Jefferson CONSULTING GROUP | NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

A Report by

JEFFERSON CONSULTING GROUP &
NATIONAL ACADEMY OF PUBLIC ADMINISTRATION
for the Federal Bureau of Prisons

Federal Bureau of Prisons:
HEALTHCARE QUALITY ASSESSMENT

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Prepared for
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Prepared by
Jefferson Consulting Group
and
National Academy of Public Administration

Federal Bureau of Prisons

Healthcare Quality Assessment

Foreword

The Federal Bureau of Prisons (Bureau), part of the U.S. Department of Justice, serves to protect public safety by ensuring that federal adults in custody (AICs) serve their sentences of imprisonment in facilities that are safe, humane, cost-efficient, and appropriately secure, and provides reentry programming to ensure their successful return to the community. With more than 158,000 adults in custody housed in 121 institutions, the Bureau's over 35,000 employees deliver an important and complex mission in challenging conditions.

This Report provides a wide-ranging assessment of how mental and physical healthcare is provided to adults in custody. It is the result of extensive collaboration from a joint study team (herein referred to as "the team") representing Jefferson Consulting Group (Jefferson) and the National Academy of Public Administration (the Academy).

The research was enriched by an extensive literature review, hundreds of interviews of both Bureau personnel and adults in its custody, and research with external organizations having similar missions. The team visited 12 Bureau institutions during the one-year period of this research project. The report acknowledges many good practices observed in institutions and identifies many more opportunities to improve healthcare and enhance the experiences of employees and adults in custody.

Providing high-quality healthcare to adults in custody is exceedingly complicated, given the confluence of challenging factors present in this closed working environment where security is a paramount concern. A key obstacle is having adequate funding and the tools to recruit and retain a sufficient number of healthcare professionals to serve a large patient population. That challenge is exacerbated by the acute mental and physical conditions adults in custody often experience. Notwithstanding this starting point, there is an overarching view that the current cohort of Bureau health service employees and their leaders are dedicated to providing the very best of physical and mental healthcare within these constraints. The Report commends several Bureau initiatives already underway to improve care and offers many actionable recommendations that can enhance these efforts.

We are grateful to both the Panel Advisory Group of Academy Fellows and the team for their extensive and thoughtful research and preparation of this Report. We greatly appreciate the cooperation of Bureau personnel and others who shared their time and experiences.

We are confident that the data, observations, and recommendations in this Report will assist the Bureau in its ongoing efforts to enhance timely and effective provision of comprehensive healthcare to each individual in its custody.

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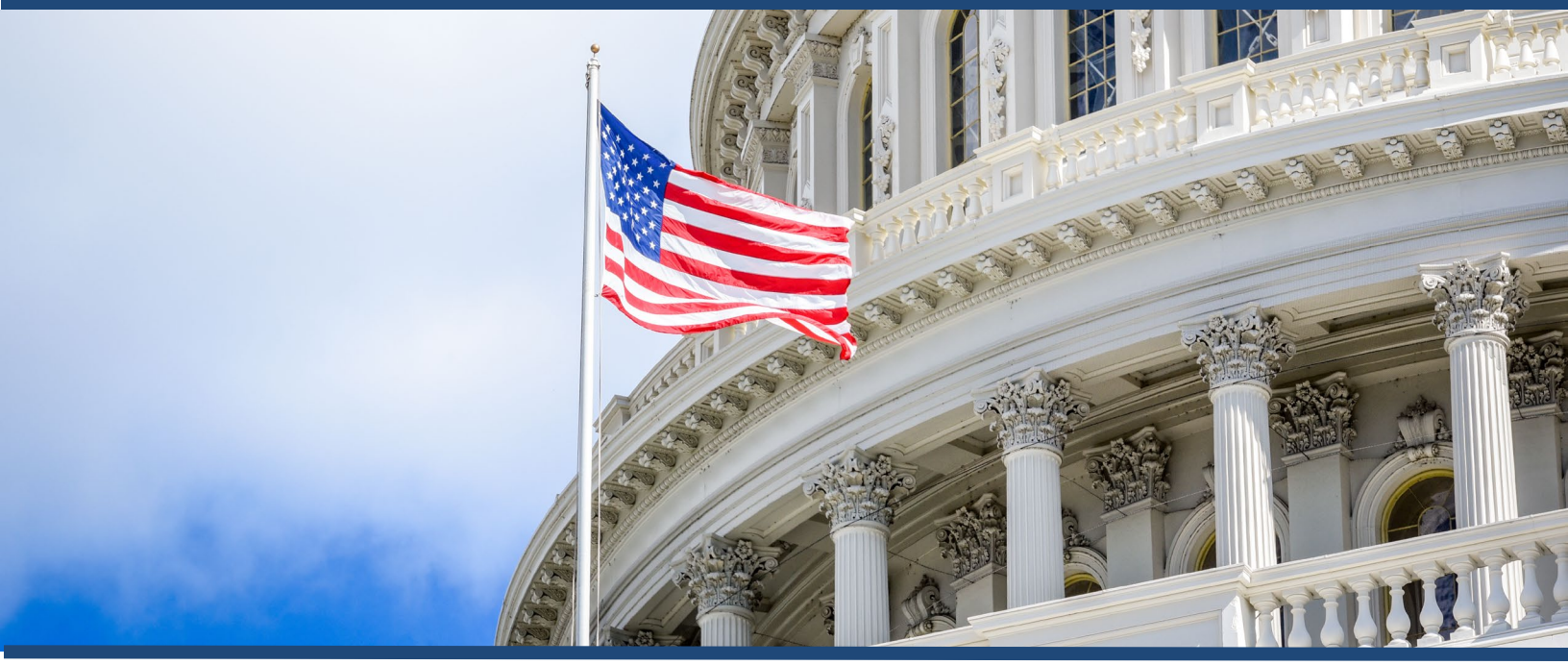

