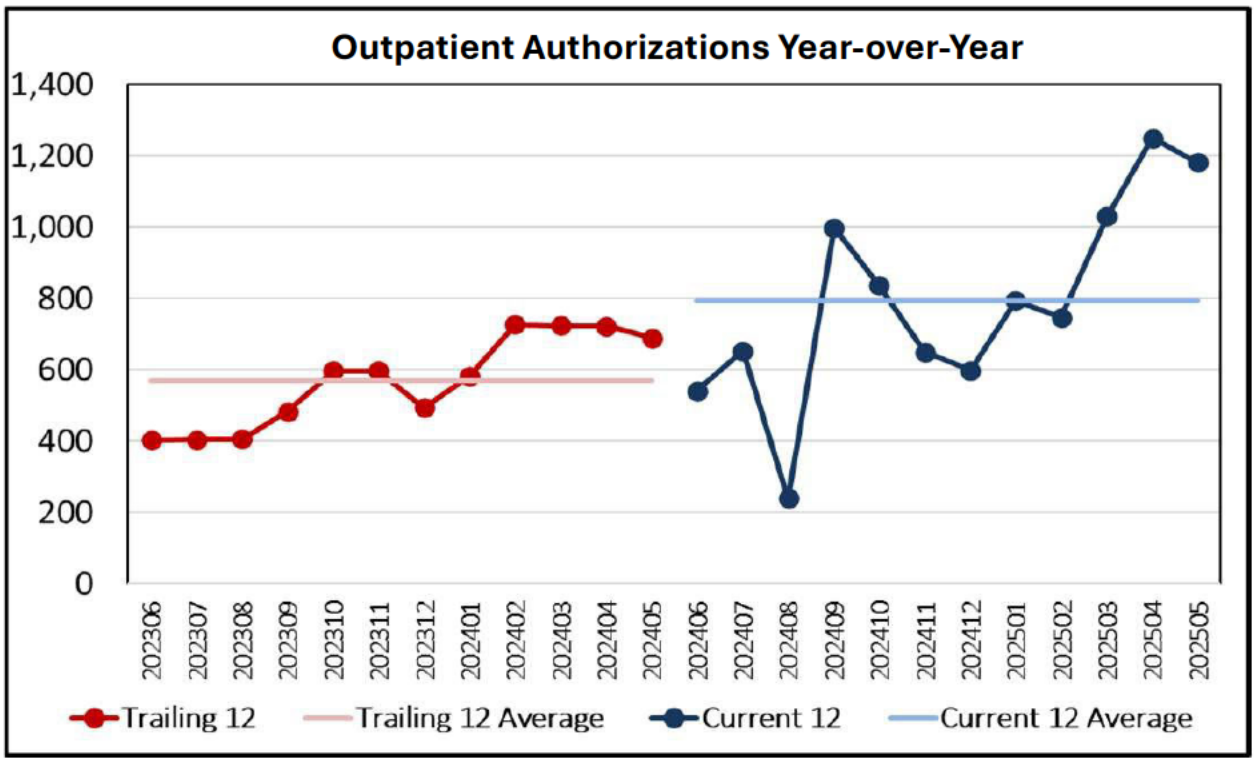
Best Practice Site: Columbia River Correctional Institution is centrally located for access to specialty care resources, in the heart of Portland, offering convenient access to major hospitals and providers. Columbia River also offers on-site neurology clinics, removing those patients from the transportation schedule for OOF consults.

Like most prisons across the country, every Oregon prison described challenges with obtaining specialty care for patients, many of which were similar between sites, while many were unique to a specific prison. While on-site, a general sense of optimism was observed from staff, specifically providers and healthcare administrators, who felt that the new Chief of Medicine had made very important changes to the TLC process that were resulting in improvements to the approval timeframes for referrals.

As Figure 26 shows, the year-over-year average monthly completions of OOF specialty consults has risen substantially in recent months, clearly a response to increased attention to this issue and the implementation of statewide policy changes and site-specific practices. The Falcon team recognized the impact of both the administrative-organizational efforts and the creativity at each of the prisons to improve access to specialty care. In March 2025 (202503), 1,033 OOF specialty consults were completed, while one year earlier in March 2024 (202403) the completion number was 731, reflecting an increase of 302 OOF specialty consults, or 29%. Month-over-month, the number of OOF specialty consults continues to rise substantially, demonstrating significant improvement, the impact of these creative solutions.

In May of 2025, a slight drop in the number of completed specialty consults was observed, relative to April of 2025. Based on the consistency across March, April, and May, ODOC and the Falcon team agree that this may be a new baseline going forward. Considering the extensive intervention around this issue, both at the statewide administrative level and at the site level, it seems likely that this will be a new benchmark until backlogs are eliminated and the need is reduced. However, for the month of May, the agency authorized 49% more visits than the prior 12-month average, and year-over-year, the monthly numbers have increased 39%.

Figure 26. Year-Over-Year Outpatient Authorizations



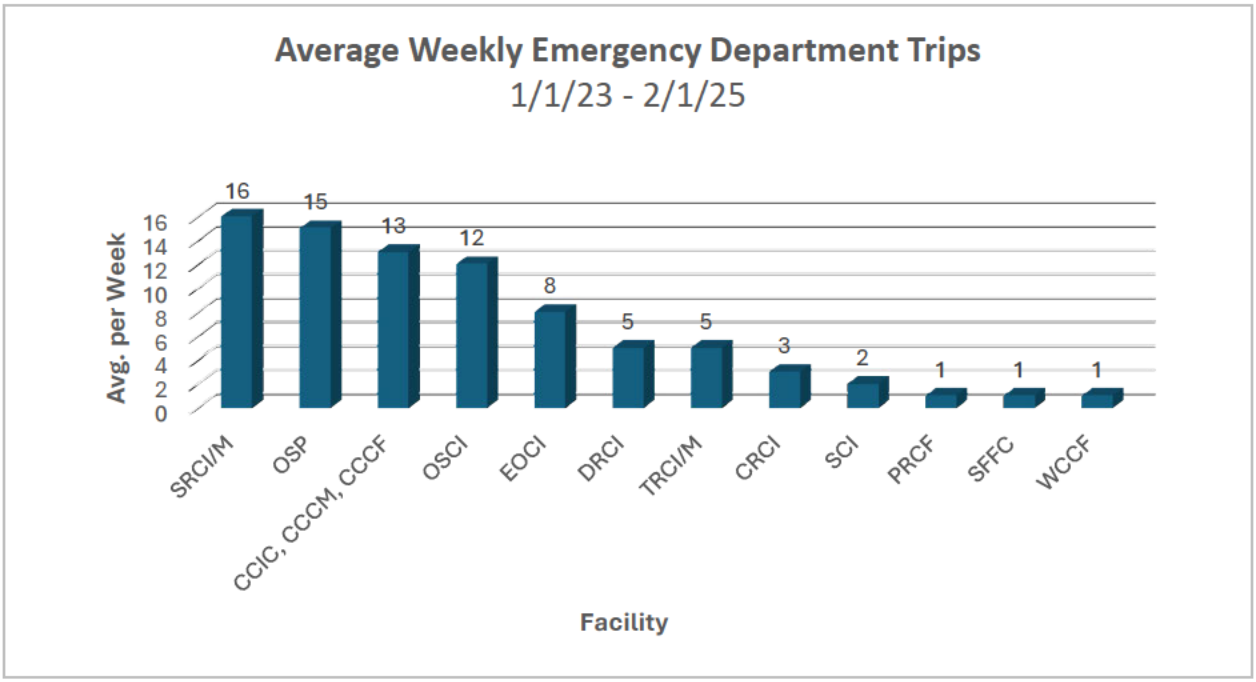
Emergency Department Visits

CHP provided emergency department information to assess the number of medical emergencies requiring ambulance transport across the state on a weekly, monthly, and annual basis. Emergency department use is a helpful proxy indicator for medical acuity, trauma, and the severity of clinical presentations within a prison or prison system. It is also an important metric to the costs associated with care delivery. In a care delivery system, the use of emergency transport can be linked to delays in care leading to emergencies, some of which were likely preventable with proactive care access.

Between January 2023 and February 2025, there were an average of **82 trips to hospital emergency departments per week.**

In calendar year 2023, 3,421 emergency department trips were made from ODOC prisons; in calendar year 2024, the number grew to 4,066 emergency transports. The average number of emergency transports per week between January of 2023 and February of 2025, by facility, is represented in Figure 27. Statewide, an average of 82 emergency transport trips were made per week in this timeframe. Access to emergency departments is critically important in a prison system. However, reviewing many of the cases revealed that emergency departments are sometimes used for routine care like imaging (i.e., X-ray), specialty care when it cannot be arranged on-site, or other non-emergency functions. Additionally, many of the emergency transports appear to be the result of missed opportunities for proactive, preventative, or routine care earlier in the process. This is an important metric for CQI studies in the future.

Figure 27. Average Weekly Emergency Department Trips



Inpatient Hospital Utilization

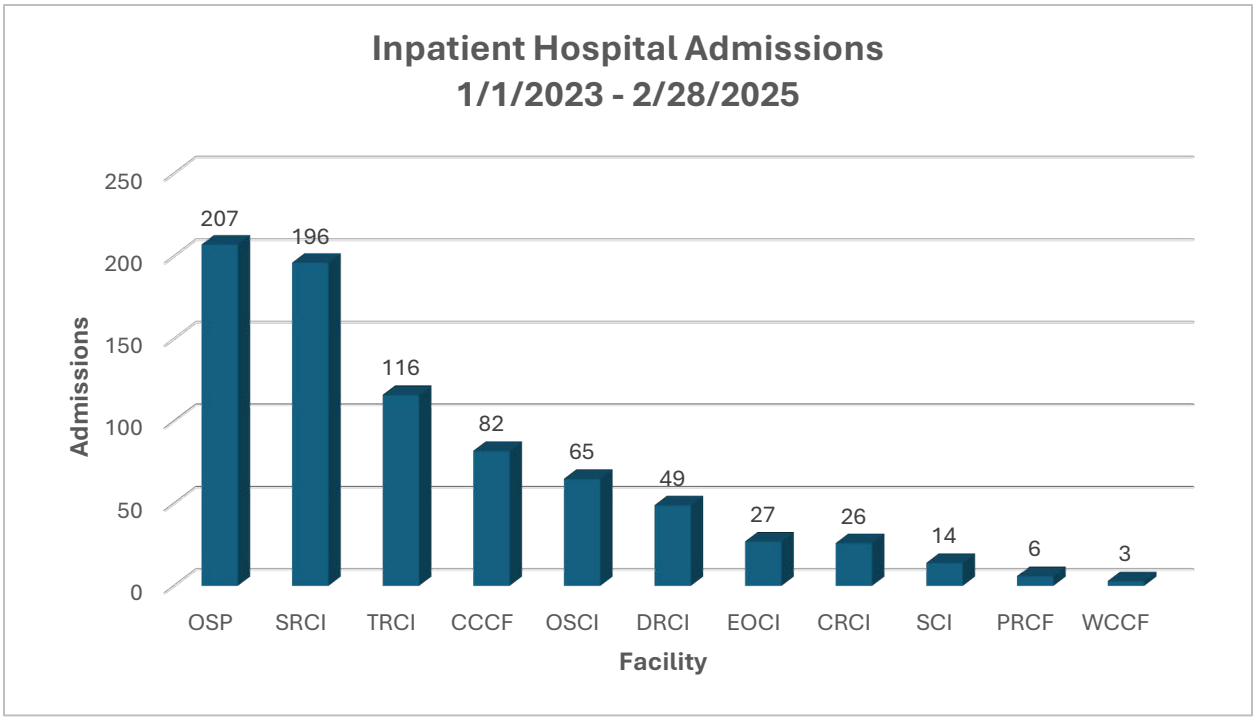
Using hospitals for inpatient treatment of AICs is one of the most expensive components of any healthcare delivery system. Not only is inpatient treatment in an acute care setting far more costly than preventative, planned, or other treatment provided inside the prison, inpatient stays require 24/7 staffing by correctional officers. Despite unprecedented staffing shortages across the country, these correctional officers are often pulled from their duty posts inside the prison, leaving the facility even further short-staffed, which can impact the regular operations of the facility. In other cases, these correctional officers are assigned to various transportation functions, including scheduled OOF consults, which are less likely to occur when staff are pulled for hospital duty.

It is common for coordination of care to suffer when the patient is transported and admitted to a hospital that is unaffiliated with ODOC, not only being admitted to a different institution (a hospital) but also transferring to a different healthcare system and back. These repeated transfers of care, as well as the monitoring of patient progress with the hospital, create additional opportunities for systemic failures that can impact patient care.

Using a three-year sample of inpatient hospital utilization provided by CHP, the data indicated 791 hospital admissions, representing 589 unique AICs admitted to hospitals across the three-year period. Some individuals, obviously, were admitted to hospitals more than one time across that three-year period. Also, 342 unique primary diagnoses were identified in the sample, with the highest utilization at Salem Health on the west side of the state, and at Saint Alphonsus on the east side.

While not represented in the data sets, the team consistently heard facilities describe using multiple local hospitals simultaneously for inpatient treatment, each of which required correctional officer staffing, at least two correctional officers per patient. At one facility, on the day of a site visit, seven patients were being treated off-site at three different inpatient settings, requiring 12 correctional officers posted 24/7 at these outside facilities. While this can be inevitable at times due to emergency department availability, the underlying causes should be studied and consolidation of patients maximized where possible. Like emergency department utilization, this is an important indicator for CQI study in the future.

Figure 28. Inpatient Hospital Admissions



Dental Health

ODOC operates a comprehensive dental health program and provides access to dental care at all facilities. The department's Dental Director has spent decades advocating for and expanding services across prisons, and the program is exemplary. Relative to other prison systems the Falcon team has visited and studied, ODOC's dental program is among the most expert and capable the team has seen. Reviewing data from calendar year 2024, a full continuum of dentistry and oral health is being practiced. As the need for dental services in prison settings has been highlighted across the country in recent years, services have expanded to meet that need within Oregon's prisons.

Relative to other prison systems the Falcon team has visited and studied, the dental program in ODOC is among the most expert, capable, and productive.

Entering a dental clinic in nearly any prison in Oregon, the space impresses as clean, orderly, professional, and similar in appearance to community dental clinics. Dental staff provide an array of services, ranging from initial oral screenings and examinations to root canals, crown cementations, various fillings, dentures, and various types of extractions as indicated.

Figure 29. Powder Ridge Correctional Facility – Dental Clinic

Behavioral Health

In the realm of behavioral health, rates of SMI have long been identified as being significantly elevated in samples of incarcerated individuals. In one landmark study, approximately ten times more individuals with SMI were in jails and prisons rather than in state hospitals. SMI is consistently measured at two-to-four times the prevalence rate of community-based samples, and nearly three-quarters of incarcerated individuals with SMI meet the diagnostic criteria for a co-occurring SUD. Suicide remains a leading cause of death in U.S. jails and prisons (*the* leading cause of death in European prisons). SUDs are overrepresented in carceral settings as well, and between 2001 and 2018, deaths in correctional facilities due to intoxication rose 600%.

Behavioral Health Services, which includes mental health services and SUD treatment, has a clear structure and organization for care delivery, represented in its Clinical Practices. Mental health levels of care create a continuum of care available to AICs. And MH Codes reflect the clinical needs of AICs, creating a mental health classification system often considered a best practice. MH Codes are included in the Inmate Profile data set, so anyone with access to the data set has at least a cursory understanding of the prevalence of behavioral health needs across the state and in each prison.

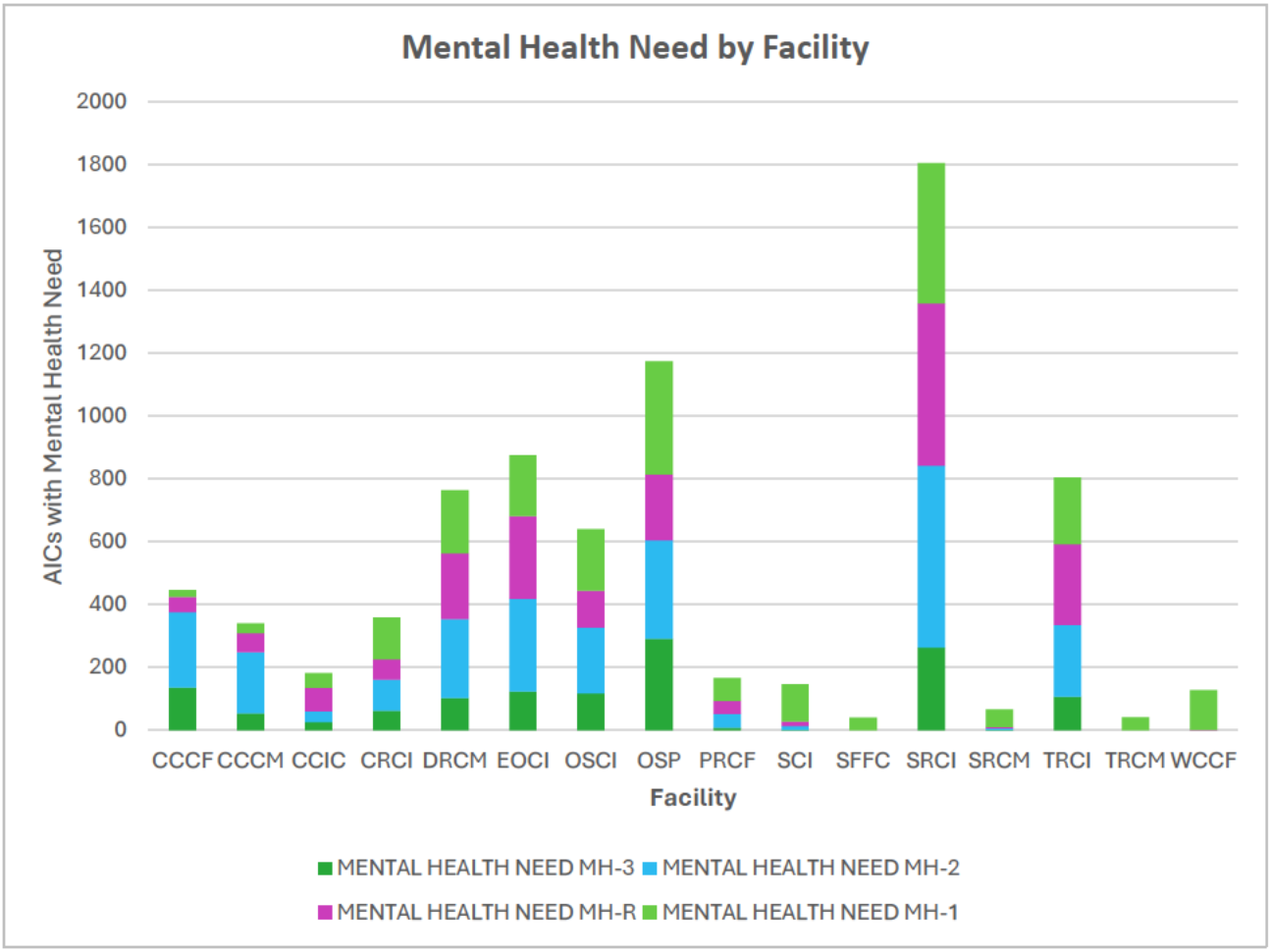
The behavioral health needs of the incarcerated population in Oregon's prisons are significant, with 66% of AICs identified as having some mental health treatment need (MH-R, MH-2, MH-3). Data indicate that 85% of women in custody and 65% of men in custody are identified with some mental health treatment need. Furthermore, 68% of women in custody and 29% of men in custody are identified as meeting criteria for severe mental health treatment needs or the highest level of treatment (MH-2 or MH-3).

Retrospectively, 51.7% of the AICs population was identified as having some mental health need in 2015 and 58% in 2020. This compares with today's population with 66% of AICs identified as having some mental health need. Since 2015, the percentage of the population with an identified mental health need has increased approximately 15%.

Since 2015, the percentage of the population with an identified mental health need has increased approximately 15%, while those AICs with the highest levels of mental health treatment need now represent almost one-third of the entire incarcerated population.

Similarly, the highest levels of identified treatment need for mental health patients in ODOC custody, indicated by designations as *highest* and *severe* treatment needs, have increased dramatically over the last ten years. In 2015, 23.4% of the AICs population fell into these two categories, while in 2020, 24% of the population was designated at these levels of need. In the current sample, the figure jumped to 31.7% of the AICs population.

Figure 30. Mental Health Need by Facility



In Figure 30, those facilities with the greatest number of AICs with MH Codes 2 and 3 were located at facilities that have residential mental health units, indicating an appropriate relationship between patient need and healthcare response.

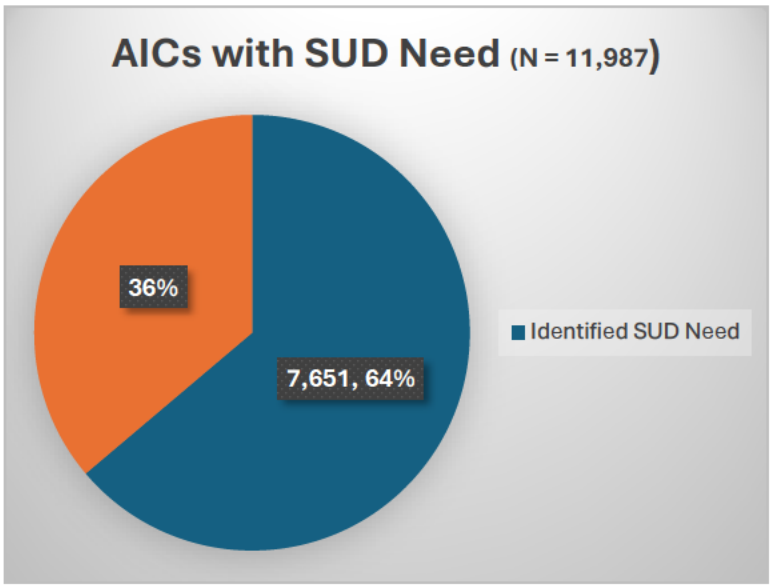
Substance Use Disorder

Across the state, treatment of SUDs has increased in recent years, with a particular focus on the population of those in treatment for SUD with MOUD. Residential treatment programs for SUDs have also emerged across the agency through partnerships with community-based organizations moving upstream into the prison system to support AICs in their recovery. SUD need is also represented in the Inmate Profile data set, making it easy for anyone with access to that daily data set to recognize the prevalence of SUD need statewide and by facility.

Statewide, 7,651 AICs (64%) are identified with some level of SUD need, with 51% of all AICs identified as meeting criteria for moderate to severe SUD, labeled “Dependence/Addiction” on the Inmate Profile, and 13% of AICs meeting criteria for mild or less severe SUD. An estimated

76% of female AICs are identified with some level of SUD need, with 69% meeting criteria for moderate to severe SUD and 7% meeting criteria for milder SUD. Of the male AICs population, an estimated 63% meet criteria for some level of SUD need, while 50% meet criteria for moderate to severe SUD and 13% meet criteria for less severe SUDs.

Figure 31. AICs with SUD Need



Throughout the prison system, several SUD and co-occurring (mental health and SUD) treatment programs exist to meet the needs of the identified AICs population. CCCF's SMART Alternative Incarceration program has a capacity of 50 AICs, and utilization remains near capacity at all times. According to ODOC utilization data, from January 2023 through March 2025, the average number of AICs served in the SMART Alternative Incarceration program was 52.5. CCCF also houses the LOTUS program for chronic SUD treatment, which has steadily increased its capacity and monthly numbers of AICs served, averaging 44.6 AICs in treatment per month.

The TRUE program at OSP and the Keys to Freedom program at SRCI are also designed to serve the chronic SUD population and have ramped up their capacity in recent months. In May of 2024, OSP's program began serving its first participant, and by February of 2025, the program was providing care for 98 AICs. Similarly, the program at SRCI is in its infancy, having served four AICs in October 2024, its first month of operation. In February 2025, the program served 11 AICs, reflecting a notable trend. Now with 30 treatment slots, the program serves an average of 31 AICs per month.

Through a contract with a community-based partner, OSCI operates the Freedom Recovery Alcohol Drug Treatment program with a capacity of 30 AICs, an increase from 24 AICs in the second half of 2024. Those treatment slots also appear to remain relatively full. Even before July 2024, when the capacity increased to 30 AICs, the program frequently exceeded its 24-slot capacity, serving more than 24 AICs 17 out of 18 months before the expansion.

At CRCI, the contracted Turning Point Alcohol and Drug Treatment program has a program capacity of 61 AICs. In calendar years 2023, 2024, and 2025, the program has consistently been at capacity, averaging 60.4 AICs served per month. Also located at CRCI, the New Foundations Co-

Occurring Disorder Treatment program has a bed capacity of 50. This residential treatment program lasts between nine and twelve months and has more stringent admission criteria. Since January 2023, the program has served an average of 33 AICs per month.

Lastly, the contracted New Directions NW Alcohol and Drug Treatment program at PRCF has a program capacity of 128 but consistently meets and exceeds that capacity, averaging 132 AICs served per month since January 2023.

In recent years, ODOC implemented MOUD statewide, but did so without additional resources. MOUD protocols require Behavioral Health Services, Medical Services, and custody operations to provide significantly more services in the areas of screening, evaluation, treatment, medication distribution, and medication line monitoring to minimize diversion.

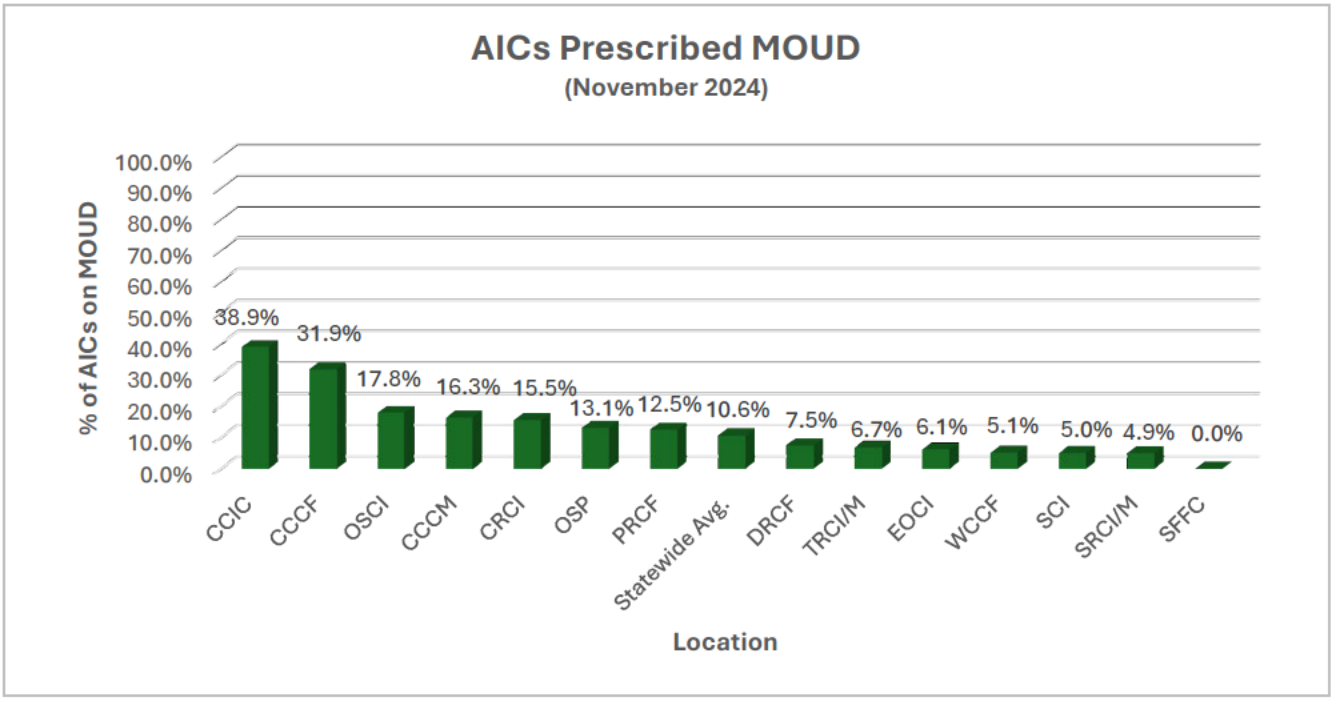
According to the MOUD SUD Diagnosing Tool developed by ODOC, the process begins with an evaluation by a QMHP, who conducts a basic, face-valid assessment of criteria for Opioid Use Disorder (OUD) from the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5).* AICs who score in the moderate to severe range of OUD and are interested in receiving MOUD are then referred to Medical Services through a Behavioral Health Services-Medical Referral form. The AIC is then scheduled to see the medical provider for MOUD consideration.

As a result of this multi-step process, bottlenecks have developed affecting MOUD evaluations by Behavioral Health Services staff as well as medical provider visits for MOUD consideration. At the time of the Falcon team's March site visits, Behavioral Health Services reported a backlog of 431 QMHP MOUD evaluations, and Medical Services reported a backlog of 587 provider visits for consideration of MOUD. Although MOUD has expanded to nearly every facility, it should be expected that these numbers underestimate the need.

Using pharmacy data from November 2024, the Falcon team observed approximately 10.6% of all AICs in treatment with MOUD. There was a wide variance among institutions, with the highest rate of MOUD prescribed at the intake center in CCIC where 38.9% of AICs were in treatment with MOUD, followed by the women's facility at CCCF, where 31.9% of female AICs were prescribed MOUD. Each facility's utilization of MOUD is presented in Figure 32, reflecting variation in treatment practices as well as the unique mission of various facilities. For example, SFFC had no utilization of MOUD, which is consistent with its mission as a forest camp with minimal resources for individuals with high levels of clinical need. The Falcon team has seen prison systems where approximately 50% of the population are prescribed MOUD, and similar challenges have been navigated.

Reflecting continued expansion of access to care for AICs with OUD, in June of 2025 pharmacy data indicated that approximately 14% of the incarcerated population were prescribed MOUD. This was another indicator of continuous improvement across the life of this assessment.

Figure 32. AICs Prescribed MOUD



For people who work inside correctional facilities, these numbers are not surprising, as each workday provides lived experience of treating a population with unmatched acuity, complexity, and rapid aging. Furthermore, professionals are asked to provide adequate care for this complex population in facilities that were simply never intended to provide for this level of clinical need.

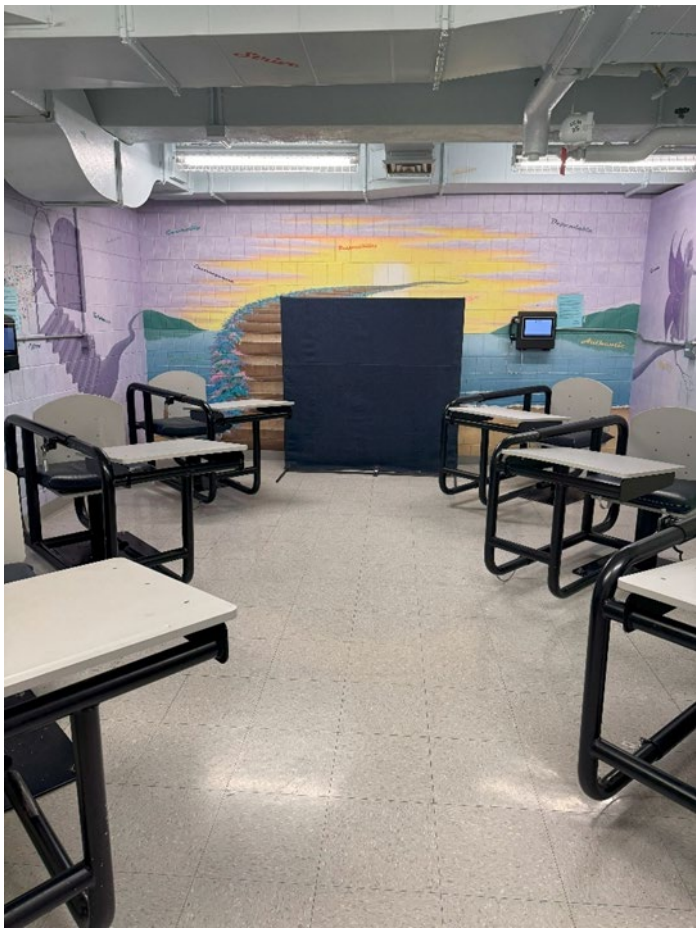
Section 6

Facility Studies

SECTION 6: FACILITY STUDIES

While prisons today have a significant healthcare mission, our correctional systems were never intended to provide for the level of complexity, acuity, or ubiquity of medical and behavioral health needs seen today. These systems were designed to incapacitate; to deter future crime; to gain retribution for crimes committed; and to rehabilitate and reduce recidivism. They were not designed to be healthcare systems, and the built environment is the most obvious embodiment of those limitations.

Prisons planned today are looking, feeling, and operating much more like hospitals, skilled nursing facilities, and residential treatment facilities rather than traditional prisons. Although they are as secure as the most hardened institutions, from California to Idaho to Baltimore to New York City, jurisdictions are reimagining what correctional facilities and systems need to look like to support staff providing incarcerated individuals with care.



Wall Mural 5. Eastern Oregon Correctional Institution - Disciplinary Segregation Unit Classroom

A. Coffee Creek Correctional Facility

With few exceptions, all AICs begin their periods of incarceration in ODOC at CCCF. For the female AICs population, CCCF is Oregon's only prison serving female AICs in medium custody. As such, it has a multi-security mission to provide care and custody for women classified at medium or maximum custody levels. CCCF also houses the intake functions for the male population, serving as a reception center for all AICs in a separate unit of the prison, where the intake and classification functions occur before AICs transfer to the facilities where they will serve their sentences. With a minimum security facility for women also on the campus, CCCF has the most complex and comprehensive mission of all Oregon prisons.

Women who are incarcerated in ODOC enter the system through CCIC and remain in the facility until and unless classified to the adjacent minimum security women's facility or released from ODOC custody. CCCF's minimum security facility opened in 2001 and now houses approximately 381 female AICs. The medium security facility opened in 2002 and now houses approximately 500 AICs.

i. Environment of Care

Because CCCF is the only medium security facility that houses female AICs and, given the shared mission of male and female intake into the system, a continuum of healthcare functions, and sheltered housing is available on-site. CCCF can provide primary medical care, chronic care clinics, clinical preventative services, general surgery consults, imaging, neurology, mammography, dialysis, OB/GYN care, laboratory services, urgent care, and emergency services. CCCF also provides a chronic disease model for SUD treatment, an alternative incarceration program for SUD treatment, peer mentors for mental health and SUD treatment, and a continuum of mental health care to include residential treatment. CCCF describes its dental services as including preventative services, dental prosthesis, restorative services, and oral screening.

Sheltered medical and behavioral health housing at CCCF includes a 13-bed infirmary with four negative pressure cells, as well as residential mental health treatment. Telehealth services were described as including virtual services for mental health, MOUD, infectious disease, dietary consults, and GNC care.

ii. NCCHC Summary

CCCF last underwent accreditation in January 2024. NCCHC surveyors placed the facility on probation, with a "focused survey" scheduled before June 30, 2024, and an additional survey currently being scheduled for late 2025. The NCCHC survey team identified a number of strengths, including professionalism across disciplines. The following areas were also highlighted as strengths: dental CQI initiatives, pharmacy audits, and suicide prevention. NCCHC recognized the revised medical error tracking system for enhancing inter-departmental communication about special needs AICs and providing comprehensive health-related materials.

However, several areas of concern were noted to impact access to care and overall quality of Medical Services. Only 50% of essential standards and 67% of important standards were met, which resulted in placing the facility on probation. Key deficiencies included long delays in specialty care referrals, absence of an effective staffing plan, lack of oversight by responsible physicians, and insufficient documentation of administrative and clinical procedures. Additional challenges included insufficient orientation and training for staff, limited CQI program, inconsistent monitoring of AICs in segregation, and backlogs in preventive and chronic care services.

The findings and recommendations of the GIPA report closely mirror those in the NCCHC survey. Both highlight the need for consistent and clear procedures, improved interdisciplinary

coordination, enhanced practices for mental health services in segregation units, adequate staffing, improved training, and an expanded CQI program.

iii. Observations

- CCCF is divided into three separate units and missions: Intake (males-females); Medium Custody Female, and Minimum Custody Female. While these separate units allow for mission-specific operations, the structure presents significant challenges to care coordination and optimized staffing across units.
- Murals and art installations throughout the facility enhance the environment and contribute to a rehabilitative and calming atmosphere.
- Shared clinic space in the intake unit serves both sick call and provider appointments for males and females, creating scheduling and operational challenges.
- The use of segregation (up to 14 days in isolation), particularly for males during the intake period, occurs at a time of significant AICs vulnerability, potentially impacting mental health. This presents an opportunity to explore alternative approaches that support adjustment and well-being during the transition to the prison system.
- Dedicated space exists for infirmary care with two negative pressure rooms, which supports infection control and the management of high-acuity cases, but the shared utilization between males and females presents challenges to gender-responsive care.
- There is no long-term medical housing for individuals with complex or chronic medical needs.
- Intake assessments and sick calls are delayed partially due to space constraints and high intake flow, averaging 99 intakes per week.
- Excellent utilization of Dental Services, which see about 300 AICs per month and are staffed with three dentists.
- Dental care is limited by union constraints; dental staff are not allowed to float between facilities.
- Transportation-related challenges (5-30 emergency department runs per week) highlight the need for on-site space to accommodate sub-acute care and enhance preventative care.
- Outdoor access for minimum and medium custody AICs contributes to a less restrictive environment and supports well-being.
- The facility has a strong connection to the community, which supports spaces for partner programming.

B. Columbia River Correctional Institution

CRCI is a centrally located minimum security facility in Portland, housing up to 595 male AICs. The facility layout includes dormitory-style housing units along with SUD and co-occurring treatment programs. A treatment unit is operated as a community model, incorporating work programs, drug and alcohol treatment, and an intensive focus on reentry initiatives. When the Falcon team visited the site, CRCI housed 515 AICs – 444 at Custody Level 1, 69 at Custody Level 2, and two AICs scoring medium at Custody Levels 3 and 4, respectively.

i. Environment of Care

The facility provides primary care, chronic care clinics, clinical preventative services, imaging, neurology, laboratory studies, urgent care, and emergency services. Behavioral Health Services includes outpatient mental health services, telepsychiatry, and a co-occurring disorder treatment program, which includes a peer recovery mentorship component. Dental Services include preventative services, dental prosthesis, restorative services, and oral screening. Pharmacy operations consist of medication line coverage from early morning through late evening across units, including keep-on-person (KOP) medications and diabetic lines.

There is no infirmary or residential mental health unit. However, a residential SUD treatment unit offers an alternative to incarceration provided by a contracted relationship with a local agency. When medical isolation or suicide watch are required, AICs are placed in the segregation area for stabilization or transfer to an infirmary.

ii. NCCHC Summary

CRCI last underwent accreditation in April 17-19, 2023. On June 23, 2023, NCCHC's Accreditation and Standards Committee awarded the facility accreditation with verification. The report highlighted several positive findings including longevity and the expertise of the Health Services staff, optimized clinical spaces for population needs, and Dental Services that added a second dentist to reduce backlogs. In addition, health education, chronic care management, emergency medical services, and medication administration met national benchmarks. The survey also complimented the collaboration between medical and custody staff.

Despite the facility's strengths, the report identified key challenges that required attention. According to the report, the CQI program had not been in place since 2020, lacking committee meetings, active monitoring, and more recent studies. Standards associated with infectious control inspections, clinical performance enhancement reviews, and the integration of preventive health screenings into routine care were partially found in compliance. NCCHC recommended the re-establishment of CQI processes, consistent administrative and clinical documentation, and staff training.

iii. Observations

- The facility offers significant programming with a focus on SUD and co-occurring disorder treatment programs.
- Dedicated program and housing units allow for specialized interventions.
- Telehealth services are available and support behavioral health and MOUD services.
- While there is no infirmary level of care, the relatively low number of emergency department runs (one-to-two per week) suggests that the facility manages non-urgent care efficiently.
- Off-site specialty care creates dependency on transport availability.
- The lack of medical housing limits the facility's ability to address long-term or complex medical cases on-site.
- Nursing coverage is 8AM-10PM, leaving a gap in overnight on-site care requiring nurse managers to be on-call.
- There is a potential risk to dental care continuity, as several experienced DOC dentists are approaching retirement. Planning for succession and expanding support for oral surgeries services will be important to maintain the current scope and quality of care.

C. Deer Ridge Correctional Institution

DRCI currently houses minimum security AICs, despite its original design to accommodate medium or maximum security populations. The facility is a 1,228-bed medium security facility, although it houses minimum security AICs. On the day of the Falcon site visit, the facility held 1,052 AICs, with 927 at Custody Level 1, 116 at Custody Level 2, seven at Custody Level 3, and two at Custody Level 4. Relative to other minimum security institutions, the facility is notably hardened, with a large disciplinary segregation unit (DSU) that is currently empty due to the classification of the AICs population.

DRCI is adjacent to a more typical minimum security facility, which is expected to be populated in the near future. It holds an additional 653 minimum security AICs, bringing the total AICs population at DRCI to 1700-2000 minimum security AICs. The facility also plans to open its infirmary in 2025, intending to launch and sustain these expanded operations with its current staffing allocations.

i. Environment of Care

DRCI is the only minimum security facility with 24/7 nursing on-site and will be the only minimum security institution with an infirmary when it opens. The facility described, and the Falcon team observed, a population with extremely complex medical and behavioral health

needs. This population is concentrated at DRCI due to its ADA accessibility, geographical location to services, and its hardened design despite a minimum security designation.

The facility can provide primary care, chronic care clinics, clinical preventative services, imaging, neurology, physical therapy, veterans' appointments, laboratory studies, urgent care, and emergency services. Telehealth is available for MOUD, infectious disease, dietary consults, GNC care, chronic pain management, neurology, pulmonology, and pre-surgical consultations. Pharmacy operations support medication line coverage from early morning through late evening across units, including KOP medications and diabetic lines.

Sheltered medical housing includes the eight-bed infirmary planned to open in the coming months. Behavioral Health Services includes outpatient mental health services and a large mental health unit, the agency's only residential treatment unit for mental illness at the minimum security level. Close observation and suicide watches are conducted in holding cells in the DSU.

ii. NCCHC Summary

DRCI underwent its most recent accreditation review, June 6–8, 2023. The facility fell short of meeting the required 100% compliance on essential standards, achieving 77%. However, it exceeded the minimum threshold of 85% for important standards of care. On August 18, 2023, DRCI was awarded provisional accreditation subject to compliance verification prior to December 2023. On February 9, 2024, DRCI was found to be 100% compliant with all essential standards and awarded its accreditation status.

The facility has made significant improvements across multiple areas previously identified by NCCHC. Medical autonomy was addressed, improving provider independence to make medical judgments. Administrative operations have improved through the consistent scheduling and documentation of monthly staff meetings and active physician participation in CQI efforts. Credentialing practices and clinical performance are being monitored more effectively. Man-down drills have been implemented, enhancing emergency preparedness. Access to care has improved with timely responses to non-emergency requests, and continuity of care is evidenced through proper follow-up after hospitalizations and patient education. Documentation of chronic care was also noted to be improved.

iii. Observations

- The facility is planning to open an eight-bed infirmary this year; however, current infrastructure and staffing levels require evaluation to ensure they can support this expansion.
- Mental health housing is currently being used to house the aging medical population due to cell design and proximity to Medical Services.
- The clinic sallyport lacks a second security camera, raising safety concerns.

- Nurses struggle to meet the 24-hour face-to-face sick call requirements due to space issues; there is a need for a housing unit triage room.
- Walkways create ADA mobility challenges for those AICs in wheelchairs, especially during adverse weather conditions, which may impact ADA accessibility.
- The mental health unit has 112 beds across two units, making DRCI the only minimum custody facility in the state with this level of mental health housing.
- The Behavioral Health Services team is fully staffed and clearly invested in treating their patients.
- The facility has a working relationship with a local community college, hosting 16-20 nursing student rotations. This collaboration not only supports student training but also serves as an effective recruitment opportunity for the agency.
- The off-site consults process is efficient, with most consults scheduled within 30 days of TLC approval.
- The complexity and acuity of the AICs have increased substantially, even relative to other prisons in Oregon.
- The MSM wears multiple hats, deeply blending clinical and administrative functions, and does not have adequate administrative support.
- Medical provider staffing is strained, with only 1.0 FTE of the 2.0 allocated positions currently filled (additional support is provided by 2.0 FTE contract NPs).
- Collection of CQI data is challenging due to delays in chart review and provider backlogs.
- Morning MOUD distribution lines now extend to approximately 90 minutes.
- Concerns remain regarding the potential for misuse and diversion within the current MOUD program.