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About Jefferson Consulting Group

Jefferson Consulting Group (Jefferson) is an award-winning professional services company that helps federal agencies solve problems and achieve results. Jefferson has conducted strategic assessments and provided operational support to more than 70 federal agencies over its 36-year history. Jefferson has provided strategic assessments to several agencies, including the Department of Justice, the U.S. Marshals Service, the Department of Veterans Affairs, and the Department of Health and Human Services. Jefferson is ISO 9001:2015 certified, the gold standard in quality management systems, and Great Places to Work certified, a global certification earned based on employee feedback. These certifications validate Jefferson's culture, which is focused on high-quality services. We are independent, non-partisan management consultants focused on helping the government deliver better services and achieve its important missions.

About the National Academy of Public Administration

The National Academy of Public Administration (the Academy) is an independent, nonprofit, and non-partisan organization established in 1967 and chartered by Congress in 1984. It provides expert advice to government leaders in building more effective, efficient, accountable, and transparent organizations. To carry out this mission, the Academy draws on the knowledge and experience of its over 1000 Fellows—including former cabinet officers, Members of Congress, governors, mayors, and state legislators, as well as prominent scholars, career public administrators, and nonprofit and business executives. The Academy helps public institutions address their most critical governance and management challenges through in-depth studies and analyses, advisory services and technical assistance, congressional testimony, forums and conferences, and online stakeholder engagement.

Jefferson Consulting Group and The Academy have worked together for more than two decades on strategic assessments of federal agencies, including the Federal Bureau of Investigation, Department of Energy, Department of Housing and Urban Development, and more. Jefferson's President, Dr. Allan Burman, is a Fellow of The Academy.

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Table of Contents

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List of Figures

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List of Tables

Acronyms and Abbreviations

Acronym or Abbreviation	Definition
AAFP	American Academy of Family Physicians
ACA	American Correctional Association
ACE	Adult Continuing Education
ACES	Adverse Childhood Experiences Questionnaire
ACLS	Advance Cardiac Life Support
AD	Assistant Director
ADL	Activities of Daily Living
AED	Automated External Defibrillator
AHRQ	Agency for Healthcare Research and Quality
AHSA	Assistant Health Services Administrator
AI	Artificial Intelligence
AIC	Adult in Custody
AIDS	Acquired Immunodeficiency Syndrome
A&O	Admissions and Orientation
APP	Advanced Practice Provider
ASAM	American Society of Addiction Medicine
ASHHRA	American Society for Healthcare Human Resources Administration
ATA	American Telehealth Association

AW	Associate Warden
BEMR	Bureau Electronic Medical Record
BI	Business Intelligence
BJS	U.S. Bureau of Justice Statistics
BMJ	British Medical Journal
BOP	Federal Bureau of Prisons
BPT	Basic Prisoner Transport
CAGE	Cut, Annoyed, Guilty, and Eye
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBT	Cognitive Behavioral Therapy
CCC	Chronic Care Clinic
CCM	Chronic Care Model
CD	Clinical Director
CDC	Centers for Disease Prevention and Control
CDCR	California Department of Corrections and Rehabilitation
CFAD	Central Fill and Distribution
CIT	Crisis Intervention Training
CMSC	Comprehensive Medical Services Contract
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services

COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer Representative
COTS	Commercial-Off-The-Shelf
CPAP	Continuous Positive Airway Pressure
CPARS	Contract Performance Assessment Rating System
CPR	Cardiopulmonary Resuscitation
CT	Computed Tomography
DAP-C	Drug Abuse Program-Coordinator
DOJ	Department of Justice
DSCC	Designation and Sentence Computation Center
EBRR	Evidence-based Recidivism Reduction
ECG	Electrocardiogram
EHR	Electronic Health Record
EMS	Emergency Medical Services
ESI	Emergency Severity Index
FCC	Federal Correctional Complex
FCI	Federal Correctional Institution
FDA	Food and Drug Administration
FDC	Federal Detention Center
FIT	Female Integrated Treatment

FMC	Federal Medical Center
FPS	Financial Program Specialist
FSA	First Step Act
FTC	Federal Transfer Center
FY	Fiscal Year
GAO	Governmental Accountability Office
GED	General Education Diploma
GS	General Schedule
HEDIS	Healthcare Effectiveness Data Information Set
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRSA	Health Resources and Services Administration
HSA	Health Services Administrator
HSAA	Health Services Administrator Assistant
HSD	Health Services Division
HSU	Health Services Unit
H & P	History and Physical
IHSC	Immigration Health Services Corps
ICE	Immigration and Customs Enforcement

IOM	Institute of Medicine
IT	Information Technology
ITC	Institutional Telehealth Coordinators
ITDD	Information Technology and Data Division
JCG	Jefferson Consulting Group
KAP	Knowledge, Attitude, and Practices
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Workers
Line institution	All institutions that are not Medical Referral Centers (MRCs)
LIP	Licensed Independent Practitioner
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LTSS	Long-Term Services and Supports
MOUD	Medications for Opioid Use Disorder
MCC	Metropolitan Correctional Center
MFT	Marriage and Family Therapists
MGH	Massachusetts General Hospital
MH	Mental Health
MINT	Mothers and Infants Together
MOUD	Medication for Opioid Use Disorder

MRC	Medical Referral Center
MRI	Magnetic Resonance Imaging
MRL	Medical Reference Laboratories
MSPV	Med-Surge-Prime Vendor
MXR	Mid-Atlantic Region
NAPA	National Academy of Public Administration; The Academy
NCCHC	National Commission on Correctional Healthcare
NCQA	National Committee for Quality Assurance
NCR	North Central Region
NER	Northeast Region
NTA	National Telehealth Administrator
NHTA	National Health Technology Administrator
NIJ	National Institute of Justice
NP	Nurse Practitioner
NPM	National Performance Measure
NRDAP	Non-Residential Drug Abuse Program
NTA	National Telehealth Administrator
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
OMB	Office of Management and Budget

OMDT	Office of Medical Designations and Transportation
OPM	Office of Personnel Management
OT	Occupational Therapy
OUD	Opioid Use Disorder
PA	Physician Assistant
PAG	Panel Advisory Group
PATTERN	Prisoner Assessment Tool Targeting Estimated Risk and Needs
PFT	Pulmonary Function Test
PMHNP	Psychiatric Mental Health Nurse Practitioner
PHS	Public Health Service
PHQ	Patient Health Questionnaire
PPT	People, Process, and Technology
PREA	Prison Rape Elimination Act
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
QI	Quality Improvement
QIIPC	Quality Improvement and Infection Prevention and Control Nurse
RBA	Results-Based Accountability
RD	Regional Director
RDAP	Residential Drug Abuse Program

RHSA	Regional Health Services Administrator
RMD	Regional Medical Director
RN	Registered Nurse
RPP	Residential Parenting Program
RRC	Residential Reentry Center
RSD	Reentry Services Division
RT	Respiratory Therapy
RTA	Regional Telehealth Administrator
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statistical Analysis System
SCR	South Central Region
SDAD	Senior Deputy Assistant Director
SDOH	Social Determinants of Health
SER	Southeast Region
SLP	Speech Language Pathologist
SMART	Specific; Measurable; Achievable; Relevant; Time-bound
SME	Subject Matter Expert
SPARC	Standardized Prisoner Assessment for Reduction in Criminality
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder

TAC	Telehealth Advisory Committee
TBI	Traumatic Brain Injury
TDY	Temporary Duty
TPE	Therapeutic Patient Education
The Team	Jefferson Consulting Group and National Academy of Public Administration
TRULINCS	Trust Fund Limited Inmate Computer System
UFMS	United Financial Management System
UK	University of Kentucky
UNICOR	Trade name for Federal Prison Industries
UR	Utilization Review
UM	Utilization Management
UMP	Utilization Management Practices
URC	Utilization Review Committee
USP	United States Penitentiary
USPSTF	United States Preventative Services Task Force
VHA	Veterans Health Administration
WADOC	Washington (State) Department of Corrections
WASPB	Women and Specialty Populations Branch
WXR	Western Region