D. Eastern Oregon Correctional Institution

EOCI is a medium security prison originally built in 1912. According to the ODOC website, it was constructed as a state mental hospital and converted to a prison in 1983, capable of housing 1,682 AICs. The facility housed 1,308 AICs during the Falcon site visit, including Custody Levels 1-5.

Wall Mural 6. Eastern Oregon Correctional Institution – Close Observation

i. Environment of Care

EOCI reports the availability of a broad range of health services, which include primary care, chronic care, preventive services, urgent care, imaging, neurology, physical therapy, surgical consults, and lab work. Behavioral Health Services is available in general population housing, including outpatient mental health, and a residential mental health unit is on-site as well. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through late evening across units, including KOP meds and diabetic lines. Telehealth services include MOUD, infectious disease, dietary, mental health, and GNC.

The Falcon team visited the eight-bed infirmary area, the mental health unit, and a DSU, which also supports suicide watch, in addition to several other areas of the prison.

ii. NCCHC Summary

On August 10, 2023, the Accreditation and Standards Committee awarded accreditation to EOCI. The facility met full compliance with all 37 applicable essential standards and 89% of the applicable important standards. EOCI demonstrated improvements in CQI activities, with documented meeting minutes, study results, and an annual review submitted for verification. In clinical preventive services, the institution met requirements by providing a quality improvement study addressing periodic health assessments. For clinical performance enhancement, a detailed

2023 spreadsheet documented peer and supervisory reviews across all required clinical roles, confirming compliance. Improvements in chronic disease care were also evident, with submission of chronic care policies and guidelines outlining condition-specific follow-up frequencies and documentation standards.

iii. Observations

- EOCI originally opened in 1913 as a mental health institution and has significant limitations due to its age. Many areas, including the infirmary and medical clinic, are small, outdated, and not designed to meet current correctional healthcare needs.
- The small space dedicated to the medical clinic maintains only four offices shared by all medical providers, including optometry, resulting in scheduling conflicts and delays in care delivery that impact efficiency and healthcare services quality.
- The facility's aging infirmary presents infrastructure challenges that are likely to become more problematic in the future and require assessment.
- Parts of the DSU remain closed due to staffing shortages.
- Limited transportation resources and shared regional coordination with TRCI have created bottlenecks in specialty consults.
- EOCI's dedicated Correctional Counselor in the DSU increases access to care.
- Behavioral Health Services leadership at EOCI was highlighted throughout the study, particularly focused on clinical innovation and supporting staff development.
- Out-of-cell time is tracked for segregated AICs, and a trauma informed approach is being applied in high-custody areas.
- The dental clinic is well-equipped and staffed, with three chairs.
- The facility offers vocational and rehabilitative programming, covering such areas as electrical, sheet metal, plumbing, apprenticeships, a music and arts initiative, and the "JLAD program," where AICs train assistance dogs.
- EOCI is operating with a 25% vacancy in uniformed staff, limiting timely AICs movement and contributing to delays in access to on-site, off-site, and specialty healthcare services.
- Approximately 70 AICs are currently receiving MOUD, with an additional 150 in the referral process.
- Medication lines are lengthy and challenging to manage, particularly due to increased demand from the MOUD program. Limited staffing contributes to concerns about diversion. There is strong interest in long-acting injectable options.

E. Oregon State Correctional Institution

According to the ODOC website, OSCI is a medium security institution established by the Oregon Legislature in 1955. With a capacity of approximately 900 beds, the facility receives male AICs convicted of crimes across the state. At the time of the Falcon site visit, the facility housed 835 AICs.

i. Environment of Care

OSCI describes the provision of comprehensive health services, including primary care, chronic care, preventive services, imaging, neurology, urgent care, physical therapy, surgical, cardiology, infectious disease consults, and lab work. Behavioral Health Services is available in general population housing, including a mental health unit and a SUD treatment program run by a contractor with access to peer mentors. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through late evening across units, including KOP medications and MOUD. Automated medication dispensing machines will be arriving in the summer of 2025. Telehealth services include MOUD, infectious disease, dietician, mental health, and GNC. The facility does not have an infirmary and houses medical isolation and suicide watch in the DSU.

ii. NCCHC Summary

On April 28, 2024, OSCI was granted a decision of Provisional Accreditation, which requires the facility to address all areas of non-compliance before full accreditation is considered. On May 19, 2025, upon review of documentation submitted by OSCI, NCCHC granted full accreditation.

The report indicated that OSCI addressed prior delays in specialty consultations with corrective actions and supporting documentation. Pharmaceutical operations were improved through updated policies and staff training, addressing prior concerns about outdated nursing protocols related to medication dispensing. Improvements in the handling of non-emergency healthcare requests were also noted, ensuring timely, face-to-face clinical encounters within 24 hours and appropriate documentation. Continuity and coordination of care were also enhanced by implementing documentation practices that ensure treatment plans, test results, and follow-up instructions are consistently communicated to patients.

iii. Observations

- The institution operates as an off-site specialty care hub for other western institutions, resulting in an increased demand for staffing, transportation vehicles, and logistical infrastructure.
- The institution offers a 143-bed mental health unit, supported by correctional officers who are committed to working with individuals diagnosed with a mental illness.

- The current infrastructure in the segregation unit does not allow for shower access for individuals on suicide watch.
- The dog training program promotes a therapeutic and rehabilitative environment for participants.
- Scheduling dental care poses challenges for AICs in restrictive housing.
- OSCI collaborates with Corban University to offer college-level programming.

F. Oregon State Penitentiary

According to the ODOC website, OSP is the state's oldest prison. The construction of a permanent facility took place between 1871 and 1872. While the prison houses AICs classified at Custody Levels 1 through 5, it operates as Oregon's only maximum security prison. With a capacity of 2,100 beds, OSP also houses AICs sentenced to death. At the time of the Falcon site visit, the facility housed 1,600 AICs.

i. Environment of Care

OSP has the capacity to offer a wide spectrum of health-related services, including primary care, chronic care, preventive services, imaging, emergent/urgent care, physical therapy, electrolysis, infectious disease, ultrasound, X-rays, and surgical and neurology consults. Behavioral Health Services operates within a chronic disease model for SUD treatment with access to peer mentors, and outpatient services are available in general population housing. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through late evening across units, including KOP medication and diabetic lines. Telehealth services include infectious disease, GNC, Veterans Affairs, mental health, and medical transition nurse consultations.

In addition to outpatient Behavioral Health Services throughout general population, a mental health DTU offers an enhanced outpatient experience in a residential setting. The unit is located on the bottom tier of a regular housing unit, which creates challenges; AICs in general population describe experiencing disruptions due to occasional instability of the DTU patients, and staff in DTU describe feeling as though the patients are vulnerable in the general population setting.

OSP also has a continuum of care within Special Management Housing (SMH), which includes the mental health infirmary (MHI) for acute patients requiring the highest level of secure intervention as the least restrictive means of maintaining their safety and that of others. Located adjacent to the MHI, the BHU provides an alternative to segregation for individuals with serious mental illness, affording intensive treatment opportunities in a secure location. The SMH also includes intermediate care housing (ICH), a step-down residential unit with service dosage falling on a continuum between general population and MHI levels of care. While the goal of treatment is to establish symptom relief and stability such that the patient can move to general population,

many patients in ICH require that level of care at their baselines of functioning and will remain in that setting indefinitely.

ii. NCCHC Summary

On April 3-5, 2023, NCCHC conducted an on-site review for OSP as part of its accreditation cycle. A decision was made on June 23, 2023, to award OSP accreditation with verification. OSP fell short of the required 100% compliance on essential standards, achieving 86%, and did not meet the 85% compliance threshold for important standards, achieving 78%. As a result, a decision was made on June 23, 2023, to award OSP accreditation with verification. Subsequently, on December 8, 2023, NCCHC awarded OSP full accreditation.

Positive findings included timely access to care, thorough medication services, and well-managed pharmaceutical operations. OSP maintained clean and well-equipped clinical spaces, demonstrated effective emergency response protocols, and provided comprehensive patient education and suicide prevention services. Health staff received appropriate training, and correctional officers were adequately prepared to handle health-related situations. Transfer screenings, initial health assessments, and medical diet provisions were all well documented.

Additionally, OSP demonstrated compliance with administrative requirements, such as maintaining up-to-date policies and procedures, ensuring patient confidentiality, and providing on-site diagnostic services. Pharmacy inspections, chronic care follow-up, and coordination for specialty and hospital care were also noted as well-organized and compliant with NCCHC standards.

Key issues included the absence of a designated Responsible Health Authority overseeing all clinical disciplines, limited on-site presence and engagement from the responsible physician, and deficiencies in the facility's quality improvement program. Clinical preventive services were managed without a policy-based structure, and infection control efforts lacked a written exposure plan. Credentialing processes and performance clinical reviews were also identified for improvement, with incomplete documentation, lack of standardized tracking, and minimal leadership involvement in verifying provider qualifications. Inmate death reviews also revealed missing documentation for several cases.

iii. Observations

- The most significant challenge is the age of the facility and physical space, which impacts Medical Services, Behavioral Health Services, and all other operations. OSP is not ADA compliant.
- The infirmary is overcrowded, with equipment stored in open spaces due to a lack of storage.
- The medical clinic and infirmary are located on the third floor, resulting in accessibility challenges for those AICs with mobility limitations.

- There is no privacy for mental health assessments in the infirmary.
- Infirmary beds run at almost full capacity, mostly for long-term care.
- OSP does not have enough long-term medical housing.
- Dark, drab environments in the MHI and BHU are not conducive to recovery or trauma informed practices for the SMI population, but the interdisciplinary team has implemented an impressive program.
- There are no negative pressure rooms and an absence of plumbed-in oxygen for emergencies.
- Despite limitations, OSP maintains a clean environment, and created a beautiful "Healing Garden."
- A newly launched SUD program offers the opportunity to interact with peer mentors.

Art 1. Oregon State Penitentiary – Healing Garden

- The Falcon team observed a multi-disciplinary team meeting that fostered collaboration across disciplines, and the Oregon Way Resource team was outstanding.
- Although the Behavioral Health Services staff in the SMH areas impressed as competent and very committed to patient care, burnout in those environments is particularly common. Due to the presence of two different labor organizations within OSP, clinical staff cannot rotate between general population and SMH without losing seniority.
- The DTU is located on a unit with regular general population AICs, resulting in a mix of fairly acute psychiatric patients and those without psychiatric disorders. The team observed the vulnerable patients being targeted by regular general population patients, and the setting is not optimal for that purpose. Patients in DTU are also forced to walk to medication lines with general population, and the medication adherence rate is low for that reason, impacting treatment and

resulting in decompensation. It would be optimal to bring the medications to this population in DTU, and to have a dedicated unit with a day room specifically for DTU.

- There is an approximately 20% nursing vacancy with agency nurses being used for care coverage. There's a strong desire to reduce reliance on the agency to improve accountability and engagement.
- Scheduling dental care poses challenges for AICs in restrictive housing.

G. Powder River Correctional Facility

According to the ODOC website, since opening in November 1989, PRCF has provided transition and reentry services to AICs classified as minimum custody. PRCF offers a 128-bed treatment program and a new collaborative program, which includes treatment, education, and community-based work for successful community reintegration.

i. Environment of Care

PRCF described access to primary care, preventive services, urgent care, and optometry. Mental health services are available in general population housing, including a SUD Alternative Incarceration program run by a contractor. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through early evening across units, including MOUD lines.

The facility does not have an infirmary or residential mental health units and houses medical isolation and suicide watch in the DSU, when needed.

Wall Mural 7. Powder River Correctional Facility

ii. NCCHC Summary

In May 2023, NCCHC conducted an on-site review at PRCF as part of its continuing accreditation process. The facility was granted accreditation with verification. The follow-up report, issued in November 2023, confirmed that PRCF met 100% of applicable essential standards and 89% of important standards.

PRCF demonstrated improvements in non-emergency healthcare requests, training correctional staff (specifically dental emergency content), chronic care protocol updates, and ensuring responsible physician oversight. Despite progress, a few important standards remained only partially compliant. The clinic was flagged for issues related to storage and medication cart maintenance, with reports of loose pills and expired medical supplies. Moreover, while the institution responded to most corrective actions, it did not submit documentation for every partially compliant important standard, such as informed refusal protocols lacking a second staff witness signature. PRCF remains accredited, with the November report confirming the verification of improvements and suggesting ongoing internal monitoring to maintain and build on this success.

iii. Observations

- The MSM at PRCF is clearly part of the leadership team, exemplifying the role of the Responsible Health Authority as an executive and responsible for all healthcare.
- There is limited clinical physical space, consisting of two exam rooms, and no room for Behavioral Health Services or to accommodate telehealth demands.
- The dental clinic is well-kept, featuring positive visual wall murals.
- After a 12-hour nursing shift, PRCF relies on on-call nursing coverage.
- The residential SUD program offers intensive group sessions but would benefit from dedicated group therapy rooms.
- Challenges remain with medication lines scheduling, such as instances where insulin is administered before meals.
- There is well-coordinated off-site care with no backlogs.
- Specialty clinics and long-term care are managed at Snake River.
- There has been no Chief Medical Officer presence on-site for some time.

H. Santiam Correctional Institution

SCI was constructed in 1946, initially functioning as a satellite to the Oregon State Hospital for individuals with mental health needs. In 1977, the mission changed to serving AICs for pre-release needs and assisting with overcrowding at OSP, OSCI and Oregon Women's Correctional

Center. In 1990, it became SCI. At the time of the Falcon site visit, the facility held approximately 350 AICs classified as minimum security, with a typical length of stay of less than 160 days.

i. Environment of Care

SCI indicated it offers comprehensive health care services, including primary care, chronic care, preventive services, imaging, urgent care, Veteran appointments, physical therapy, and on-site consults for several specialties. Part-time Behavioral Health Services are available in general population housing. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through evening hours across units, including KOP meds and MOUD lines. The facility does not operate an infirmary nor residential mental health units.

ii. NCCHC Summary

The initial NCCHC survey conducted in February 2024 resulted in a preliminary accreditation status for SCI with verification. Corrective action items were identified as delayed specialty consults, inconsistent documentation of clinical performance reviews, and quality of CQI program. Nursing protocols were also noted as in need of correction, as were pharmacy inspections and staff meetings.

The facility progressed from a status of accreditation with verification to obtaining full accreditation, according to the report issued in February 2025. SCI addressed previously identified issues, including access to care, improved physician involvement, administrative and CQI meetings, staffing adequacy, clinical performance reviews, and pharmacy operations. Corrective actions included revising policies, enhancing documentation, improving multidisciplinary participation in meetings, and submitting verifiable data demonstrating compliance.

Despite improvements in healthcare practices, Nursing Assessments Protocols and Procedures remain in partial compliance. NCCHC recommends that SCI aligns nursing practices with accreditation standards, which is nearly complete at the time this report is being issued and is incorporated into the EHR.

iii. Observations

- Housing is open dormitory-style, suitable for minimum custody AICs.
- The facility relies on transfers for higher levels of medical and mental health care.
- Prior to COVID, there were significant incidents of overdose; improvements were seen with 100% mandatory searches. Strip searches have been done on all AIC workers returning from work, and this activity has led to a significant drop in Fentanyl overdoses.
- The facility has an opportunity to enhance access to care through expansion of telehealth capabilities.

- There is a lack of a standardized system for tracking and managing specialty care referrals, leading to inconsistencies.
- There has been a 15% increase in off-site referrals, reflecting the rise in acuity within the population.
- Dental services are limited to a single-chair clinic, which operates efficiently in a limited space.
- SCI's built environment supports its mission as a minimum security, work-focused facility.

I. Snake River Correctional Institution

SRCI opened in August 1991 as a multi-security facility. SRCI is the largest prison in Oregon with 2,336 medium security beds, 154 minimum security beds, and 510 beds for special housing (administrative segregation, disciplinary segregation, intensive management, and infirmary). The construction of this facility makes it the largest publicly funded state construction project in Oregon's history. Not far from SRCI, the Falcon team also visited the Ontario Pharmacy, which supports pharmacy distribution and logistics across ODOC sites.

i. Environment of Care

SRCI described a wide spectrum of on-site health-related services, including primary care, chronic care, preventive services, imaging, urgent care, physical therapy, electrolysis, optometry, and lab work. Behavioral Health Services operates within a chronic disease model for SUD treatment with access to peer mentors in SUD, and outpatient services are available in general population housing. Additionally, SRCI has a mental health unit and a DTU. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through late evening across units, including KOP meds. Pharmacy operations are currently piloting automated dispensing machines. Telehealth services include MOUD, infectious disease, dietary, GNC, veterans appointments, mental health, pulmonology, pain management, neurology and infectious disease consultations. The facility has a designated infirmary area with 16 beds with additional infirmary bed overflow that supports suicide watch. The DSU also houses AICs on suicide watch.

ii. NCCHC Summary

An NCCHC survey was conducted at SRCI in July 2022, as part of a routine accreditation cycle, which granted SRCI continuing accreditation with verification. The report issued in March 2023 noted that SRCI fell short of the required 100% compliance on essential standards and below 85% on applicable important standards. Areas of concern included the CQI program, clinical preventive services, medical surveillance of AICs workers, and clinical performance enhancement.

Corrective actions submitted in December 2022 confirmed substantial improvements. CQI meetings have resumed, with studies focusing on hepatitis C medication compliance. While progress has been made, further improvement is needed in the areas of documentation and follow-up. Preventive services and assessments were re-implemented following COVID-19 disruptions, and policy revisions were aligned with clinical guidelines. Additional recommendations were provided to enhance documentation for staff performance reviews, the mortality review process, and inter-departmental collaboration between custody and medical staff. As of the latest status, SRCI holds a continuing accreditation with verification.

iii. Observations from the Ontario Pharmacy

- Impressive operation analogous to well-run community-based pharmacies.
- Fully licensed dispensing pharmacy supports SRCI and other facilities on the east side of the state.
- The pharmacy manages all medications, durable medical equipment, and biomedical supplies.
- The pharmacy prefers owning over renting equipment for better control and cost-efficiency.
- Efficient logistics cover daily deliveries via DOC trucks, UPS, and USPS; next day and STAT orders are available.
- Specialty medications are sourced through a managed pharmacy network where there is strong coordination through TLC participation.
- Few grievances were reported.
- Durable medical equipment operations are coordinated by dedicated staff; manual inventory tracking systems use outdated technology, including no barcode functionality.
- Product recalls have required manual identification and resolution.

iv. Observations from SRCI

- SRCI benefits from a single-level design, making it more accessible for AICs with limited mobility and reducing the need for transfers based on physical limitations.
- The medical and infirmary spaces are spacious, well equipped, and contain necessary medical equipment, gas outlets, and hospice rooms with murals, creating a more humane and healing environment.
- SRCI developed an electronic system for communication among treatment teams and schedulers, connecting medical records, the TLC approval process, scheduled appointments, completion of specialty care visits, and follow-up, as needed.

- SRCI requests a case manager with clinical training who can fill the liaison function for the facility and track hospital patients and coordinate with providers.
- SRCI has developed an on-site orthopedic lab and capacity for sleep studies, reducing the need for off-site service referrals.
- Outdoor recreation spaces, murals, and nature videos in dayrooms contribute to a positive environment.
- Dedicated dental and outpatient clinic areas are functional, clean, and efficient.
- Pharmacy services are supported by an in-house automated dispensing system.
- There is a lack of long-term medical housing, and the former mental health infirmary remains unused, despite increasing clinical demands.
- Cell design limitations (lack of 110V outlets) restrict CPAP and similar equipment use. While retrofitting is underway, its capacity is limited.
- Off-site care visit coordination is challenging, but the new process is systematically improving completion of consults.
- Specialty care transportation is limited; expansion of medical transport capacity is key.
- Medication pass occurring on the mental health units would be preferred over combination of KOP and medication line models.

J. South Fork Forest Camp

SFFC, established in 1951, is a minimum security work camp. It operates as a satellite facility to CRCI. SFFC is managed jointly through an agreement with the Oregon Department of Forestry (ODF). AICs contribute up to 15 ODF crews and one crew contracted by the Oregon Parks and Recreation Department. In addition to these assignments, AICs also provide essential labor in SFFC's physical plant, kitchen, laundry, and boot room. The facility has a rated capacity of 200 beds; 119 AICs were on the count at the time of the Falcon visit.

i. Environment of Care

SFFC has access to primary care, preventive services, urgent and chronic care. Mental health services are not available. Dental services are provided at CRCI. Pharmacy operations are supported by KOP medications with no medication lines. Telehealth services are limited to the management of mental health crises and other urgent matters. The facility does not have infirmary or residential mental health units.

ii. NCCHC Summary

SFFC is not independently accredited by NCCHC.

iii. Observations

- The facility features a 50-bed open dormitory-style bunkhouse and cabins with 12 beds, offering communal, minimally secure housing suited to serve AICs with less than 48 months on their sentence.
- The camp's rural location presents significant challenges for emergency medical care, resulting in the use of flight transport for serious incidents and long travel distances (28 miles) to the nearest emergency department in Tillamook.
- Only KOP medications are allowed, and AICs must be relatively healthy to be classified to SFFC.
- The medical clinic is staffed only 2.5 days per week and a provider visits bi-weekly.
- MOUD is not available.
- Psychiatric emergencies are rare and managed through telehealth or transport to CRCI.
- There are two holding cells used for temporary placement (under 72 hours) but transfers generally occur within 24 hours.
- The physical terrain and fire-related duties require AICs to be in good physical health, limiting the population to those without cardiac, orthopedic, or other health-related conditions.

K. Two Rivers Correctional Institution

Construction of TRCI was completed in March 2000, with a capacity of 1,632 AICs. The facility also houses minimum custody work crews in a collocated minimum security facility, sending work crews to provide support to the community and prison grounds. At the time of Falcon's team site visits, 1,197 AICs were housed in general population, 222 in DSUs (statewide utilization), 20 in the administrative segregation unit (ASU), and 128 at Twin Rivers Correctional Minimum across the street.

Wall Mural 8. Two Rivers Correctional Institution

i. Environment of Care

TRCI has the capacity to offer comprehensive health-related services, including primary care, chronic care, preventive services, imaging, urgent care, physical therapy, optometry, dialysis, and a variety of specialty consults. Outpatient Behavioral Health Services is available in general population housing with access to peer mentors. Dental care includes screenings, preventative, restorative, and prosthetic services. Pharmacy operations support extensive medication line coverage from early morning through late evening across units, including KOP meds and diabetic lines. Telehealth services include MOUD, infectious disease, GNC, mental health, and pulmonology. The facility has a designated infirmary area with 16 beds and four exam rooms, along with a mental health unit. Individuals on close observation or suicide watch are housed in the infirmary or the DSU areas.

ii. NCCHC Summary

In October 2022, TRCI was granted a continuing accreditation decision, with verification, contingent upon receiving requested compliance verification. ODOC has requested, but has not yet received, the most recent update on the corrective action status. The facility demonstrated substantial compliance with most governance and administration standards. Intake processes were appropriately documented and included timely health assessments, while emergency services, infection control, and environmental health and safety protocols were also described as compliant.

The survey identified some areas requiring further attention. The report states that the CQI program did not fully meet standards due to insufficient documentation of quarterly meetings and clinical performance activities. Clinical preventive services also required corrective action according to NCCHC.

iii. Observations

- The medical clinic is busy with multiple services offered on-site, including X-ray (shared with EOCI), ultrasound, and orthopedic consults.
- Dental is fully staffed with three chairs and no backlogs.
- A pharmacy technician manages a small medication room with some space limitations.
- TRCI has a dedicated space for long-term medical housing, including a hospice bed, but increasing demand and space constraints have occasionally led to medical beds being absorbed into behavioral health housing.
- The dialysis suite is modern and well-equipped, with adjacent water room.
- The mental health unit serves a high-acuity population, including AICs with neurocognitive and behavioral health needs.
- Behavioral Health Services impressed as particularly engaged and competent, with strong knowledge of best practices and clear commitment to the mission of patient care.
- The facility also houses a large number of AICs needing ADL support.
- TRCI's single-level layout is advantageous for accommodating elderly AICs and those with mobility issues. It serves as a regional hub for high-acuity AICs, including those on dialysis or with complex medical needs.
- The minimum security unit (120 beds) provides basic health services, such as vital signs and medication line access, but lacks a behavioral health presence.
- There was no backup wheelchair van for extended periods, disrupting off-site access.
- Increased medical and mental health needs have outpaced infrastructure, especially under the MOUD program and during provider shortages.

L. NCCHC Statewide Observations

Recent NCCHC accreditation surveys across ODOC facilities revealed significant progress in response to corrective action, as well as some ongoing challenges meeting national correctional healthcare standards. DRCI, EOCI, OSCI, OSP, and SCI obtained or regained full accreditation following targeted corrective actions that addressed deficiencies in medical autonomy, quality improvement processes, access to care, and inter-departmental coordination. Notable strengths across institutions included improved chronic disease management, enhanced documentation practices, reliable pharmacy operations, timely emergency response protocols, and increased provider involvement in administrative oversight. These facilities implemented the necessary

steps to improve the timeliness of non-emergency healthcare requests, ensure continuity of care, and improve staff training and credentialing procedures.

However, common areas of concern were identified statewide, particularly regarding nursing assessment protocols, which remained in partial compliance at DRCI, EOCI, OSCI, and SCI. Issues included the nursing staff's use of prescription medications without proper provider oversight, annual competency evaluations, and the absence of updated protocols in line with state nursing regulations. Nursing protocols have been updated in recent months and are deploying to facilities imminently; those updated protocols have also been incorporated into the EHR to institutionalize that process improvement.

Other issues across the state included inconsistent or absent CQI activities, delayed specialty referrals, insufficient physician oversight, and lapses in clinical performance review documentation. Facilities such as CCCF and SRCI, while demonstrating strengths in areas like suicide prevention and infection control, continue to face challenges in staffing, interdisciplinary coordination, and segregation monitoring. Some facilities also showed gaps in clinical preventive services, requiring continued efforts to ensure full compliance.

Overall, while the accreditation process has driven improvements across ODOC's institutions, the findings underscore a critical need for investment in healthcare infrastructure, workforce development, and standardized practices. NCCHC recommendations point to the importance of consistent CQI implementation, aligned nursing practices, and enhanced interdisciplinary governance to support safe, effective, and constitutionally adequate care delivery within ODOC correctional settings.

NCCHC reports tell a critical story for the agency, highlighting areas of strength, improvement, and ongoing challenges. Most importantly, the presence of NCCHC in Oregon's prisons cannot be overstated. The process of accreditation has clearly led to performance improvement and improved access to care. In each instance where NCCHC identified an area in need of improvement, ODOC has clearly taken steps to remedy the identified issues and improve the healthcare system as a result.

Section 7

Key Findings and Observations

SECTION 7: KEY FINDINGS AND OBSERVATIONS

1. The combination of an NCCHC-accredited system, an energized workforce, authentic commitment from ODOC leadership, and the alignment among so many stakeholders should inspire optimism among those who wish to see improvements in healthcare within Oregon's prisons.

2. The director of the ODOC and his leadership team are authentically committed to studying and improving the healthcare delivery system. Throughout the course of this assessment, ODOC leadership impressed as eager to understand issues around access to care for AICs, the experience of delivering care inside Oregon's prisons, and solutions to improve ODOC healthcare.

3. The Health Services workforce is particularly energized and eager to support improvements in care delivery. Administrators, physicians, nurses, clinicians, office specialists, and many other professionals engaged with the Falcon team to share their concerns and ideas, and most volunteered to provide further support going forward. In every facility and administrative office, the Falcon team found peers and colleagues who were passionate, qualified, and eager to create a system that functions more effectively.

4. Despite this level of enthusiasm and engagement, staffing shortages and high levels of burnout are significant challenges to developing a healthier model of care delivery.

5. The landscape of organized labor in ODOC is uniquely complicated in the experience of the Falcon team. This team has worked in many states where unions play important roles. In Oregon, however, the combination of multiple unions, representing members in different facilities or even areas within the same prison, make implementing changes particularly challenging. Organized labor must be included in change management and implementation of any recommendations going forward.

6. The whistleblower and fact-finding investigation initiated by Director Reese using an outside consulting firm appears to have boosted staff morale and optimism for many Health Services staff, while also creating some uncertainty about the future leadership within the division.

7. There is a sense of optimism among stakeholders around this healthcare assessment and the recent changes in clinical and administrative leadership within Health Services, resulting in a renewed commitment to improving the care delivery system.

8. Stakeholders from outside of the agency were highly aligned with stakeholders from inside ODOC. Groups like HEAL-R at OHSU and Oregon CURE were particularly collaborative and took the opportunity to offer support and access to resources like physicians, mental health professionals, case workers, and families of incarcerated individuals. Both organizations were outstanding partners in this assessment.

9. Staffing concerns permeated the study, with a focus on the number of staff available, the type and mix of staff, staff supervisory roles, and the transient nature of contracted and agency staff.

10. The organization of administration and clinical leadership across the state has led to blended clinical and administrative roles, overwhelmed administrators and managers, diluted medical autonomy, fragmentation of disciplines within Health Services, and disillusionment between facility-based personnel and statewide leadership.

11. Like many prison systems and governmental institutions, the COVID-19 pandemic decimated operations, reduced programming and services, and has had a long-term impact on the ability to staff and operate facilities safely.

12. Specialty care and OOF consults were consistently identified by all stakeholders as the most urgent clinical area in need of immediate attention, and efforts over the previous six months have proven effective at addressing the systemic issues.

13. The lack of a systemwide CQI program is glaring and has led to care that is fragmented, disorganized, and inefficient, despite a workforce that is highly professional and deeply committed to the health and wellness of AICs. According to Health Services leaders, until 2020 and pandemic-related budget cuts, there was a systemwide CQI program staffed by at least two clinical professionals. However, those positions were cut and have not been replaced.

14. In general, the prison facilities were exceptionally clean and well-kept. The murals painted by AICs throughout the state were impressive and create a pleasant atmosphere for all. While to many this may seem superficial, in the experience of this team it is a proxy for many other operational issues and should be celebrated.

15. Paper health records are affecting the safety and quality of AICs healthcare, resulting in extreme inefficiencies, wasted time finding and reviewing charts, and ubiquitous frustration among staff. Any risk associated with converting to the EHR is dwarfed by the risks presented by the current health record system.

16. Across all prisons, clinicians and administrators are eager to convert from paper records to an EHR. It is critically important for scheduling, documenting, communicating between providers, establishing complete workflows, and collecting utilization data. These functions are desperately needed and will improve the quality of the data framework, care documentation, and ultimately access to care for AICs. Although not a panacea, the impact of the EHR in this system, at this time, cannot be overstated. At the time this report was issued, super-user training was under way and the implementation plan had been deployed.

17. Although the population of AICs is getting smaller, the population is aging, becoming more acute, and growing more clinically complex. Prison closures result in greater concentrations of complex patients in a smaller number of facilities, creating increased treatment needs throughout the system.

18. In the AICs population, 76.7% of all AICs are prescribed medication by a provider. Some are prescribed one medication, but the average patient is prescribed six medications, with 41.8% of patients prescribed seven or more, implicating the need for routine systemwide CQI studies of polypharmacy. At the time of this report, Pharmacy Operations was working to develop a cadre of clinical pharmacists to deploy into institutions with this mission.

19. Given the acuity of the population, too many people are moving through intake without complete healthcare assessments, including History and Physicals (H&P), laboratory studies, mental health assessments, etc. This leads to subsequent challenges with intra-system transfer, continuity of care, treatment delays, and misalignment between the patient's needs and the capabilities of the receiving facility.

20. Indicators like emergency department trips, inpatient hospital utilization, OOF consults, and prescribing practices observed during this study are indicative of a reactive system of care, without basic systemwide CQI surveillance processes and controls. Healthcare providers are likely scrambling to provide as much care as possible but in a fashion that is disorganized and highly inefficient. With a more organized and planful approach, supported by a strong systemwide CQI program, use of these indicators and the expenses associated with them should all be expected to drop precipitously as care is delivered more effectively and efficiently.

21. While metrics like off-site utilization are important for surveillance and cost containment, care decisions should not be driven by these factors. AICs have a right to care that is ordered, provided in a reasonable timeframe, and of a quality that approximates that would be available in the community. If a provider places

an order, whether for medication or a 911 emergency department trip, the AIC has a right to that care, and the provider must expect that care will be delivered as ordered. This is an entirely clinical process, requiring medical autonomy, and only licensed and appropriately credentialed clinicians should oversee clinical directives.

22. OOF specialty care consults represent the greatest area of concern, requiring intensive attention and resources to address the backlog and to improve the underlying process, so those services are accessed more efficiently going forward. The recent changes to the TLC process have resulted in increased efficiency. Pre-authorization, allowing facility-based providers to approve consults, using designees when the Chief of Medicine cannot be present, significant changes to tracking and case management, and unique facility-specific ingenuity have resulted in more expedient approval and scheduling, although a bottleneck now exists in scheduling and transportation for OOF consults.

23. During the course of this study, ODOC shifted responsibility for the OOF consults to an experienced clinician-administrator who now oversees scheduling and case management and can triage cases more effectively. However, these duties are in addition to many other important responsibilities and additional capacity is needed.

24. There are barriers to community-based specialists coming on-site to deliver care in the prisons, including malpractice insurance concerns, as well as technological barriers to expanding telehealth and asynchronous technologies, but these can be overcome to reduce reliance on OOF consults, and the new Chief of Medicine is actively addressing these issues.

25. Most recently, healthcare leadership has taken steps to optimize the use of medical transport by ensuring capacity is utilized efficiently. This adjustment has improved coordination and helped maximize access to off-site medical appointments, and the results are promising.

26. With inefficient hospital utilization, far too many correctional officers are required off-site during a national correctional staffing crisis. Without stronger utilization management and systemwide CQI processes, these inefficiencies are very difficult to improve and should be the focus of CQI study.

27. By far, OSP and SRCI are the greatest utilizers of inpatient hospital services. These are the two largest institutions in the state and house the highest levels of security, presenting unique challenges to movement outside the facility. Not only

is the volume of all service utilization expected to be greater than other institutions, the risk level of AICs using those services is also greater.

28. Caseloads and patient ratios are inconsistent across the state, specifically highlighted in the behavioral health disciplines, with outpatient and general population QMHP caseloads ranging from 45 to 125+ patients-per-clinician in various prisons, and similar variability among psychiatric providers.

29. With 85% of women and 65% of men identified as having mental health treatment needs, facilities should be operating under the assumption of clinical need. Women are a priority population. Between mental health, medical, and SUD treatment, CCCF could be conceptualized as a treatment facility.

30. The behavioral health needs of the AICs population are extensive, and the agency is struggling to meet the need for assessment of SUDs specifically, but treatment capability appears to be expanding to meet the growing need. Over the course of this study, the number of AICs prescribed MOUD grew by more than 30%, for example.

31. Even when an AIC is assessed and identified as having an OUD, delays can persist due to the need for a referral from mental health to Medical Services for MOUD prescribing. The lack of integrated coordination between departments often results in treatment delays, even after a diagnosis is made.

32. Understanding the clinical needs of AICs is critical to systemwide CQI processes, and a strong data framework is the foundation. Data sets managed by ODOC's research department were well-organized and useful, including information on demographics as well as identified needs at various levels of severity for Behavioral Health Services. Representatives were able to quickly provide useable raw data, which made baseline assessment smooth and efficient.

33. Data collected by Pharmacy Services is excellent and easy to use in various studies. The raw data is standardized, organized, and able to be analyzed quickly to observe prescribing practices statewide by facility and providers, as well as to track expenditures on pharmaceuticals.

34. Data collected and reported by Behavioral Health Services is also very good, specifically using a standardized mental health classification system with MH Codes and LOF to represent complex patient assessments with simple coding systems. Similarly, SUD treatment has clearly been expanding quickly across the state. Simple data on the numbers of AICs served in these programs is very helpful and contributes to the narrative of expanding capacity.

35. Clinical data from medical, behavioral health, dental, pharmacy, and ancillary care are not collected, organized, or stored in any central repository, making routine CQI studies nearly impossible in the current state.

36. There is no standardized HSR or equivalent that tabulates indicators of routine healthcare need and utilization uniformly across institutions, in a way that can be rolled up into an aggregated format for analysis, reporting, and performance improvement.

37. There is currently no clinical data specific to the transgender and GNC population statewide or by facility, leaving this vulnerable and complex population unstudied. While transgender and GNC care actually appear to be very good, there is no tracking system to reflect that statement quantitatively.

38. The procedure for Health Services requests (i.e., medical "kytes") is not standardized across prisons, with facilities developing home-grown systems for triaging requests. In several prisons, Health Services requests were submitted on the same forms as other administrative requests, handed by the AIC to a correctional officer rather than placed in a locked box or handed to a nurse, thereby creating barriers to accessing care.

39. Facility-level, homegrown procedures are not incorporated into written orientation materials, directives, or guidelines. As a result, healthcare staff often rely on word-of-mouth communication to learn operational procedures, leading to inconsistencies across facilities.

40. The grievance process does not seem to prioritize or adequately facilitate healthcare responses. There is no standardized informal resolution process, although AICs can use the "kyte" system for communicating concerns. Better training on how to respond informally to complaints using the "kyte" system, and doing so with improved staffing levels for nursing, would likely result in fewer formal grievances around healthcare issues.

41. Communication between Health Services and the AICs population was a common complaint, with AICs and staff alike requesting the ability to share updates, administrative responses, and even basic testing results. Many systems have found that tablet-based communications are particularly helpful to address administrative communications.

42. Investigations into allegations against employees take far longer than in many other prison systems, sometimes lasting years, at great expense to the agency, AICs, and taxpayers.

43. There are no standardized expectations for administrative meetings in facilities, intentionally bringing medical, behavioral health, dental, pharmacy, and custody leadership together to review challenging cases and collaborate on a shared mission and priority cases.

44. Behavioral Health Services, Dental Services, Pharmacy Services, and ancillary care are fragmented from Medical Services because of the administrative-organizational reporting structure within each prison and at the statewide leadership level.

45. In general, at the facility level, communication between Medical Services and Behavioral Health Services is insufficient, especially in complex cases like self-directed violence or hunger strikes and relies on informal channels of communication for coordination of care. Where communication is effective, this is due to informal relationships and the initiative of specific staff.

46. Chronic care follow-up appointments do not occur at standardized intervals, primarily due to scheduling difficulties, staffing shortages, and difficulty tracking patients in the existing system.

47. The healthcare system functions reactively rather than proactively, prioritizing triaged cases that require urgent attention, often to the detriment of preventative practices. Laboratory studies, like A1C or psychiatric medication monitoring, are often overdue, incomplete, or not reviewed. While the EHR will help with this issue tremendously, it is imperative that these workflow issues are addressed and incorporated into those permanent fixes.

48. Access to Health Services requests, especially in segregation and restrictive housing areas, is inconsistent across facilities.

49. Town hall meetings are seen as a best practice for improving communication and trust among AICs and staff. While this practice is a positive step and preferable to relying only on the “kyte” system, they could also serve as opportunities to respond to specific healthcare issues in real time.

50. The death review process has been inconsistent in the past, lacking follow-up, intervention, and process improvement. The psychological autopsies are often very well-done, but the observations and recommendations do not lead to action plans, accountability, or performance improvement. Death reviews afford a unique opportunity to assess access to care, system issues, and other critical components of performance improvement and should be prioritized in the future CQI program.

51. Dental services are outstanding, reflect the community standard of care, and dental health ought to be a point of pride within Health Services and ODOC.

52. Pharmacy operations are exemplary, with a well-organized, efficient, and professional model in place that reflects the community standard of care and one of the best operations this team has seen.

53. The introduction of a Clinical Pharmacy Manager and clinical pharmacists is a best practice and will help target polypharmacy, increasing the safety and efficacy of care and reducing costs significantly.

54. The MH Code and dynamic LOF system create a best practice classification model for caseload segmentation, resource allocation, access to care, and communication among professional disciplines.

55. The implementation of MOUD was done without additional resources, and the impact on Health Services and custody staff has been profound. Long medication lines, concerns about diversion, coordination complexities between medical and Behavioral Health Services, and backlogs of evaluations have contributed to frustration with the MOUD program. Staff are optimistic about the rollout of extended-release buprenorphine to combat some of these issues. Oregon is a leader in this area, and will offer extended-release buprenorphine in July 2025, as well as options for long-acting and oral naltrexone.

56. The current MOUD program faces challenges; patients are diagnosed with an OUD by QMHPs (behavioral health clinicians), while treatment decisions are made by medical providers. This separation can result in differing diagnostic impressions and a lack of alignment in treatment planning, while the actual screening, diagnosis, and treatment can be managed by a single discipline (i.e., medical and/or Behavioral Health Services).

57. With the exception of OSP, infirmaries across the state appeared to be adequate, but there are no designated step-down, skilled nursing or long-term medical housing areas to create continuums of care between general population and infirmary level services.

58. With few exceptions, there are significant limitations to the built environment impeding the ability to meet the growing needs of AICs patient population. Specifically, OSP's infirmary and SMH (mental health infirmary, BHU, and ICH) are particularly concerning, reflecting crumbling infrastructure and poor environments of care, which are unfortunately strategically located near concentrated resources in the greater Portland – Salem area.

59. Gaps in intermediate levels of medical housing result in a mismatch between patient needs and available medical resources, leading to inefficiencies in care delivery and potential overuse of higher acuity services allocated to infirmaries.

60. At some facilities, there exist communication challenges between QMHPs and psychiatric providers regarding diagnoses, patient presentations, and collaborative treatment approaches. In these facilities, the gaps were acknowledged and standardized processes for improved communication were requested. It was also clear that the EHR would greatly aid in improved collaboration.

61. Discharge planning and care coordination were consistently described as areas for improvement across the state.

62. Although appropriately credentialed for their positions as QMHAs and QMHPs, Behavioral Health Services clinicians without clinical licenses described needing to obtain clinical supervision outside of their workplaces and on their own time and at their expense to pursue advancement in their professions.

63. Peer reviews are completed inconsistently, but chart reviews are occurring regularly. There is an opportunity to combine these functions by reviewing the work of colleagues while conducting chart reviews. This is another area where the EHR should greatly assist the agency.

64. Nurses are being placed into patient care responsibilities “too quickly,” without standardized preceptorship or consistent training across facilities. Outdated protocols remain in use, and agency nurses often receive little to no orientation.

65. Medical providers described insufficient onboarding processes, with no standardized curriculum, poor continuity planning, and a “good luck” approach to beginning their roles.

66. Managers noted the absence of formal training, relying instead on trial-and-error learning; onboarding is overly focused on administrative tasks rather than supervisory or operational competencies.

67. There is a potential risk to dental care continuity, as several experienced DOC dentists are approaching retirement. Planning for succession and expanding support for oral surgeries services will be important to maintain the current scope and quality of care.

Section 8

Recommendations

SECTION 8: RECOMMENDATIONS

The following recommendations are the culmination of more than six months of assessment. They are offered as part of a systemwide CQI activity, intended to reflect the current state of healthcare delivery in Oregon's prisons, to improve the quality of care, and to improve the experience of delivering and receiving care for those who live and work within the correctional healthcare system.

These recommendations are submitted to ODOC for consideration in terms of feasibility, prioritization, and chronology, as some are massive undertakings, while others are more straightforward. Once the department has considered the recommendations, those selected for implementation must be incorporated into an implementation plan, to be developed and led by the Assistant Director of Health Services and Deputy Director as the Project Sponsors, and with the Director remaining the Executive Sponsor.

In developing the implementation plan, the following factors should be considered and incorporated into a comprehensive roadmap, supported and informed by experienced external subject matter experts:

- Level of expected impact for each recommendation
- Level of effort required to implement each recommendation
- Projected cost (FTE, training, materials, infrastructure) of each recommendation
- Level of risk associated with choosing not to implement each recommendation

While several of the following recommendations can be implemented quickly and with little or no additional cost, others will require substantial collaboration from stakeholders including members of the Legislative branch of government in Oregon. As an Executive branch agency, ODOC is limited in terms of its ability to allocate funding and resources beyond that which has been allocated in the current biennium. The Falcon team is optimistic that the existing collaborative relationship between branches of government can continue as an implementation plan is developed.

A. Commit to Implementation and Change Management.

The Falcon team found unprecedented levels of engagement among the workforce, with professionals eager to share their experiences, concerns, hopes, and ideas for performance improvement. AICs interviewed described precisely the same issues that staff reported, and outside agencies, advocacy groups, families, and other stakeholders shared similar observations. ODOC leaders have repeatedly stated publicly that the agency is invested in improving healthcare in its prisons. The opportunities for improvement are clear, but they require a vehicle for change. ODOC should not assume these recommendations can be incorporated into the existing infrastructure and workforce responsibilities.