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Executive Summary

Purpose

The purpose of this report is to deliver an independent assessment of the healthcare services provided by the Bureau of Prisons (BOP or Bureau) to Adults in Custody (AIC or patients), as conducted over one year by the joint team (herein referred to as "the team") from Jefferson Consulting Group and the National Academy of Public Administration. This evaluation, solicited by the BOP to pursue a systematic and humanized approach to AIC healthcare, examines and benchmarks the current practices against community standards through a three-phase assessment process.

The Bureau of Prisons

The Bureau provides healthcare to approximately 158,000 AICs dispersed throughout the contiguous United States, Hawaii, and Puerto Rico. The Health Services Division (HSD) is responsible for medical, dental, social work, and mental health (psychiatric) services for federal AICs in all 121 BOP facilities. HSD's associated services cost $1.46 billion annually, accounting for approximately one-sixth of their overall budget. The cost of AIC medical care has increased by approximately 23 percent from 2017 ($615 million) to 2023 ($800 million), highlighting the growing financial demands of healthcare within the Bureau.[1]

The system faces increasingly complex healthcare challenges driven by an aging AIC population, long sentences, and the disadvantaged socioeconomic backgrounds of those in custody. Nearly one-third of AICs are over the age of 46, with a significant portion approaching or exceeding 60, making them more susceptible to chronic illnesses that require ongoing specialized care. Coupled with this, 72.8 percent of the AIC population is serving sentences of five years or longer, further intensifying healthcare demands as these individuals age within the system. These trends strain resources and underscore the need for enhanced medical facilities and specialized employees to address the growing needs. Moreover, with more than 97 percent of AICs eventually returning to society—41,174 of them in 2023 alone—the quality of healthcare they receive while incarcerated plays a crucial role in their successful reintegration, reducing potential strain on community health resources.[2] Finally, the demographics of the AIC population, which is 93 percent male and predominantly consists of individuals aged 26-55 from Hispanic, Black, and White backgrounds, reflect a group that often enters the system with significant health disadvantages due to poor

[1] U.S. Department of Justice. *Federal Prison System: Salaries and Expenses – FY 2025 Performance Budget, Congressional Submission*. Washington, D.C., March 7, 2024. https://www.justice.gov/d9/2024-03/bop_se_fy_2025_pb_narrative_3.7.24_omb_cleared_final_1.pdf.

[2] Kouyoumdjian, F.G., K.E. McIsaac, J. Liauw, et al. "A systematic review of randomized controlled trials of interventions to improve the health of persons during imprisonment and in the year after release." *Am J Public Health*, 105, no. 4 (2015): e13-33. doi: 10.2105/AJPH.2014.302498; Caba, Justin. "Inmate Healthcare: Improving the Health of Prisoners Could Improve the Health Of The General Public." *Medical Daily*. February 25, 2015. https://www.medicaldaily.com/inmate-health-care-improving-health-prisoners-could-improve-health-general-public-323564

socioeconomic conditions. Many AICs lack prior access to regular healthcare, resulting in advanced health issues upon incarceration. This reality necessitates a robust continuum of care to optimize health outcomes by better preparing AICs for reentry into society, ultimately benefiting public health and community well-being.

Study Overview

This study is part of a larger phased set of projects. Phase 1 of the study, detailed in this report, encompasses a comprehensive assessment of healthcare practices. It covers three main tasks: reviewing medical and mental health processes from the entry of an AIC into the system through to their release; assessing the current utilization review processes and comparing these with other healthcare systems; and evaluating the existing telemedicine processes while identifying barriers to its expanded use. This initial phase is a critical foundation for understanding current operations and challenges, ensuring that future phases can effectively target areas for enhancement and integration into a cohesive healthcare system.

The subsequent phases of this study will expand upon Phase 1's findings by addressing broader organizational issues, drawing lessons from Norway's correctional system (Phase 2), and aiming to improve healthcare and custody integration. Phase 3 will focus on assessing organizational capacity as an integrated healthcare system, identifying staffing and leadership needs, and enhancing employee safety and wellness to align with overall system improvements.

Approach & Limitations

The evaluation employed a qualitative research approach, utilizing the methodologies detailed in chapter 2. The study was structured around the Institute of Medicine's Six Domains of Healthcare Quality—safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity—to assess operational and systemic factors comprehensively. A strength-based approach was used to identify opportunities to leverage its existing capabilities and improve healthcare delivery, with the People, Process, Technology outline applied to pinpoint the key starting points for resource allocation.