1. Continue to publicly commit to improving healthcare for AICs, including consistently messaging to all stakeholders that the agency is moving in this direction and that health and wellness of those who live and work in Oregon's prisons will remain a priority for the agency.
2. The team recommends a **120-day planning period** after the new Assistant Director of Health Services begins. Some of these recommendations can be implemented immediately, within 3-12 months, while others will require longer implementation processes, contingent on collaboration between branches of government**.**
3. Prioritize recruitment, hiring, and orientation of a new Assistant Director of Health Services. The new Assistant Director must be prepared to implement sweeping change across the division, working closely with other ODOC divisions and various stakeholders to effect change. Qualified candidates will find this report and its recommendations to be helpful to orientation. The Assistant Director of Health Services should be the lead Project Sponsor for an implementation plan.
4. It is strongly recommended that the agency partner with external resources to implement these comprehensive recommendations. The agency does not possess the capacity to make these changes independently, and an implementation period of approximately three to four years is suggested.
5. The Falcon team recommends that the Assistant Director designate a strong clinician-administrator and project manager, at a minimum, to lead these efforts internally. It is further recommended that ODOC partner with external subject matter experts to provide guidance on expected practices as the agency moves through the required elements of the recommendations.
6. Celebrate this invigorated but exhausted workforce for the committed and resourceful group they are and frequently remind employees that, "we are all on this journey together."
7. It is recommended that the findings, observations, and recommendations in this report be incorporated into an agency-wide strategic planning process going forward.

B. Develop and deploy a plan for internal and external communication.

1. Communicating the agency's intention to implement change is a critical next step in the process. With such an invested workforce, the Falcon team recommends that internal communication be prioritized, sharing these findings and recommendations with Health Services staff through town halls meetings, workshops, or presentations. It is crucial that staff recognize that their

contributions to this assessment were extremely influential and that their concerns and ideas were incorporated into the report and implementation plan.

Staff deserve regular updates and the chance to remain engaged as implementation initiatives are rolled out. The Falcon team has witnessed how important it is to regularly share progress updates with AICs, their families, legislative partners, and taxpayers across the state. Creating SMART goals (Specific, Measurable, Achievable, Relevant, and Time-bound), tracking implementation through defined metrics.

2. Similarly, the agency should explore opportunities to improve communication between Health Services staff and AICs. With the proliferation of tablets inside prisons, opportunities and examples of communication modules are available across the country. Providing general updates to AICs is recommended, but the ability to provide administrative responses to AIC Communication Forms or even to communicate laboratory results or other routine follow-up information would be very helpful.

3. Share progress, whether through newsletters, internal briefings, or public website updates, to foster transparency and build trust. During the assessment period, the Deputy Director sent weekly updates to all Health Services staff. Survey results indicated an overwhelmingly positive response to this communication. These efforts not only sustain momentum, promote accountability, and ensure that both internal and external stakeholders remain informed and involved throughout the process but also reinforce the commitment to increase transparency and enhance systemwide accountability. Approximately 65% of those who responded to the staff survey agreed to be contacted for follow-up engagement. Keep them informed and ask for feedback.

4. Create more effective avenues for facility-based staff to communicate concerns to administrators. Whether through the Office of Corrections Ombudsman or through a Patient Advocacy office, those directly serving patients need an avenue to inform regional and statewide administrators when issues arise. This should be a lesson learned from the 2024 whistleblower investigation and should be prioritized.

5. It is recommended that external stakeholders be provided with education and increased transparency around ODOC operations, in general. One example of improved communication and transparency would be to establish a citizen's corrections academy, a concept growing in popularity across the country. Open to the public, these academies provide community members with a behind-the-scenes look at the operations of correctional facilities. Invite legislators, advocacy groups, elected officials, community-based providers, and other agencies to gain

firsthand knowledge of correctional system operations, promote education on the complexities, limitations, and needs of providing care in custody settings, and increase community engagement.

6. The 2022 Task Force on Healthcare for Adults In Custody recommended regular updates to the legislature on four items, some of which have made significant progress in the last three years. The legislature should receive updates on the EHR implementation progress, workforce development including enhanced recruiting efforts, technological expansion for access to care, and efforts to expand systemwide CQI practices. By the next legislative session, it is expected that each of these four areas will have substantial improvement to share.

C. Continue with improvements in the TLC Process and Specialty Care Consults.

The improvements in OOF consults since the start of this study have been truly remarkable. The new Chief of Medicine, the Deputy Director, statewide Medical Services leaders, and each of the facility-based teams should be applauded for their creativity and ingenuity in accomplishing these improvements. ODOC has made significant strides to improve access to specialty care, but the initiative must continue and even grow in order to meet the demand of the population in perpetuity.

1. It is recommended that Case Management and Care Coordination be prioritized for staffing allocations immediately. 4.0 FTE Case Managers/Care Coordinators should be allocated, with 2.0 FTE on the east side and 2.0 FTE on the west side of the state to establish and deploy standardized tracking and triage of cases.

2. The Falcon team recommends that Health Services address backlogs using temporary investments in providers (i.e., Advanced Practice Providers (APPs)) and allocate MD and DO resources to chart reviews, OOF reviews, telehealth, asynchronous technologies (i.e., eConsults), and other quality assurance and supervisory activities to increase efficiency and resource management.

3. The team also recommends that each prison develop a localized (i.e., facility-specific) roster of specialty care providers and services, to include and prioritize providers who are willing and able to come into the prison to provide on-site specialty care. Additionally, recommendations include optimizing the use of telehealth and asynchronous care providers, as well as off-site specialty care providers accessible to patients at specific prisons. This list of providers should be available statewide, and AICs may be transported to other facilities for OOF consults.

4. Recognizing the need to prioritize OOF consults and hospital escorts for a population that is aging and demonstrating a growing need for services that are unavailable inside the walls of Oregon's prisons, the Falcon team recommends that

ODOC develops a position for Medical Transport Officers. These officers, while fully trained in security protocols for OOF transport, are dedicated to medical transport and escort. Requiring specialized training to serve in these capacities, they can provide support and identify medical emergencies, in addition to providing for secure transport. Additional resources in the form of medical vans for transport are also required. The intention is to reduce or eliminate the occurrences of missed medical appointments because of unavailable transportation, and to increase the rate at which OOF consults are being accomplished.

5. Requests for non-formulary medications may be removed from the TLC process, documented with clinical justification and forwarded for approval on a routine basis, noting the rationale for non-formulary use. Utilization would be reviewed monthly at P&T Committee meetings. Trends can be measured and analyzed, and changes in policy and practice communicated to providers.

6. Ultimately, it is important to create and deploy a clear vision around patient-centered healthcare in the agency. The vision should include prioritizing continuity of care, including the use of medical holds for patients with pending consults and established care, a robust chronic care program, and ensuring all AICs are offered preventive care consistent with community standards. Additionally, it is necessary that medical holds are placed on incarcerated patients pending completion of scheduled specialty care consults approved by the TLC or authorized by the on-site healthcare providers. These holds should be managed by the Responsible Health Authority in the facility and monitored in conjunction with the individuals overseeing the tracking of specialty care consults, along with the facility superintendent or designee.

D. Continue to prioritize implementation of the EHR.

The EHR and the improvements to the TLC process that have resulted in increased access to specialty care are the two most important initiatives in the agency currently. The recent efforts by ODOC to improve in both areas need to be celebrated and supported. The implementation plan for the EHR is under way, with super-user training started and a planned rollout by the end of 2025. This systemwide improvement is critical and should remain a top priority for the department.

E. Enhance interdisciplinary communication through standardized administrative meetings and increased administrative support.

1. It is recommended that each facility establish a standing meeting to review the most complex clinical cases in the facility. Attendees must include the MSM (chair), the Behavioral Health Services Manager, and the Superintendent of the facility, at a minimum. These attendees should identify qualified designees if they cannot

attend, and other staff should be invited as appropriate to provide care coordination, clinical supervision, or to support information sharing. Documentation of the reviews should be placed in the health record and shared among the treatment team following the meeting.

In medium security institutions, this should occur at least weekly, but the meeting cadence should be set based on reviewing each patient on the list at least monthly. In larger institutions, or in institutions with particularly complex populations, it is not uncommon to see these special needs meetings occur twice or three times weekly.

2. It is recommended that Health Services reevaluate the use of administrative support for clinicians, managers, and administrators across the agency, and that administrative support professionals be further incorporated into the organizational structure to reduce the burden on those delivering, supervising, and managing care. Meeting agendas, minutes, and other administrative tasks are often performed by the MSM, Nurse Manager, Behavioral Health Services Manager, or other administrators. Similarly, providers and clinicians are spending too much time on administrative or clerical tasks currently, and incorporating administrative assistants like office specialists can relieve some of the burden from those responsible for providing and supervising clinical care.

F. Establish a Department of Innovation and CQI or expand and elevate the Clinical Education and Audits department.

1. The Falcon team recommends that ODOC creates a department within Health Services, with a suggested title of "Innovation and Continuous Quality Improvement," or that the functions of the Clinical Education and Audits department are expanded and elevated. Development of a systemwide CQI program has been recommended since at least 2022's Task Force report, and the absence of CQI remains glaring. CQI programs create routine healthcare delivery oversight and surveillance, resulting in early detection and intervention before crises emerge. In ODOC's system, a basic systemwide CQI program will have significant impact on access to care for AICs. Not only is the quality of healthcare expected to improve as a result, but the experience of delivering and receiving care will improve, and the costs of healthcare will be reduced.

   The core responsibilities of the department would be as follow:

   - Developing a full systemwide CQI program.
   - Overseeing regular audits and data surveillance.
   - Creating process and outcome studies as indicated.

- Identifying variances or indicators of under-performance.
- Developing performance improvement plans following studies.
- Ensuring accountability for performance improvement plan completion.
- Re-auditing to measure improvements.
- Tracking and ensuring death reviews and psychological autopsies are completed, and that the death of an AIC results in meaningful study and improvement of processes.
- Managing development, revision, and deployment of Health Services policies and procedures.
- Reviewing and revising new employee orientation, training, and compliance within Health Services.
- Developing discipline-specific training programs with manuals to support consistent initial training statewide.
- Ensuring facility-specific new employee orientation includes core competencies and site-specific procedures.
- Managing feedback loops from staff regarding patient safety, care quality, policy implementation, training needs, and general Health Services program governance.
- Aligning systemwide CQI priorities with ODOC strategic plan and accreditation standards.
- Utilizing dashboards or scorecards to track performance metrics and promote transparency.

The department would be responsible for routine audits, ad hoc studies, and the development of performance improvement recommendations, ensuring that all recommendations are completed within prescribed timeframes, documenting completion (i.e., sign-in sheets, training materials, etc.), and re-auditing to measure improvement.

The department would routinely conduct audits of policies and site-specific procedures on a regular calendar, using audit tools that are developed from policy documents. As policies are developed and revised, site-specific procedures direct the work of care delivery in clear and measurable ways. Staff are trained in site-specific procedures that reflect statewide policy, which is based on accreditation standards, OARs, agency mission and values, and ultimately the standard of care. If staff follow standards of professional practice and the policy requirements in

site-specific procedures, care delivery ought to reflect the quality of care as intended by the State of Oregon and as protected by the United States Constitution.

A strong systemwide CQI program can serve as the driving force behind ODOC's healthcare training and workforce development efforts. By taking the lead in assessing training needs, monitoring onboarding practices, and standardizing educational content across facilities, CQI can align staff development with specific roles, facility mission, and population needs. This includes identifying and addressing inconsistencies in orientation, outdated institutional materials, and the reliance on informal training methods. A CQI-led approach supports the development of structured, role-specific curricula and accountability measures that promote consistency, improve performance, and reduce variability in care delivery.

This approach fosters a learning environment grounded in best practices and continuous improvement. Improving training efforts is often perceived by staff as a clear sign of the agency's professional investment in their growth and success. When employees feel supported, it not only increases commitment to the job but also enhances morale, fosters trust in leadership, and contributes to the agency's retention efforts.[24]

Examples of priority audits based on facility studies and workshops with staff and AICs include the following:

a. Implementing a standardized triage protocol for all sick call reviews, incorporating symptoms, red flags, and urgent response triggers. Triage categories (routine, urgent, emergent) should be documented in the medical record.
b. Adopting a chronic care schedule based on evidence-based clinical guidelines.
c. Aligning medication renewal duration with scheduled chronic care visit intervals. For example, prescribing providers order 60 days' worth of medication for a 30-day follow-up and place orders for 120 days of medication for a 90-day follow-up.
d. Standardizing sick call access by requiring daily collection and triage of sick call slips in all housing units, including restrictive housing. Add sick call boxes to segregated units so AICs can place slips when out of cell. Establish

[24] For a sample CQI policy, see Appendix C: *Department of Corrections Health Services Division Policy – Continuous Quality Improvement Program (HS Policy: P-A-06)*.

nurse-led daily rounds to every AIC in segregation to proactively identify and respond to health concerns.

e. Holding meetings at least weekly in which medical, behavioral health, custody, and other healthcare staff are present. Prior to each meeting, review cases that will be discussed and ensure that the correct parties are present.

f. Integrating MOUD discharge planning into all release workflows.

g. Documenting all discharge planning in the EHR.

h. Creating a medication-specific sick call pathway within the standard sick call workflow, such as including a checkbox for "medication issue" on sick call forms.

i. Developing and implementing a standardized process for clinical and behavioral follow-up after the third consecutive missed or refused medication dose.

2. ODOC should prioritize at least 1.0 FTE Chief of Innovation and CQI and 2.0 FTE Regional CQI Coordinators to staff this new department, along with the requisite complement of administrative and office support. Prioritize filling existing Clinical Educator positions and incorporate Clinical Education and Audits into the new departmental structure and add these new positions. An additional 2.0 FTE of Clinical Educators is also recommended, along with office support for enrollment, tracking, graphic design, Artificial Intelligence creation, and administrative tasks.

   Regardless of whether an existing department is expanded or a new department is created, the department must be elevated to the HSAT. Given the importance of this department at this time, its leader should be meeting regularly with the Chief of Medicine, Assistant Director of Health Services, and the top clinician-administrators from Medical Services, Behavioral Health Services, Dental Services, and Pharmacy Services.

3. Rather than selecting KPMs that aim for cost containment alone, a good systemwide CQI program focuses on broad utilization of healthcare services, resulting quality of care, and the efficiency of service delivery (utilization management). Now is the time to establish a culture of CQI and to invest in quality assurance and performance improvement.

4. As Health Services develops its capabilities around data collection, storage, analysis, and reporting, it is also recommended that they work closely with the research office, and that the research office expand throughout all of the divisions within ODOC. While the CQI department within Health Services must have independence and focus squarely on Health Services data, they should be clearly

and regularly linked with the research department more broadly. This work should result in data dashboards that are publicly facing. Falcon has seen many versions, but Allegheny County, Pennsylvania is considered a best practice jurisdiction in the creation of dashboards and public-facing data.

5. The statewide CQI department should incorporate liaisons from each specialty, including medicine, nursing, behavioral health, pharmacy, dental, and administration, all communicating to the clinician-administrators leading the department.

6. The CQI department must also have liaison representation in each facility, coordinated by a Qualified Healthcare Professional (QHP) who collects data, conducts facility-specific audits, and provides support and tracking for implementing recommendations at the facility level. This function is often performed by a nurse with infection control, education, training, and other safety and quality functions.

7. Reliable data sets are critical, and accurate utilization reviews should be prioritized immediately, before interventions aimed at systemic improvement. ODOC should deploy resources needed to accurately and reliably establish baseline measurements of relevant Key Performance Indicators (KPIs) around access to care broadly, but specifically monitoring those KPIs that reflect potential delays in care. These KPIs would be captured in a standardized HSR and would begin with basic tallies of quantifiable services, expected timelines, and other clear compliance indicators. KPIs of measurable or quantifiable services, timelines, and compliance indicators will be facilitated by the implementation of the EHR, and the CQI team should be super-users of the new EHR reporting functions.

G. Create an interdisciplinary working group to support implementation, increase transparency, and enhance accountability.

Although the implementation of these recommendations must be led by Health Services, the changes will not be effective or sustainable without significant input and support from other divisions and partners. The Falcon team recommends that the working group include clinician-administrators from other agencies to inform evolutions in policy and practice.

1. The working group should be chaired by the Assistant Director of Health Services once that individual is oriented to the role.

2. Rather than relying exclusively on clinicians and administrators who work in ODOC facilities, it is recommended that the working group include community-based public health perspectives. This is not without precedent in Oregon, as the 2022 Joint Task Force on Corrections Medical Care Report on Access to Health Care Services for Oregon AIC was similarly developed. That Task Force was co-chaired

by the ODOC Assistant Director of Health Services and a physician from the community-based Clackamas Health Centers. This composition of expertise in public health and healthcare delivery in correctional settings can balance the realities of working in prison with the requirement to meet a community standard of healthcare for AICs.

3. Members of a working group must be champions for the cause, and potential conflicts of interest should be carefully considered. Across the nation, the Falcon team often sees members of similar groups who may appear to benefit from the department's failure, and who may work to undermine success that threatens their positions. When considering the membership of a working group, optimism and investment in the agency's success is critical.

H. Distinguish CCIC from CCCF to promote gender-responsive approaches and prioritize the intake process for all AICs.

The role of a reception and intake facility in a prison system is of critical importance, as is the role of a women's institution. As prior studies have shown, the competing interests of CCIC and CCCF result in a shifting of resources reactively, using a triaged approach to cover the facility with the greatest need on that day.

1. In a best practice model, the functions occurring at CCIC would be completed in a facility separate and distinct from CCCF. Given the current composition of the facility, Falcon recommends that CCIC be conceptualized separately from CCCF, and that it has a distinct complement of staffing and administration. While CCCF has received a great deal of attention from a gender-responsive perspective, CCIC is responsible for intake, health assessment, chronic care enrollment, treatment planning, and preparing AICs for incarceration in Oregon. This role is paramount in a prison system.

2. It is recommended that a new position be created to contact county jails, especially on busy intake days at CCIC, to request clinical documentation that was not transported with the AIC. This individual would document compliance by various counties and when necessary, escalate concerns to management for resolution between ODOC and the county.

3. In terms of process flows, it is recommended that a provider be present in I&R such that each AIC is seen for a receiving screening and then seen by the provider for a H&P before placement in housing. This workflow ensures that the AIC has comprehensive screening, full initial physical exam, receives new orders for treatment and medication, and may even complete the first chronic care visit prior to placement on the intake housing unit. It is likely that this recommendation would require additional provider time, specifically on [redacted]

and if documentation from the county jail is insufficient or medication lists are incomplete, the initial physical and chronic care appointments may not be appropriate. The agency should study this possibility and endeavor to complete physicals prior to placement in housing, when practical.

4. The use of the PAI should be re-evaluated. The current process results in threats to validity and little utility to the clinical process of Behavioral Health Services assessment. Despite the test manufacturer's requirements, administration is not supervised or administered by a qualified professional, and requiring AICs to complete a 344-item self-report measure under these conditions is of little value to clinical or risk assessment. It is recommended that this step in the classification process be abandoned or modified significantly. The psychology department at CCIC is well-qualified to conduct psychological assessments, including the use of the PAI, but they currently have no role in that process. When indicated, referrals can be made for assessments by psychologists. Alternatively, the entire process of procuring, administering, and interpreting the results of the PAI must fall under the purview of an individual who meets the required qualifications policy.

5. In addition to distinguishing between the missions, staffing allocations, and administration of services at CCIC and CCCF, the treatment needs are so great at this combined site that economies of scale exist, and efficiencies can be maximized. Based on utilization among the population, site visits, and workshops with clinical leaders, the team recommends an additional pharmacy to be added to the system to service CCIC and CCCF. This is one way that AICs can move more efficiently through the intake process and improve quality and timeliness of care.

6. Similarly, the Falcon team recommends that, except in exigent and documented circumstances, AICs complete the full complement of healthcare assessments and treatment planning at CCIC before moving to subsequent facilities. If laboratory or imaging studies are ordered, results must be received and reviewed prior to transfer to the next facility. It is also recommended that AICs receive their first chronic care visit while at CCIC if enrolled in a chronic care clinic. The EHR will likely make these efficiencies possible through efficient scheduling, enrollment in clinics, and improved workflows and documentation.

7. Lastly, it is recommended that CCIC leaders intentionally improve coordination among all AICs awaiting classification and transport, sharing where each AIC is in the process of assessments by medical, dental, behavioral health, and classification. Maintaining a triaged log and communicating about the needs of each AIC, the team can prioritize the same AICs and coordinate resources for the more complex cases. This should be done through regularly scheduled meetings

among department leaders, to include medical, behavioral health, and facility leadership, at least weekly.

I. Conduct a comprehensive Health Services staffing analysis once the EHR is fully implemented, update the analysis regularly, and address immediate staffing needs at specific prisons.

It can be enticing to request additional staff as a panacea to systemic problems. In Falcon's experience, adding valuable resources to an inefficient system usually does not result in the intended improvements. Usually, as is the case in Oregon, some additional staff are needed to improve care delivery immediately even as the underlying systemic inefficiencies are improving. In the existing model Falcon assessed, there was an identified need for additional staff, and the team worked collaboratively with Health Services to define those priority staffing needs early in the study process.

The priority staffing needs were intended to immediately address the issues around the OOF consults, TLC process, and statewide support for quality improvement. Fiscal realities made implementation of all positions impossible, so Falcon also worked with ODOC to prioritize specific positions to maximize impact in the current authorizing environment.

1. While Falcon is reluctant to offer comprehensive staffing recommendations at the facility-level just months before the EHR is scheduled to roll out, there are priority facilities that require attention immediately. Specifically, DRCI's unique needs are presented in a subsequent recommendation, but the Falcon team recommends affording additional nursing staff at TRCI and OSCI, as well. Along with DRCI, these facilities have seen the greatest changes in population need, yet without commensurate resource allocation.

2. It is recommended that Health Services conduct a full staffing analysis 6-12 months after deploying the EHR and that it makes every effort to achieve those levels. Recruitment in rural areas can be challenging, even impossible in certain circumstances, and organized labor will also need to be included in the process. The team also recommends updating the analysis at regular intervals, not to exceed every two years.

   During the 2025 Regular Session of the Legislative Assembly, *Senate Bill (SB) 24* was proposed. *SB 24* focused on Health Services staffing. *SB 24* was extremely prescriptive in nature, requiring biennial staffing analyses and mandating provider and nursing coverage across various specific settings and at levels the Falcon team has not seen proposed anywhere else. In the Falcon team's experience, the proposed ratios and requirements are unprecedented, although the spirit of the proposal is sound.

3. In the interim, strategies to attract and retain qualified staff should be implemented. The Falcon team recommends that partnerships continue to be established with universities, specifically those with nursing and behavioral health programs, where early career trainees and clinicians can gain valuable experience. By providing required clinical supervision, certain classes of clinicians can grow with the agency, earning full licensure, establishing careers in correctional healthcare, and becoming the future of the Health Services Division. Similarly, it is recommended that ODOC study community-based models of recruitment, retention, and advancement in large hospital systems in the region. Learning from other large healthcare systems, rather than solely focusing on correctional healthcare, is strongly recommended to enhance the workforce and professionalize healthcare delivery in correctional settings.

4. Providing routine continuing education is also important, specifically the continuing education that is required for maintaining licensure or certification. Healthcare systems often offer annual stipends for continuing education, which are offered to provider staff in ODOC. That support should be expanded for other job classes where licensure or certification is a requirement. This is recommended to compete with community-based healthcare systems who are offering these benefits. Health Services should also provide regular training to non-clinical staff, including schedulers, office assistants, and other administrative personnel who are hungry for job-specific knowledge. If computer-based continuing education is available through programs like UpToDate already, all Health Services staff should be informed and encouraged to participate in those educational curricula.

5. Lastly, it is recommended that facility-based administrators, including Superintendents, revisit the efficiencies of Health Services scheduling, to improve the quantity and quality of care that can be provided. This effort will require support from statewide leaders and other ODOC divisions, as Health Services must exercise their medical autonomy to reconsider how and when services are scheduled. In the words of one survey respondent, “We need more nurses and providers, but I also think if we focused on how we schedule and WHEN we schedule, that would make a huge difference.” These ideas were specifically offered in the context of improving staff wellness.

J. Reconsider the staffing levels and complements specifically at DRCI.

DRCI is designated as a minimum security facility, even though the institution itself was designed as a medium security facility. Whether due to population management and intentional placement at DRCI, or due to the environment cuing behavior at a facility intended for medium security AICs, the facility’s culture is far more challenging than its minimum security designation implies. Combined with its ADA accessible design (single-level) and central location to willing

community partners in Bend and Redmond, the facility has attracted a complex population of high-risk, high-need patients. The medical and behavioral health needs combined with the medium security feel of the institution warrant a unique approach to staffing and operations.

1. Because the facility feels like a medium security treatment facility, rather than a minimum security facility, it is recommended that the facility's designation and classification be reconsidered along with additional clinical and custodial resources.

2. Specifically, the planned infirmary opening at DRCI is collocated with the outpatient clinic, medication line, and healthcare provider offices. It is recommended that additional staff be allocated to both clinical and custody operations in that building. One officer should not be expected to attend the medication line, while stationed outside of the clinic area. During medication lines, the building should be conceptualized as having three posts, one at medication line, one in the clinic area, and one in the infirmary, staffed appropriately at each post.

K. Provide clinical supervision toward licensure for eligible QMHAs and QMHPs looking to advance in their professions.

All clinical staff require clinical supervision consistent with the requirements of the State of Oregon, and in addition to the required supervision of QMHPs and QMHAs, Health Services should endeavor to support clinicians seeking to obtain licensure when possible. Clinical supervision that helps unlicensed professionals, such as QMHAs or unlicensed QMHPs work toward full licensure when eligible, without bearing personal expenses, is strongly recommended. This will help in recruiting, retaining, and advancing clinical professionals in the organization, and creates the opportunity to create or restart practicum opportunities, internships, fellowships, and other trainee programs in partnership with local universities. This is also recommended as a best practice.

The team learned that there has been a workgroup convening around this issue, but that collective bargaining agreements preclude the supervisory relationship in some circumstances. This recommendation should be explored with the relevant union officials, and if unable to arrive at an agreement, it should be discussed and incorporated as a component of the next collective bargaining agreement process.

The team also learned that the statewide QMHP and QMHA credentialing process is centralized for all agencies in Oregon except the Department of Corrections. There is no reason why the Department of Corrections should be excluded from a centralized credentialing process that reflects the community standard of care. All QMHP and QMHA credentialing should fall under the same administrative body within the State of Oregon.

L. Prioritize hiring of psychologists to fill existing vacancies and expand access to doctoral-level assessment, treatment, supervision and consultation services.

Psychologists hold education and training in psychological assessment and diagnostics, brief and long-term psychotherapy, clinical supervision, and consultation, all critically important functions in a prison system. The Falcon team learned that there was historically a greater number of psychologists across the agency, and that there are currently frozen positions due to budget constraints. Additionally, a robust training program formerly existed for psychology trainees. The use of practicum students, interns, and post-doctoral fellows is an excellent opportunity to supplement the workforce with trainees and provide invaluable training experiences, all while working under the supervision of psychologists. Across the country, psychologists are often clinical directors in prison systems, leading Behavioral Health Services departments in facilities and serving as clinician-administrators. The agency should endeavor to fill the psychologist vacancies and expand the statewide footprint of psychologists if possible.

Additionally, the position of Clinical Director for Behavioral Health Services has been planned for some time. This position should be a psychologist or other licensed clinician who directs and supervises the clinical work of Behavioral Health Services, consults on challenging cases, and aids in CQI activities like mortality reviews and psychological autopsies.

M. Standardize outpatient caseloads for QMHPs, QMHAs, Psychiatrists, and Advanced Practice Providers (Nurse Practitioners, Physician Assistants, etc.).

Throughout the course of the study, and specifically while conducting site visits, the Falcon team observed significant variability across facilities in outpatient mental health caseloads. This was observed for QMHP caseloads and psychiatric provider caseloads. Workshops and meetings with providers, administrators, and AICs revealed barriers to accessing care as a result of ratios that were misaligned. While some of these observations were due to staffing shortages or vacancies, the Falcon team considered the full staffing complement when arriving at these recommendations.

While there is no patient-to-provider ratio that exists as a standard for healthcare settings, let alone correctional healthcare, caseload size is often a point of discussion in healthcare studies and settings. The Falcon team has studied this issue across the country, and at the request of Behavioral Health Services, offers the following recommendations for outpatient QMHP and psychiatric provider caseloads in Oregon.

- The current model of care delivery for psychiatric patients supports approximately **200 outpatients** for each psychiatric provider.
- The current model of care delivery for psychotherapy, counseling, and QMHP case management supports approximately **60 outpatients** for each QMHP.

When considering staffing requirements, not only by number of clinicians but by allocations per facility, these baseline numbers are recommended references, and staffing

allocations should be updated at least annually to reflect shifts in population demands across the state.

N. Revisit governing statutes, administrative rules, and policy structure to improve governance, oversight, direction, and accountability.

1. Oregon Revised Statutes.

   During stakeholder engagement, several collaborating partners advocated for legislative action on behalf of ODOC in general and ODOC healthcare specifically. In Oregon, the *Oregon Revised Statutes 179.040, 423.020, 423.030*, and *423.075* represent the extent of legislative directives regarding AICs healthcare. These statutes are notably sparse and basically state that ODOC shall provide healthcare for AICs. While it can be enticing to envision comprehensive guidance offered by the legislature, prescriptive laws almost always create unforeseen challenges in the experience of the Falcon team. In Oregon, striking a balance between legislative mandates and the realities of operating a prison system is foundational for improving AICs healthcare.

   Each step of the policymaking process should receive renewed attention, including Oregon Revised Statutes (ORS), OARs, and ODOC Policy documents. The Falcon team recommends that a basic revision to ORS be considered to increase the sustainability of recommended policy changes. During the 2025 Regular Session of the Legislative Assembly, *SB 293* was proposed, which concerns the healthcare of AICs. The Act proposed four provisions, stating that ODOC:

   - "Shall provide medical care to AIC for pre-existing conditions.
   - May not consider the remaining duration of incarceration for an AIC in determining medical care for the AIC.
   - Shall document in the medical file of an AIC the specific reasons for any denial or refusal of medical care.
   - Shall provide AIC access to, at a minimum, prescriptions listed on the formulary adopted by the Centers for Medicare and Medicaid Services in effect on June 1, 2025."

   While this proposed bill appears logical on its surface, each of the four provisions require significant clarification, and as it is written the bill would create more problems than it would solve. The Falcon team would not recommend supporting the bill as written.

   For example, *pre-existing conditions* need to be defined, along with a process for confirming the conditions exist, and a threshold for medical necessity. At no time did the Falcon team have the impression that a provider in ODOC would refuse to

treat a condition solely because its onset was prior to incarceration; just the opposite, the majority of chronic conditions are diagnosed at the AIC's first encounter. However, the vagueness in the language is a major limitation of the proposed bill.

Similarly, there are times when treating providers *must* consider the remaining duration of incarceration for an AIC in determining medical care. Referrals for major medical procedures like renal transplants, hip replacements, or operations requiring significant recovery time are best arranged in community settings. Again, the vagueness on the language is a major limitation of the bill as written.

With respect to tying ODOC's formulary to the Centers for Medicare and Medicaid Services, the Falcon team's impression of the formulary is that it is already fairly open and clearly dictated by governing documents and guidance that are not unlike those from the Centers for Medicare and Medicaid Services. However, as the 2022 Joint Task Force on Medical Care report articulated, costs associated with treatments reimbursed by Medicare and Medicaid are borne primarily by the federal government, and those same costs are precluded from third-party reimbursement due to the Medicaid Inmate Exclusion Policy (MIEP) found in the Social Security Act of 1965. Except in specific and relatively rare circumstances, such as through the use of 1115 Waiver programs in the 90 days prior to release from prison, the cost of these medications would be borne by the state, likely at astronomical expense.

Additionally, some of the medications that would be found on the formulary from the Centers for Medicare and Medicaid Services have high potential for diversion and misuse in a correctional setting. It has long been established that formularies in prison settings, where rates of substance use disorders are extremely high, must take this fact into consideration when constructing a formulary. Other considerations include those medications with intensive monitoring requirements, as well as the logistical ability to deliver some more complex medication regimens and the risk of heat sensitivity in correctional settings. The correctional psychiatrist, Dr. Kathy Burns,[25] wrote the following of these prescribing considerations:

> Factors requiring special consideration in correctional facilities include the very high prevalence rate of substance use disorders occurring in correctional populations, which dictates that formularies limit or exclude medications that have high abuse potential, and the environmental and other conditions (work details) that may exacerbate the already increased

[25] Burns, K. (2010). Pharmacotherapy in correctional settings. In C. Scott (Ed.), *Handbook of correctional mental health* (2nd Ed.) (pp. 321 – 344). American Psychiatric Publishing, Inc.

risk of malignant heat-related conditions occurring in persons taking some psychotropic medications.

Reflecting on the 2022 Task Force Report, the group concluded that the TLC process serves "a prioritization function, albeit one that is far more general than the Prioritized List [Centers for Medicare and Medicaid]," but the Task Force found "general alignment" between the TLC levels and examples, and the Prioritized List from the Oregon Health Plan.

Although *SB 293* is not the solution, the team recommends that ODOC work with the legislature to describe the limitations of the Act as proposed, and that the branches of government work collaboratively to capture the spirit of the Act and elevate the legislation's utility in a correctional setting.

2. Oregon Administrative Rules.

   The OARs are crafted by ODOC and reflect the agency's interpretation of the relevant ORS and how they plan to implement the law(s). The process of rulemaking, although criticized by some stakeholders as dictated by ODOC rather than a truly inclusive process, does invite comment and contribution, and it is transparent. In an effort to increase the likelihood of sustainable change, it is recommended that policy changes are reflected in OARs, and that ODOC undertake a comprehensive approach to reviewing and revising relevant OARs to reflect the spirit of the ORS and the intention to elevate healthcare delivery in ODOC facilities.

3. ODOC Health Services Policies.

   ODOC creates policies for Health Services and revises them annually. In the current model, Health Services policies are brief and somewhat vague. For each policy, there is a procedure applicable to all facilities statewide. Those procedures are more prescriptive, more similar to OARs specifically, and generally well-written and useful. It is recommended that the policy structure be revised to include the statewide procedure in the governing policy document. In this way, Health Services is directing patient care not only through a policy statement, but also through an expected procedure for how each facility should interpret and apply the policy.

   The team also recommends that Behavioral Health Services policies be elevated from "Clinical Practices" to Health Services policies. The Clinical Practices are well-written, clear, and generally reflect best practices in correctional healthcare. However, they are relegated to a position below policies for Medical Services. Clinical Practices should become policies, incorporated into the full Health Services table of contents in their own chapter. Although ODOC is only accredited using the *Standards for Health Services in Prisons (2018)* – and not also using the *Standards*

for Mental Health Services in Correctional Facilities (2015)[26] – many facilities and systems still incorporate the mental health standards into their policies to ensure fidelity to the model, even if not to pursue accreditation.

Lastly, it is recommended that the agency adopt a formal procedure for policy creation, review, and revision. The routine cycle of policy review and revision should be owned by the office responsible for innovation and CQI, with a calendar established, and a procedure for document management, subject matter expert input, dissemination, and training. The current process requires clinicians and administrators to complete policy review and revision in an ad hoc manner, in addition to the myriad other duties assigned to the same individuals.

Note: Beginning at the July 2025 Mental Health Conference in San Francisco, NCCHC will be previewing its updated *Standards for Health Services in Prisons (2026)* and *Standards for Mental Health Services in Correctional Facilities (2026).*

4. Site-Specific Procedures.

   With statewide policies now including general procedures, each facility is tasked with defining the means by which they carry out the policy in a specific facility. PRCF and OSP are going to implement policies differently. For example, OSP's infirmary operations will require a more detailed description of infirmary operations than PRCF, where no infirmary exists. However, PRCF must define how a patient accesses infirmary level care when it is indicated, including transfer to a different facility. Since each facility will implement policies differently, these detailed instructions serve as clear directives to staff. With strong site-specific procedures, staff can feel confident in their roles and responsibilities, knowing that if they are complying with those site-specific procedures, then they are compliant with the governing policy, NCCHC standards, the relevant OARs, and the ORS. Lack of direction and problems with role clarity were among the most common complaints the Falcon team heard, and revising the policy structure to be far more specific to a facility is strongly recommended.

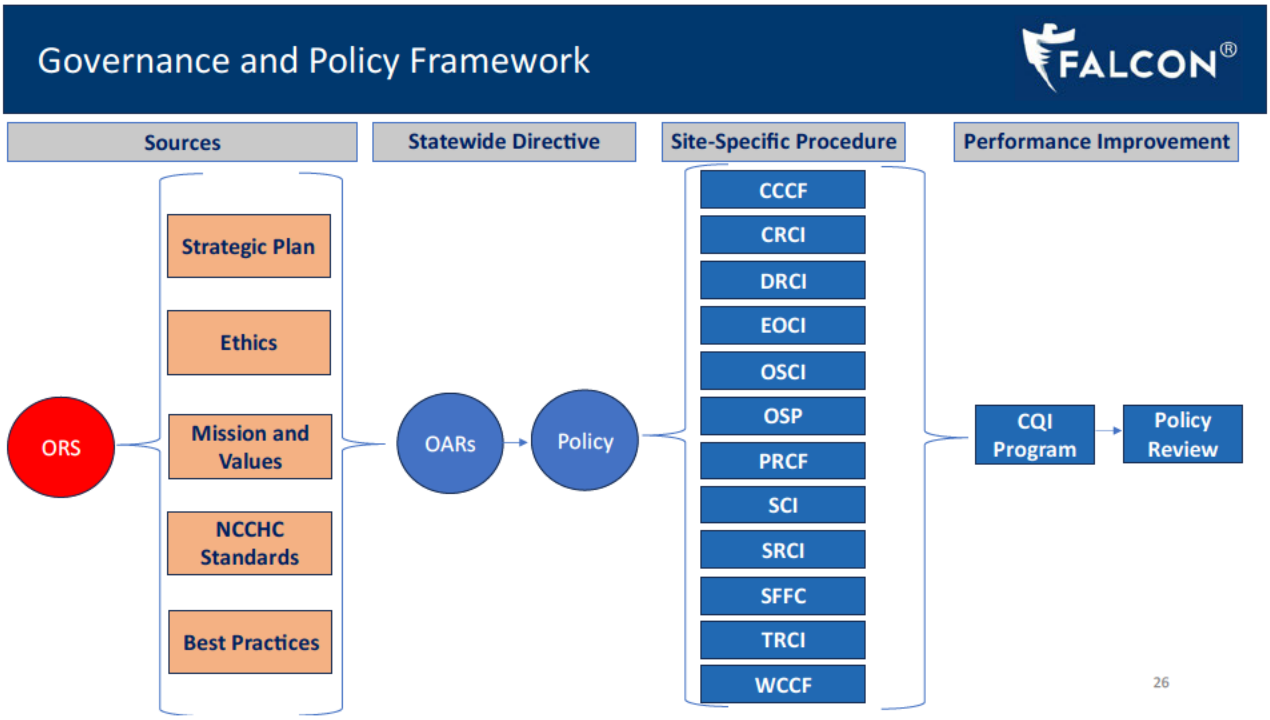
5. Compliance Auditing and Performance Improvement.

   Well-written site-specific procedures include measurable and quantifiable requirements, such as timelines, caseloads, staffing allocations, and other specific indicators that can be extracted to create audit tools. The CQI department would be tasked with creating regular audits of all essential and important site-specific procedures (in addition to other studies). The results of these audits would be

[26] It should be noted that the NCCHC accreditation standards used in Oregon are by far the most common NCCHC standards used for accreditation, and they include requirements for mental health services.

shared with facilities, discussed in terms of variances and trends, and when needed, performance improvement plans would be developed and supported with training, clinical supervision, and other resources aimed at quality improvement. Annually, policies would be reviewed in response to feedback from sites, updates to NCCHC standards, changes to OARs, etc., and each site-specific procedure would then be updated within a standard amount of time. Education and training then follow, so that all staff in all facilities are consistently practicing with the most up-to-date, site-specific procedures and directives.

Figure 33. Recommended Model for Governance and Policy Framework



O. Standardize AIC Communication Form (i.e., "kytes") and medical grievance procedures to distinguish Health Services requests from others and promote rapid informal resolution of grievances across all facilities.

1. The current AIC Communication Form is used for all formal communication between AICs and prison administration, including Health Services personnel. To improve efficiency, preserve confidentiality, and enhance accountability, it is recommended that Health Services requests be distinguished from AIC Communication Forms and processes standardized across prisons. Health Services requests should be delivered by the AIC to a Health Services professional, like a nurse, or placed by the AIC into a locked box on the housing unit. These requests do not require the involvement of non-Health Services staff, including Correctional Officers. A confidential process must exist, but AIC Communication Forms or any

written or verbal communication to any ODOC staff should also result in referrals to Health Services as if they were completed on dedicated Health Services request forms. While some prisons have developed these processes, others have not, and standardization and training should be incorporated statewide.

2. Grievances are a critical component of a correctional healthcare system. Each healthcare grievance tells a story, and aggregated healthcare grievances help a system identify trends. To the extent possible, grievances related to healthcare should be addressed informally and immediately, separated from grievances pertaining to any other topic. Many healthcare grievances include protected health information, and a trained clinician can respond and address the complaint quickly and without escalation, especially if alerted early. Informal grievance resolution reflects a rapid response, obviates the need for formal grievances, and ultimately provides better patient care while reducing risk to the agency. Currently, AICs can communicate to Health Services staff via AIC Communication Forms ("kytes"), and improvements in triaging those forms combined with increased staffing levels for nursing is likely to result in a reduction in healthcare-related grievances. To be clear, the formal grievance process must still exist and be accessible to all AICs.

3. It is also recommended that all clinical decisions become appealable, including those made by the TLC committee. The clinical leaders on the TLC are beholden to licensing laws and ethics codes, and they can reconsider their clinical opinions and document the decision-making process on appeal. In the current system, too many cases could have benefitted from reconsideration as a preventative or earlier intervention.

P. Invest in community partnerships with hospitals, healthcare clinics and providers to create a more effective continuum of care.

1. Secure Treatment Units.

   Some states have established partnerships with local hospital systems to lease units for AICs use. This model has many advantages, including centralizing patients in a single hospital unit, which can justify permanent posts for correctional officers rather than relying on overtime or transportation officers to cover hospital escorts. This effort results in efficiencies not only in planning for the posts, but also in the ability for a fewer number of officers to be responsible for a larger number of AICs in hospital settings.

   Patients can also be centralized in a way that consolidates care and costs to a single hospital unit, simplifying the network of community-based hospital providers and establishing a single relationship with a provider, rather than relying on an unpredictable network.

For Oregon, this model seems optimal, especially as an interim measure if a new facility is being contemplated. On the west side of the state, Salem Health is a natural partner, while on the east side of the state, Saint Alphonsus would be the recommended outreach. Hospital systems should see this as a natural partnership, a mission-driven initiative, and a responsible business model.

The first step in evaluating the feasibility of this model is to conduct a more granular CQI study of inpatient hospital utilization. The model requires the ability to collocate patients with various needs in a single unit, and utilization data from partner hospitals will serve as complementary data to better inform the clinical utility of the model while potential partnerships with hospital systems are simultaneously explored.

2. Establish a Neurocognitive Unit or SNF.

   In addition to establishing secure treatment units at OOF hospitals, the team recommends that ODOC strategically relocate health units from OSP. Given the aging infrastructure at OSP and the increasing complexity of health and behavioral health needs among the maximin custody population, ODOC should develop a strategic plan to relocate or replace key therapeutic units, including the infirmary, mental health infirmary, and BHU to facilities that can adequately support the clinical and environmental requirements. Currently, the location of the infirmary on the third floor presents ongoing accessibility challenges, specifically when the elevator system fails. Similarly, the MHI and BHU lack appropriate lighting, therapeutic design, and rehabilitative conditions essential for psychiatric stabilization and recovery.

   One potential site for some of these services would be the vacant infirmary space at SRCI. Although the decision was made to move what was the MHI away from SRCI due to staffing concerns, the space at SRCI is perfect to relocate some of these functions, especially for the higher custody levels at OSP who also require intensive medical or Behavioral Health Services. The aging population, individuals with SMI, or even additional infirmary patients would benefit greatly from the environment in that unit. The ability to staff the area should be reassessed as the agency looks to concentrate these populations on the eastern and western sides of the state, specifically moving them out of OSP where conditions are inadequate for patient care of this level.

3. Community Partnerships for Care Coordination and Discharge Planning.

   To improve discharge planning and care coordination for reentering AICs, it is recommended that ODOC considers partnerships with community-based healthcare clinics and providers. Especially in the western region of the state,

qualified groups appear to be looking to partner with ODOC to improve reentry and healthcare outcomes.

It is also recommended that delineation of responsibility for the patient be a critical part of the discussions, and that clear handoffs of patient care be established in advance and as part of the informed consent process with the patient.

Oregon was approved for a 1115 Medicaid Waiver in 2024, expanding opportunities to enhance continuity of care for reentering AICs, to establish patient-provider relationships up to 90 days prior to release, and to invite community-based partners into the treatment team to establish a strong discharge plan for reentering patients. Across the country, states have encountered significant administrative challenges to implementation and reimbursement, and the Falcon team understands that ODOC has opted out of the current plan for the 1115 Medicaid Waivers. Participation in the 1115 Medicaid Waiver program is not required for this recommendation to partner with community-based organizations, but it is one example of how these relationships can be facilitated.

The administrative complexities around 1115 Medicaid Waivers are common in states that were approved for the waivers. As a component of this recommendation, these complexities should be studied, and Medicaid eligibility should be optimized. Enrollment in Medicaid should be prioritized prior to release, and AICs reentering the community should have full access to eligible benefits immediately upon release and prior to their first community-based appointments. Any steps that can be taken to enhance benefit eligibility upon release and address gaps in care for individuals reentering the community should be maximized.

4. Study Feasibility of University-Based Model of Delivery.

   Although Oregon uses a self-operated model of healthcare delivery, the Falcon team has worked with states using privatized models, university hospital system models, and hybrid models. The Falcon team does not recommend exploring a privatized model in the current system. However, there are indications that a university hospital system model is worth exploring. The most well-known model across the country is found in Texas Department of Criminal Justice through partnerships with the University of Texas Medical Branch and Texas Tech University Health Sciences Center. Similarly, the New Jersey Department of Corrections operates its healthcare system through a partnership with Rutgers University. In both models, services within prisons are provided by employees of the state university system through legislative or contractual agreements. Employees of the state university system, affiliated with teaching hospitals, provide healthcare in the prisons. Off-site and specialty care is provided by community-based partners and

university resources through procurement mechanisms, contracting, utilizing the university hospital's existing network of care providers. In this model, the state DOC retains a systemwide CQI function, ensuring contract compliance and conducting studies while supporting the partners providing care.

5. Replace OSP with a purpose-built healthcare facility.

   The Falcon team has collectively visited hundreds or thousands of jails and prisons around the world. The current state of the built environment at OSP, and specifically the environment of care for those in the infirmary, DTU, ICH, MHI, and BHU are among the most challenging the team has encountered. The care that Health Services staff are providing in that setting is amazing to this team, given the setting in which it is being delivered. Falcon frequently works as subject matter experts with architecture and engineering firms in the planning, programming, and design of new correctional facilities. Since 2018, Falcon has consulted on more than 30 justice architecture projects. None of the existing facilities have been in the state of disrepair observed at OSP, and it is strongly recommended that ODOC continue moving forward with those efforts, while also improving their ability to deliver care in the interim.

6. Study existing built environments and explore opportunities for expanding environment of care.

   While OSP is by far the most challenging environment in which care must be provided, several other facilities are clearly experiencing space shortages due to the expanding need for access to care. During the assessment, suggestions from staff included conducting a survey at each facility to identify under-utilized areas that could be used for Health Services functions. Examples could include meeting rooms used as offices, converting single-occupancy offices into bullpen-style shared spaces, or using temporary structures like trailers or modular buildings to expand confidential treatment space. Additionally, it is recommended to consider staff wellness and respite when conducting the space surveys, prioritizing mental health and wellness by providing outdoor areas or designated spaces for staff to rest and recover from extremely stressful jobs. Examples of these low-cost solutions exist within correctional agencies in other states, such as the notion of "treatment trailers," and Falcon can connect ODOC with those agencies upon request.

7. Revisit legislation pertaining to expanded compassionate release or medical parole.

   Like many states, Oregon is realizing the financial and humanitarian burdens of long sentences and an aging population. The Falcon team has seen this issue

dominate healthcare discussions across the country. In addition to internal efforts to meet the needs of the aging population (i.e., ADA accessibility, skilled nursing units, partnerships with tertiary-care and teaching hospitals), a second and critical prong is legislative consideration for early release for low-risk and infirmed AICs. It is recommended that the Oregon legislature re-examine its position on compassionate release.

Q. Maintain NCCHC Accreditation and performance improvement.

NCCHC accreditation demonstrates a commitment to adequate healthcare delivery, and maintenance of each facility's accreditation status has been instrumental in creating the foundation on which to build an improved system. NCCHC's accreditation processes have resulted in consistent improvements across the system, as NCCHC has celebrated best practices while also holding ODOC accountable to improve in several areas. The Falcon team recommends that ODOC continues with NCCHC accreditation as a core component of the systemwide CQI program.

Beginning at the July Mental Health Conference, NCCHC will be previewing its updated *Standards for Health Services in Prisons (2026)* and *Standards for Mental Health Services in Correctional Facilities (2026).* It is recommended that ODOC obtain the new standards and house accreditation schedules and requirements in the Innovation and CQI department. It is also recommended that Behavioral Health Services incorporate and reference the new mental health standards, consider pursuing accreditation by NCCHC for mental health services, but at least incorporate references and aspire to meet those standards.

R. Improve access to care through proactive and less structured formats.

1. While the town hall meetings are a wonderful tool to communicate, they can also be used to resolve issues. For example, if AICs are complaining that they are not being seen by providers, have the providers attend the town hall meetings. The AICs can be seen right then and there. In addition, to open the lines of communication and trust, when the AIC is voicing concern, ODOC staff can take notes and then follow-up on issues that were not resolved during the meeting.

2. This same approach is represented in staff requests for "line-up, sign-up," or open clinic hours, where AICs can simply show up to a sick call just as one would go to an urgent care center in the community. Reducing or eliminating barriers to accessing care will result in initial spikes in service demand, but over time the demand will subside as AICs receive better care, more efficiently.

S. Prioritize confidentiality of patient contacts.

Not only do AICs have a right to care that is ordered and commensurate with the community standard, but they have a right to privacy when engaged in a clinical encounter. Except in exigent circumstances, confidentiality includes acoustic privacy from all other AICs and staff,

and visual privacy from all other AICs during the encounter. Except in exigent circumstances, such as with significant security risks, all encounters should be offered outside of the cell in a private space where patients can speak openly and engage with their clinicians without privacy concerns.

T. Move suicide watch and close observation out of segregation areas.

Across the country, there is a movement away from using segregated areas to house individuals on suicide watch or with other behavioral health statuses. These individuals present some of the highest risks for self- and other-directed violence due to SMI or psychiatric decompensation. The effects of isolation and progressive discipline on this population often exacerbate the risk for violence and, except in exigent circumstances with documented rationale, these individuals should be in the most therapeutic housing areas until the crisis resolves.

U. Consider revising the administrative-organizational structure to increase medical autonomy, distinguish between administrative and clinical roles, and integrate healthcare disciplines across the state.

The current organization of ODOC Health Services places extensive clinical and administrative responsibilities onto statewide leaders and facility leaders, alike. Medical, dental, pharmacy, behavioral health, and administrative leaders have too many responsibilities and are overwhelmed. There is not enough administrative support and administrative assistants, office specialists, and executive assistants can make a big difference. The vast number of responsibilities on the administrative team impede the ability to function as effective leaders at times, which is perceived by facility-based staff as dismissive or even toxic. At both the statewide and facility levels, Health Services should more clearly delineate roles to reduce the burden on staff and allow for a more relational approach to leadership.

The Assistant Director of Health Services is the Responsible Health Authority for ODOC, with all administrative decisions resting with the Responsible Health Authority. However, the Chief of Medicine is the Responsible Physician (RP) in this model, and all clinical decisions made throughout the agency ultimately rest with the RP. The two offices work together to accomplish the clinical and administrative healthcare functions of the agency. This partnership should be mirrored at the facility level, with the MSM serving as the Responsible Health Authority for the prison and the Chief Medical Officer serving as the RP. Administrative and clinical decisions can be escalated above the prison by appealing to the regional or statewide roles of Responsible Health Authority and RP, including specialists (i.e., psychiatry, pharmacy, etc.)

Strong healthcare systems integrate dimensions of health into unified teams of care providers. The current model leaves individual disciplines like Behavioral Health Services, dental, and pharmacy without adequate input or awareness within the facility and across the organization. One of the most important activities in prison healthcare is the interdisciplinary collaboration that occurs during administrative meetings. The agency should aim to bring all Health Services under one umbrella to support a holistic approach to integrated healthcare.

Assistant Director of Health Services

The future of Health Services will include new leadership, and this report is intended to provide the new Assistant Director with background information and guidance for quality improvement going forward. The new Assistant Director will have the opportunity to implement changes and build an improved Health Services Division. During this assessment, the Falcon team worked with ODOC to review and revise the Minimum Qualifications, Position Description, and Job Posting for the Assistant Director of Health Services. Specifically, the Falcon team recommended the following updated qualifications:

- Graduate degree (Masters or Doctoral level) in healthcare-related field, such as PhD, PsyD, MSN, DNP, MD, MA, or MS.
- Five years of executive-level leadership experience within a healthcare organization.
- Five years of experience working with correctional or forensic facilities or systems.
- Experience managing large multifaceted budgets.
- Experience managing departments or divisions with interdisciplinary personnel.

The following suggested preferences were also offered to ODOC for the Assistant Director of Health Services:

- License or license eligible as a clinical professional, such as a psychologist, NP, registered nurse, physician assistant or physician.
- Experience as senior level manager within correctional healthcare organizations.
- Involvement with professional organizations like the NCCHC and the ACA.

1. It is recommended that the organizational chart for the HSAT be reconsidered to include several important additions or changes:

    a. The Chief of Medicine should be clearly defined as the sole RP for the agency, with all clinical decisions resting ultimately with that office. Although the Assistant Director may supervise the Chief of Medicine administratively, there is no higher clinical authority than the RP.

    b. Clinical nursing functions should be separated from administrative functions from the top of the organization to clinical supervision of floor nurses.

    c. CQI and related functions should be elevated to the highest level of the HSAT, joining other clinical and administrative experts in decision-making and informing policy, training, and CQI trends.

2. It is recommended that each facility move toward a more inclusive model that integrates all Health Services under a single Responsible Health Authority for the facility or facilities. In Oregon, this title is the MSM, but in many places it is the Health Services Administrator (HSA). This person is an experienced administrator, not necessarily a clinician, although most strong HSAs have a clinical background. The HSA oversees all healthcare within the facility, not just Medical Services, and is the single point of contact for any inquiry. All administrative functions, including those associated with staff schedules, CQI audit cycles, mortality and morbidity reviews, vacation schedules, and any other Health Services activities in the facility or facilities, fall under the purview of the HSA.

   Across the country, the HSA is usually a nursing professional, often with a BSN or MSN degree and registered nurse license. However, the Falcon team has seen these roles filled impressively by individuals who are excellent healthcare administrators, but not necessarily clinicians, as well as examples of psychologists or other Behavioral Health Services clinician-administrators.

   In this model, the Behavioral Health Services Manager reports to the HSA for the facility or facilities, while receiving clinical supervision and discipline-specific support from the clinical chain of reporting to the Chief of Behavioral Health. The Behavioral Health Services Manager is responsible for coordinating all behavioral health activities within the facility or facilities and supervises one or more Clinical Supervisors. Behavioral Health Services Clinical Supervisors do not currently exist, but they play a critical role in the operations of an advanced system of Health Services. Clinical Supervisors are licensed QMHPs who usually carry a caseload but also provide clinical supervision to Behavioral Health Services clinical staff. Not only does this ensure a high level of Behavioral Health Services care, but it also ensures compliance with licensing laws and affords unlicensed staff the opportunity to work toward licensure in their respective fields. This creates a best practice model of Behavioral Health Services care, while also encouraging advancement within the profession and the agency.

   Like the Director of Nursing, the Charge Nurse is a new position to ODOC, currently the equivalent of a Lead Nurse, but with supervisory authority. In the current model, the Lead Nurse is still represented by organized labor, and as such cannot supervise other represented staff. The Charge Nurse is a direct service clinician who performs nursing functions but is the designated clinical lead for nursing on a shift and/or in an area (i.e., clinic,

infirmary, etc.). This clinical supervisor ensures that all clinical nursing functions are accomplished and reports to a Clinical Nurse Manager and HSA for clinical and administrative functions, respectively. Dentists, physicians, and APPs retain current functions of care delivery and continue to receive clinical supervision and support from their respective disciplines but report administratively to the HSA at the facility or facilities. This is a common model that is consistent with expectations of NCCHC, and several variations have been seen as effective across the country, worth exploring.

Providers (Physicians and Advanced Practice Professionals [Nurse Practitioners and Physicians Assistants]), including medical, psychiatric, dental, and any ancillary provider staff, are managed administratively by the HSA as well, often through discipline-specific reporting channels (i.e., Behavioral Health Services Manager administratively supervises the psychiatrist), but providers are clinically supervised by the Site Medical Director (medical) or discipline-specific clinical supervision from regional and statewide clinical leadership (i.e., Chief Psychiatric Officer). The intent is for the HSA to have administrative responsibility for all healthcare personnel and activities occurring in the prison or prisons, but some of that responsibility may be designated to manage workload and due to the specialized nature of some services.

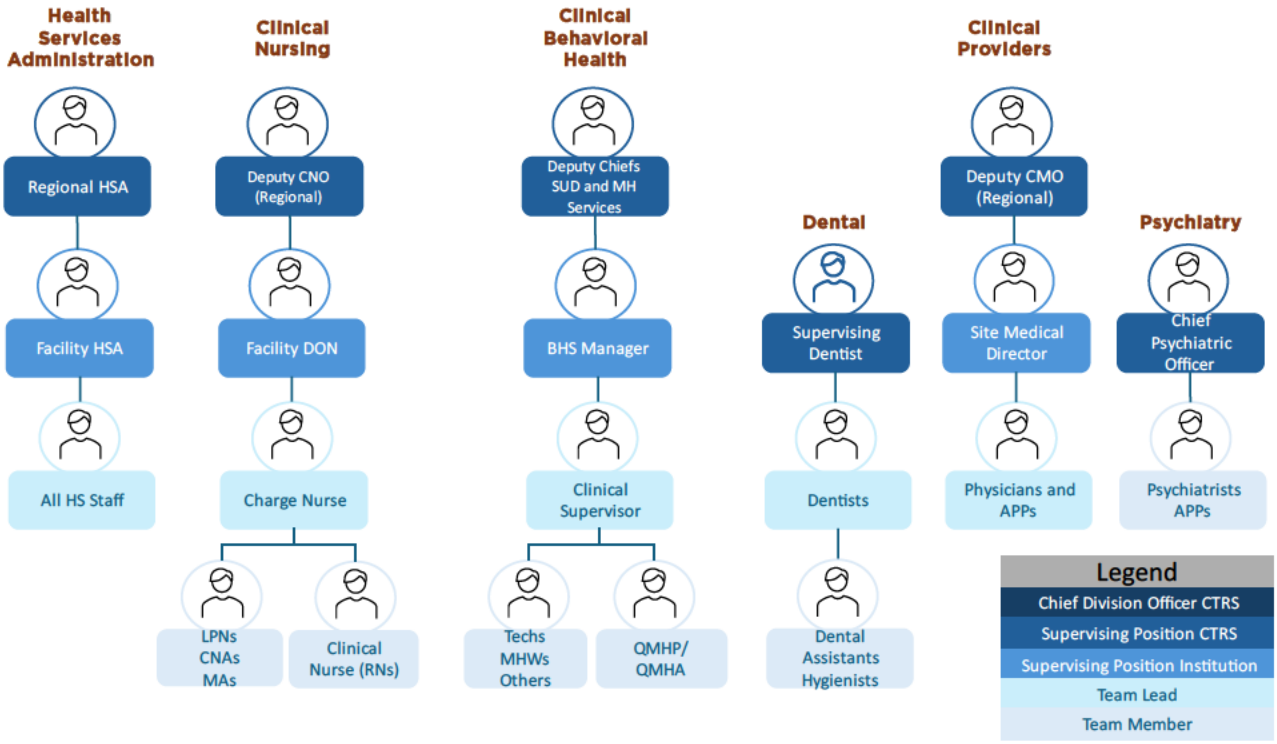
Recognizing the role and importance of organized labor in terms of supervisory relationships, this model is intended to begin a discussion, study its impact and feasibility, and tailor an organizational structure accordingly.

Figure 34. Sample Facility Organizational Structure

Position Title	Current Title	Qualifications & Role
Health Services Administrator	MSM	• Healthcare Administrator • Responsible Health Authority for facility or facilities • Administrative oversight of all Health Services personnel
Behavioral Health Services Manager	Behavioral Health Services Manager	• Clinician-Administrator • Coordinates all Behavioral Health Services for facility or facilities • Administrative report to HSA

Position Title	Current Title	Qualifications & Role
		• Clinical report to Regional Behavioral Health Services Administrators
Charge Nurse	Lead Nurse	• Clinician • Floor nurse with clinical supervisory duties
Behavioral Health Services Clinical Supervisor	New Position	• Licensed QMHP • Provides clinical supervision to all QMHP/QMHA
Dentists	Dentists	• Provide direct dental care • Administrative report to HAS • Clinical supervision from Site Medical Director and/or Regional/Statewide Specialists
Physicians and APPs	Physicians and APPs	• Provide direct medical and psychiatric care • Administrative report to HSA • Clinical supervision from Site Medical Director or Regional/Statewide Specialists

Figure 35. Facility Organizational Chart



Section 9

Appendices

SECTION 9: APPENDICES

Appendix A: Acronyms

AAFP	American Academy of Forensic Psychology
ACA	American Correctional Association
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ADP	Average Daily Population
AICs	Adults in Custody
AOCE	Association of Oregon Corrections Employees
APP	Advanced Practice Provider
ASU	Administrative Segregation Unit
BHU	Behavioral Health Unit
CCCF	Coffee Creek Correctional Facility
CCHP	Certified Correctional Health Professional
CHP	Correctional Health Partners
CIPS	Correctional Institution Pharmacy Software
CPAP	Continuous Positive Airway Pressure
CQI	Continuous Quality Improvement
CRCF	Columbia River Correctional Facility
CURE	Citizens United for Rehabilitation of Errants
DRCI	Deer Ridge Correctional Institution
DSU	Disciplinary Segregation Unit
DTU	Day Treatment Unit
EHR	Electronic Health Record
EOCI	Eastern Oregon Correctional Institution
FTE	Full-time Equivalent
GIPA	Gender Informed Practices Assessment
GNC	Gender Nonconforming
GRAP	Gender Responsive Advisory Panel
H&P	History and Physical
HRT	Hormone Replacement Therapy

HSA	Health Services Administrator
HSAT	Health Services Administrative Team
HSR	Health Services Report
I&R	Intake and Reception
ICH	Intermediate Care Housing
KOP	Keep-on-Person
KPI	Key Performance Indicator
KPM	Key Performance Measure
LOF	Level of Functioning
LS/CMI	Level of Service/Case Management Inventory
MAR	Medication Administration Record
MAT	Medication Assisted Treatment
MHI	Mental Health Infirmary
MOUD	Medication for Opioid Use Disorder
MSM	Medical Services Manager
NCCHC	National Commission on Correctional Health Care
NP	Nurse Practitioner
OAR	Oregon Administrative Rules
ODF	Oregon Department of Forestry
ODOC	Oregon Department of Corrections
ODOJ	Oregon Department of Justice
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OOF	Out of Facility
ORS	Oregon Revised Statute
OSCI	Oregon State Correctional Institution
OSP	Oregon State Penitentiary
OTC	Over-the-Counter
OUD	Opioid Use Disorder
P&T	Pharmacy and Therapeutics
PAI	Personality Assessment Inventory
PIP	Performance Improvement Plan

PRCF	Powder River Correctional Facility
QMHA	Qualified Mental Health Associate
QMHP	Qualified Mental Health Professional
RFP	Request for Proposal
RP	Responsible Physician
RQA	Rapid Qualitative Analysis
SB	Senate Bill
SCI	Santiam Correctional Institution
SFFC	South Fork Forest Camp
SMI	Serious Mental Illness
SMH	Special Management Housing
SNF	Skilled Nursing Facility
SRCI	Snake River Correctional Institution
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TLC	Therapeutic Levels of Care
TRCI	Two Rivers Correctional Institution
WRNS	Women's Risk and Needs Assessment

Appendix B: Pre-Assessment Priority Needs Memo

Oregon Department of Corrections

Consulting Expert Services and Healthcare System Pre-Assessment

PRIVILEGED AND CONFIDENTIAL WORK PRODUCT

To: Heidi Steward
Deputy Director & Acting Assistant Director for Health Services
Oregon Department of Corrections

From: Robin Timme, Psy.D., ABPP, CCHP-A
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cc: Mike Reese, Director, Oregon Department of Corrections
Dr. Michael Seale, Interim Chief of Medicine, Oregon Department of Corrections

Date: February 18, 2025

Re: Pre-Assessment Observations and Recommendations

For the past two months, the Falcon team has met with administrative and clinical leadership throughout the Oregon Department of Corrections (ODOC), reviewed extensive documentation, and collaboratively engaged in an examination of the current ODOC healthcare delivery model. Additionally, the team has provided real-time advice and guidance specific to priority needs within the healthcare delivery system, working with decision-makers in an iterative process of quality improvement. This document serves to memorialize our observations during this Pre-Assessment period, identify prioritized areas for immediate attention, and to make recommendations specific to those areas.

ODOC has engaged Falcon to conduct a comprehensive assessment of Health Services across the agency, which will begin immediately. The methodology for a systemwide assessment is more comprehensive, inclusive of internal and external stakeholders, incorporating site visits and workshops, and will result in a full written report with recommendations to ODOC to improve delivery of healthcare for adults in custody (AICs). What follows in this memorandum are the key observations and recommendations specific to this initial Pre-Assessment engagement as consulting experts, and it is expected that – in addition to many other components of healthcare delivery - these items will be further assessed and expanded upon in the next phase of work.

Pre-Assessment Observations

1. The Director of the Oregon Department of Corrections, Mike Reese, and his leadership team have made it clear that they are committed to enhancing health services within ODOC, and that they are willing to take the necessary steps to improve the lives of those who live and work within Oregon's prisons. This vision and commitment permeate all aspects of the correctional system, including the Health Services Division and those leaders with whom we worked on the Pre-Assessment phase.

2. In recent months and years, there has been an increase in complaints around Health Services, received from AICs in custody and healthcare staff alike. These concerns were elevated to the Director, resulting in an investigation and subsequent separation from employment with the Chief of Medicine and the Assistant Director for Health Services.

3. Simultaneously, the Oregon Department of Justice (ODOJ) engaged Falcon Correctional and Community Services, Inc. (Falcon) to serve as consulting experts in an assessment of the immediate needs of the healthcare delivery system. By contracting directly with ODOJ, Falcon was able to begin working immediately, and consulting expert services began just days after the initial engagement. This vehicle for engagement prioritized the required agility of the outside consultant team, created a privileged relationship with a team of consulting experts, and Falcon began nearly daily consultation with ODOC.

4. Immediately upon execution of the contract, Falcon issued a request for data and documents to orient to the prison system and quickly gained insight into operations and healthcare delivery. This is a standard part of the Falcon method, and although we have seen similar requests filled expediently in the past, this was one of the smoothest and most professional examples of data and document

production for our work. The administrative operations for this project specifically have been outstanding.

5. In the ongoing consultation over the past eight weeks, as ODOC and Falcon have identified opportunities for improvement, ODOC has simultaneously developed immediate, short-term, and long-term interventions to address those areas responsively and efficiently in real time.

6. In consultation with Falcon, ODOC immediately identified professionals to take the chief clinical and administrative roles for patient care and healthcare delivery. ODOC retained an experienced physician as Interim Chief of Medicine, Dr. Michael Seale. Dr. Seale's credentials are exemplary for the position of chief clinician for the agency. ODOC's Deputy Director, Heidi Steward, assumed the executive role responsible for all administrative functions within Health Services. Deputy Director Steward has been with the agency for decades and is highly qualified as a correctional and administrative executive to temporarily oversee Health Services as an administrator, while Dr. Seale is the final authority for clinical decisions. This bifurcated clinical-administrative model is commonly seen in healthcare organizations, including correctional systems across the country.

7. Based on a review of data and documents, meetings and workshops with clinical and administrative leaders, and in consultation with ODOC, Falcon identified three (3) priority areas to improve access to care, utilize more timely specialty care, and to develop a more robust Continuous Quality Improvement (CQI) program. These include the following areas:

    a. Access to Care and the Therapeutic Levels of Care (TLC) Process

    b. CQI Program

    c. Organizational Structure and Staffing

Pre-Assessment Recommendations

1. Communicate the Director's commitment to improving Health Services for those who live and work inside Oregon's prisons. Communicate the specifics of the immediate action plan, as well as the intention to comprehensively and transparently assess the healthcare delivery system and improve the care delivery model. Celebrate your workforce and frequently remind employees that you are all on this journey together, and that their roles are critically important to the health and wellness of AICs.

2. What cannot be measured, cannot be improved. Reliable data are critical, and accurate utilization review should be prioritized immediately, before interventions aimed at systemic improvement. ODOC should deploy resources needed to accurately and reliably establish baseline measurements of relevant Key Performance Indicators (KPIs) around access to care broadly, but specifically monitoring those KPIs that reflect potential delays in care. Examples of these KPIs include Health Services requests (i.e., sick call), initial physical examinations, provider visits, specialty care consults and off-site medical appointments.

3. Review and revise the position description of the Assistant Director for Health Services, as needed. Post and recruit for the position and develop a transition plan that returns Deputy Director Steward to her full role within the agency. It is assumed that Deputy Director Steward will remain in the acting role through the assessment period to gain comprehensive understanding of Health Services and the plan for improvement.

4. Access to Care and the TLC Process

    a. As the underlying infrastructure around access to care is being assessed and improved, allocate resources immediately to address backlogs of those services associated with the KPIs in #2 above. By temporarily investing in nursing and Advanced Practice Providers (APP), targeting sick calls and provider visits, the backlogs will be reduced and patient care will be improved. Prioritize physician-level resources (MD, DO) for review of specialty care requests, using telehealth and asynchronous care (i.e., eConsults) as complements to in-person or off-site consults. This 'blitz' aims to address the immediate problem in front of the department, while simultaneously studying and improving the efficiency and effectiveness of the underlying system.

    b. Additional provider staff will also be needed for the upcoming transition to an Electronic Health Record (EHR). Productivity should be expected to drop temporarily during such an implementation, and maintaining those APP and other temporary resources during the initial implementation and training is strongly recommended. The aim is to maintain service delivery levels, while avoiding burnout for providers. This recommendation should be implemented in advance of the EHR rollout, so that staff are all trained and operational before the demands of training and implementation are impacting service delivery. There is never a convenient time to implement

an EHR, but the positive impact on patient care, data management, and CQI in this particular system is likely to be profound.

c. Revise *Procedure A-02.1* and related policy documents to specifically apply to Medical Health, Behavioral Health, and Gender Nonconforming care. When changes are made to improve the TLC process, ensure that the governing policy documents are updated to reflect actual practice.

d. Develop a localized (i.e., facility-specific) roster of specialty care providers and services, to include and prioritize providers who are willing and able to come into the prison to provide on-site specialty care; optimizing the use of telehealth and asynchronous care providers; and off-site specialty care providers accessible to patients at specific prisons.

e. Create and expand medical transport capabilities for off-site specialty care consults. Consider dedicating Medical Transport Officers, as needed by facility, and ensure adequate vehicles are available. Implement an immediate action plan but create infrastructure for permanent positions and resources.

f. Improve mechanisms for tracking specialty care referrals, reviews by the TLC, scheduling of specialty care consults, completion of specialty care consults, and disposition of referral.

g. Identify a senior Qualified Healthcare Professional (QHP) to maintain a master list of specialty care referrals, triaged to ensure prioritization, prepared for review at each TLC meeting, which tracks the TLC decisions, scheduling of specialty care consults, completion of specialty care consults, disposition of referrals, and flags cases for triaged or urgent review by the TLC.

h. Identify the threshold for required review of specialty care consult, clarifying that cases that are automatically approved do not need to be reviewed by the TLC, expediting those referrals that would not require TLC review.

i. Requests for non-formulary medications may be removed from the TLC process, documented with clinical justification and forwarded for approval on a routine basis, noting the rationale for non-formulary use, and utilization reviewed monthly at Pharmacy and Therapeutics (P&T)

Committee meetings. Trends can be measured and analyzed, and changes in policy and practice communicated to providers.

j. Facilities should enact what is already established in policy, ensuring that procedures are followed as intended. This includes empowering "Health Services prescribing providers" to practice at the top of their licenses by authorizing Level 1 and Level 2 medical care with written justification for referrals (level 2). As outlined in policy P-A-02.1, the Chief Medical Officer has the authority to review facility specific referrals, expediting the process. This policy also establishes that Medically Mandatory Level I and Presently Medically Necessary Level 2 care do not require TLC referrals, avoiding unnecessary delays in treatment.

k. Create and deploy a clear vision around patient-centered healthcare in the agency. The vision should include prioritizing continuity of care, including the use of medical holds for patients with pending consults, a robust chronic care program, and ensuring all AICs are offered preventive care consistent with community standards. Ensure medical holds are placed on incarcerated patients pending completion of scheduled specialty care consults approved by the TLC or authorized by the on-site healthcare providers. Those holds should be managed by the Responsible Health Authority in the facility, monitored in conjunction with the individual overseeing the tracking of specialty care consults in the facility, along with the facility Superintendent or designee.

l. During the Assessment phase of work, Falcon will continue to study this area, provide technical assistance and additional recommendations, and will include the current state of the TLC process in the final report when it is issued.

5. CQI Program

a. Revise *Procedure A-06* and related policy documents around CQI to create a statewide CQI department reporting to the Assistant Director for Health Services, develop a calendar of routine policy audits, delegate responsibility to specific individuals in each facility, and be more specific in directives and expectations.

b. A senior clinician-administrator (i.e., QHP) should manage a dedicated statewide CQI program, with a calendar of regularly scheduled audits,

process and outcome studies, ensuring compliance with policies and procedures, and developing performance improvement plans when deficiencies are identified.

c. The statewide CQI department should be comprised of identified liaisons from each specialty, including medicine, nursing, behavioral health, pharmacy, dental, and administration, all communicating to the senior clinician-administrator QHP.

d. The CQI department must have liaison representation in each facility, coordinated by a QHP who collects data, conducts facility-specific audits, and provides support and tracking for implementation of recommendations at the facility level.

e. The CQI program department is responsible for routine audits, ad hoc studies, development of performance improvement recommendations, ensuring that all recommendations are completed within prescribed timeframes, documenting completion (i.e., sign-in sheets, training materials, etc.), and re-auditing to measure improvement.

f. In the Assessment phase of the project, Falcon will continue to study the developing CQI program and will offer technical assistance and additional recommendations as more is learned through the comprehensive systemwide study.

6. Organizational Structure and Staffing

a. Create a compliance and CQI department within the agency, consistent with recommendation #5.a. above. The department should be tasked with Health Service policy document management, regular review and revision, compliance audits, and the CQI program.

b. Identify a dedicated Health Services Recruiter and provide resources to enhance capabilities around recruitment, retention, and advancement of qualified healthcare and administrative staff.

c. ODOC is considering creation of a Clinical Pharmacy program. We think this is an excellent model and a best practice to improve the quality, safety, and efficiency of patient care.

d. Conduct a staffing analysis for Health Services, inclusive of any support functions (i.e., Medical Transport Officers, medical escort officers,

administrative support specialists, etc.), and set a schedule for regularly reviewing and updating the staffing plan in response to evolving needs of the patient population and required healthcare services.

e. Falcon observed that the administrative-organizational structure of ODOC would likely benefit from a focused study of the roles and responsibilities at the management level. In The Assessment phase, Falcon will focus broader attention on the organizational structure to maximize efficiency, enhance communication, and ultimately improve care delivery.

Appendix C: Sample CQI Policy

DEPARTMENT OF CORRECTIONS HEALTH SERVICES DIVISION POLICY	
Title: Continuous Quality Improvement Program	**HS Policy: P-A-06**
Reviewed:	**Supersedes:**

Policy: The Oregon Department of Corrections Continuous Quality Improvement (CQI) Program promotes wellness among the population of Adults in Custody (AIC) by maintaining a system that continually identifies opportunities for improvement through measured quality of care outcomes and ensures compliance with internal policies, National Commission on Correctional Health Care (NCCHC) standards and other applicable regulatory requirements.

I. Definitions:

A. Health services: Clinical services that encompass physical health, behavioral health (mental health and substance use treatment), dental health services, pharmacy operations, and ancillary care.

B. Continuous Quality Improvement (CQI): A process of ongoing monitoring and evaluation to systematically and objectively assess the adequacy and appropriateness of health care provided to AICs and to recommend and execute improvements as needed.

C. CQI Data: Statistics and other protected health information required to be entered in the ODOC Health Services Database. Such data includes Medication Administration Records, AIC Grievances, sentinel event reviews, peer review summaries, CQI Committee Agendas, Minutes as well as reports required by the ODOC Chief of Medicine.

D. Institutional CQI Committee: A group of healthcare providers and other correctional institution staff who are responsible for the review of processes and outcomes of the correctional institution's health service delivery system.

E. Quality Indicators: Quality Indicators are measurable, evidence-based metrics used to assess and monitor the quality of services, programs, and systems.

F. Statewide CQI Coordinator: A designated individual assigned to coordinate all statewide CQI activities which include evaluation, recommendations, implementation and ongoing monitoring.

G. Statewide CQI Committee: A group of healthcare professionals from various disciplines (e.g., medicine, nursing, behavioral health, dentistry, health records, pharmacy, laboratory, custody staff). Members are appointed by the ODOC Chief of Medicine to identify opportunities for quality improvement, evaluate outcomes through quality indicators, discuss results, and implement corrective action.

II. Procedures

A. General: The Health Services policy and standards for CQI are informed by the current edition of Standards for Health Services in Prisons prepared by NCCHC, along with other standards and regulations selected by the agency.

B. There shall be a Statewide CQI Committee comprised of a group of health services professionals who shall:

1. Identify aspects of healthcare to be monitored and establishes performance thresholds, designs quality improvement activities, analyses the results for factors that may have contributed to below threshold performance, designs and implements strategies to correct the identified healthcare concern, and monitors the performance after implementation of the improvement strategies.
2. The committee shall meet at least quarterly.
3. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel.
4. On an annual basis, the Statewide CQI Committee shall meet to review the outcomes and effectiveness of the plan, including monthly data collection dashboards, corrective action plans (CAPs) or performance improvement plans (PIPs), and process and outcome studies from the previous year. The review process should include input from all Institutional and CQI Sub-committee members. The following areas shall be included in the annual review process:
    i. Policies: Review of all Health Services Policies implemented during the calendar year, review and update any changes to CQI Quality Indicators.
    ii. Staff Training/Education: Review and evaluation of staff training provided as a result of CAPs or PIPs, newly implemented protocols/policies, peer review findings, sentinel events review, morbidity and mortality reviews, and identified quality improvement opportunities. This includes updated competency-based training and education to address identified system weaknesses and improve patient care outcomes.
    iii. Dental Inspections/Regulating Body
    iv. Site Radiology Registration Certificate/Expirations
    v. Staffing: Changes in staffing patterns as it relates to outcomes
    vi. Statistics as per Quality Indicators
    vii. Review of Infection Prevention Quality Indicators

viii. Standing CAP and PIP items for all CQI Committee/Sub-committees

ix. CQI Plan Changes: Updates to Self-Monitoring Audit Tools, updates to Quality Indicators, outcome/process studies, CQI Calendar for the next year

5. The Statewide CQI Committee shall review aggregate data related to Utilization Management (UM) and Therapeutic Level of Care (TLC) activities. This includes monitoring the consistency, appropriateness, timeliness, and policy adherence of UM/TLC determinations across the system. The CQI Committee will evaluate systemic patterns, identify process inefficiencies, monitor compliance with established criteria, and make recommendations for quality improvement or policy revision as needed. CQI oversight applies to the functioning of the UM/TLC processes at a system level and does not involve the review or adjudication of individual case determinations.

C. Quality improvement studies shall examine the effectiveness of the healthcare delivery processes by:

1. Identifying a healthcare system concern (e.g. delayed sick call appointments)
2. Determining a threshold based on problem identified
3. Conducting a baseline study (e.g. root cause)
4. Developing and implementing a corrective action plan
5. Restudying the problem to assess the effectiveness of the corrective action plan
6. The process and evaluation of the quality of care through measured outcomes shall be evaluated primarily by each institutional CQI Committee with oversight by the Statewide CQI Committee
7. A comprehensive quality Improvement program shall measure major service areas regarding one or more of these measures annually. The major service areas are as follows:

i. Intake processing
ii. Access to care
iii. Medication services
iv. Chronic care services
v. Intersystem transfer services
vi. Scheduled off-site services (consultations and procedures)
vii. Unscheduled on-site and off-site services (urgent/emergent care)
viii. Behavioral health services

ix. Dental services

x. Pharmacy services

xi. Ancillary services (e.g., lab and X-ray)

xii. Dietary services, and

xiii. Infirmary services

D. Sub-committees: The Statewide CQI Committee shall direct the following sub-committees, which are responsible for reporting findings and recommendations to the Statewide CQI Committee for review and action as appropriate.

1. Infectious Disease Committee: Responsible for developing a comprehensive program of surveillance and implementing protocols to address the control and prevention of communicable diseases within ODOC.

2. Peer Review Committee: Responsible for developing written evaluation of professional competence of all physicians, psychologists, qualified mental health professionals (QMHPs), nurses, pharmacists, and dentists, every two years. Where necessary, the committee shall review specific cases and/or patterns of professionals.

3. Morbidity and Mortality Review Committee: Responsible for reviewing all data related to AIC deaths and illness and reporting the findings to the *Federal Bureau of Justice for publication of national statistics*. The committee will also identify risk factors related to AIC morbidity and mortality, as well as recommend and implement strategies to reduce risk factors and improve the health of the AIC. For any completed suicide, the Morbidity and Mortality Review Committee shall conduct a comprehensive review incorporating findings of a psychological autopsy. Findings and recommendations from these reviews shall be reported to the Statewide CQI Committee and integrated into quality improvement activities, staff training, and policy updates as appropriate.

4. Pharmacy and Therapeutics Committee: Responsible for developing and maintaining departmental drug formulary and reviewing the utilization and cost effectiveness of the pharmacy system. The committee may also review policies and procedures for management and administration of pharmaceuticals, as well as recommend procedural changes and interventions.

E. Institutional CQI Committees: The Medical Services Manager *(MSM)* shall be responsible for maintaining a monthly institutional Healthcare CQI committee meeting and shall also serve as the committee advisor for structure and goals.

1. The committee composition shall minimally include health and behavioral health administrator/designee, Warden/designee, institutional physician/medical director, CQI Coordinator, representatives from nursing, dental, behavioral health/psychiatry. Health record management, food services, fire and safety, and security staff representation should be included on an ad hoc basis as CQI issues indicate.
2. Each institutional MSM shall designate one nurse whose primary responsibilities include serving as the institutional CQI Coordinator and overseeing the institutional infection control/surveillance program.
3. The MSM, in consultation with the institutional CQI Coordinator, shall appoint or reappoint committee membership annually. Membership appointment and reappointment shall be recorded in the committee minutes. An institutional CQI Committee membership roster shall be maintained in the ODOC healthcare services database. Appointments to fill committee vacancies shall be made as soon as possible.
4. The committee shall meet monthly to review and discuss CQI reports and opportunities for quality improvement.
5. The committee shall document all identified opportunities for improvement, corresponding action items, assigned responsible party(ies), and target completion dates. The status of each item shall be reviewed at each subsequent meeting to track progress and verify completion. This documentation shall be maintained as part of the permanent meeting minutes and made available for Statewide CQI Coordinator review.
6. When opportunities for improvement are identified that require action beyond the scope of healthcare services personnel authority, the health administrator shall forward those institutional CQI Committee findings and recommendations for action to the Deputy Superintendent.
7. The minutes shall be recorded at each proceeding and shall provide a permanent, factual, historical record.
8. The Statewide CQI Coordinator shall review the Institutional ICQI meeting minutes and report findings to the Chief Medical Officer quarterly or more often if indicated.

F. Professional Peer Review and Supervision

1. A documented peer review program for all health care practitioners, and a documented external peer review program will be utilized for all physicians, psychologists, and dentists, and shall be completed every 2 years. Peer review outcomes will inform education and credentialing.

2. The peer review of all physicians, psychologists, and dentists should be routine every two years with an ability to have an immediate review if problems of practice arise. In the event of an AIC care complaint or an observation by other health services providers, security, or other nonmedical providers the responsible physician can call a panel of independent physicians to review the practice and practice patterns of the physician on whom the complaint has been made. The investigation and findings will be kept in the employees' file and remain confidential.
3. Supervisors shall review the clinical care of other practitioners within their discipline. If the supervisors provide clinical care, they also are reviewed through this process. Reviews may be accomplished through a memorandum of agreement with an outside practitioner, by contracting with an outside group (e.g., medical school, hospital)

Quality Indicators

The Statewide CQI Committee establishes Quality Indicators. Performance will be reviewed by utilization of scorecards/dashboards to monitor the quality of health care. An annual review of Quality Indicators will be conducted by the Statewide CQI Committee.

Medications: Pharmacy & Therapeutics (P&T)

- All psychotropic medication administered to AICs
- Total Number of AIC on medications (Medical)
    - Analyze by:
        - Top medications prescribed
        - Polypharmacy
        - Prescribers' trends
        - Number of medication errors
        - Expired orders
        - Use of Force Orders
        - Population Vs # of AICs on psych meds

Medical Services: Utilization Management (UM)

- Number Of Emergency Department (ED) Runs by facility and referral diagnosis (UM)
    - Analyze by:
        - % resulted in admissions
        - Top 5 reasons for ED Referrals

        - Medical Necessity for all ED runs (% of those who met medical necessity)
        - Time of Transport and time of care
- Number of Hospital Admissions and why (UM)
    - Analyze by:
        - Length of Stay
        - Outside Hospital Utilization
        - Outliers (AICs that exceed the average length of stay)
        - Top 5 reasons for Hospital Admissions
- Infirmary Admissions (MD & MH) for non-emergency treatment and why - CQI
    - Analyze by:
        - AICs admitted to Medical and Infirmary Housing
        - AICs admitted to Suicide Watch/Observation
        - Length of stay

Medical Services: TLC

- Analyze by:
    - TLC Request Timeliness (% requests reviewed and resolved)
    - Approval Consistency based on documented clinical criteria
    - % of TLC denials

Consultation for Chronic Conditions: Medical Services

- Analyze by:
    - Number of referrals at intake,
    - Types of Chronic Care conditions, # of AIC per clinic

Suicides and Suicide Attempts: Morbidity & Mortality (M&M)

- All Suicides
    - Analyze by:
        - Occurrences
        - Corrective Action Plan per Incident:
            - Immediate response/corrective action
            - Systematic corrective action (if trend identified)
        - Location, MH Code and Level of Functioning (LOF)
        - Analysis of M&M Review

- All Serious Suicide Attempts
    - Analyze by:
        - Occurrences
        - Corrective Action Plan per Incident:
            - Immediate response/corrective action
            - Systematic corrective action (if trend identified)
        - Location, MH Code and LOF
        - Follow-up appointments with QMHP upon DC
- List of AICs placed on Suicide Watch/Observation
    - Analyze by:
        - Length of Stay
        - Daily Consultations received by psychiatrists or physicians
        - Follow-up appointments with QMHP upon DC
    - Incidents of Harm in areas:
        - Self-Harm incidents by Level of Care
        - Near Misses

AIC Counseling Services:

- AICs on MH Case Load by Level of Care
- Patterns, increase, decrease
- # of AICs identified upon intake
- # of AICs DC from MH caseload
- # Of AICs receiving 1:1 and GRP therapy by institution
- # of AICs 1:1 by QMHP
- # of AICs 1:1 by psychiatrists (Medication management)

Disciplinary Results: (CQI/MH)

- Total # Disciplinary
- Total # of Disciplinary for AICs in MH Case Load by Level of care (QMHP participated of review)
    - Analyze by:
        - Disposition of Disciplinary action for those in MH case load (Restrictive Housing)

        - AICs cleared to proceed with disciplinary process
        - MH AICs in segregation by level

Reportable Incidents (CQI/M&M)

- Sentinel Events resulting in harm to the AIC, staff or visitor.
- All deaths
- Suicide attempts or completions
- Adverse events or near misses with potential to cause harm.
- Other events as referred for review by ODOC staff.
    - Type, Date, Summary
        - Required reviewed conducted
- Number of grievances
    - Substantiated
    - Number of AIC grievances related to health care, dental care and BH care services found in favor of the AIC

Action plans after quarterly reviews (CQI)

- Deficiency type, Action Plan, date of review

Infection Control (CQI)

- Vaccine Programs
    - Tuberculosis screening
    - TD
    - Hepatitis A & B
    - Pneumonia
    - Flu
    - COVID-19
    - Other emerging infectious disease
- Illness outbreaks
    - MRSA
    - Scabies
    - Chicken pox
    - Active TB, food poisoning
- Autoclave Spare Count Monitoring