The team reviewed literature, analyzed previous audits and findings, and examined data dashboards and other BOP documents and reports. The team also performed comparative analysis (benchmarking) to inform best practices and areas for improvement for both utilization review and telehealth. Lastly, the team applied thematic analysis to interviews and site visit observations, enabling it to identify recurring themes and patterns in healthcare delivery and system-wide challenges. Key activities included:

- **Nearly 400 Interviews Conducted**: Participants in these conversations included Bureau employees, stakeholders, and external subject matter experts (SMEs).
- **12 Institutions Visited**: The team spent much of their time on-site observing healthcare practices and facility conditions.
- **Over 170 Adults in Custody Interviewed**: These conversations enabled the team to gather firsthand accounts of patient experiences.

The study encountered several challenges that affected the scope and consistency of the evaluation. With only 12 out of 121 facilities visited, the findings may not fully represent the broadly diverse and complex operating environment. Difficulty accessing population prevalence data limited the ability to fully assess the distribution and needs of the population (though the team has the opportunity to revisit this in Phase 3). The study also encountered some challenges in securing interviews with regional leadership, with only two out of six regional directors (RDs) being available for interviews. Additionally, healthcare delivery observations were limited during some site visits due to lockdowns and modified operations. Lastly, the team had access to several external organizations for benchmarking. That said, the team's target list was longer but did not materialize in collaboration for various reasons.

Findings Overview

The team presents the following key findings, strengths, challenges, and recommendations for improving healthcare services for AICs. Those selected to discuss below are thematic and not exhaustive, focusing on critical areas where targeted improvements can significantly enhance the quality of care.

Chapter 4 (Healthcare Quality Assessment) provides additional detail, highlighting strengths and challenges across three parts: a) Care Dynamics (care levels, continuum, environment), b) Healthcare Services (intake, prevention, emergency, sick care, dental, behavioral health, etc.), and c) Healthcare Operations (staffing, finance, data).

The recommendations provided below are meant to provide high-level executive summaries, as this report contains 70 detailed recommendations. For the specific recommendations, please refer to the corresponding recommendation sections within the report or the extracted recommendations displayed on a spreadsheet referred to as Appendix G. All the recommendations have been categorized by priority levels—top, high, medium, and low (as shown in Table 7).

Key Findings: Healthcare Quality Assessment (see chapter 4)

I. Staffing Levels and Resource Allocations Do Not Align with Care Demands

- **Strength:** BOP employees demonstrate remarkable adaptability and commitment, often taking on multiple roles to fulfill diverse responsibilities, underscoring their critical role in supporting the safety and security of the institutions.
- **Challenge:** The current staffing levels, recruitment strategies, and the utilization of support roles are not meeting the increased healthcare demands, leading to inefficiencies and potential risks to patient safety and timeliness of care.
- **Recommendation:** Implement staffing-to-patient ratios aligned with care level requirements, deploy a specialized HR team for healthcare recruitment and retention, and expand the use of paraprofessionals to support clinical employees.

II. Specialty Populations and Behavioral Health Services Require More Coordination

- **Strength:** BOP employee's commitment to providing care despite resource constraints is a key strength, as they strive to meet the needs of AICs, including those with specialty population needs and behavioral health services.
- **Challenge:** There is limited availability of specialty care, integrated healthcare services, trauma-informed care practices, and post-release support, as well as standardized training for both stigma reduction and knowledge enhancement in areas related to specialty populations, which impacts the effectiveness and equity of care.
- **Recommendation:** Broaden the range of mental health professionals, expand trauma-informed care practices, and provide targeted mental health training to providers and correctional officers. Establish community outreach and peer support specialists to support post-release healthcare continuity.

III. Standardization and Integration of Care Require Immediate Improvement

- **Strength:** The BOP has demonstrated innovation in process efficiency by using medical buses and integrating multi-disciplinary teams, which enhance operational cohesiveness and patient-centered care.

  Challenge: Inconsistencies in screening, triage, and emergency protocols, along with fragmented healthcare delivery, contribute to variability in the safety, effectiveness, and equity of care.

  Recommendation: Standardize screening and triage protocols, integrate healthcare services across medical, dental, vision, and mental health domains, and ensure that healthcare equipment and procedures are consistent across all facilities based on care levels and staffing patterns to improve the safety, effectiveness, and equity of care.

IV. Data-Driven Financial Management Falls Short in Projecting Rising Care Cost

- **Strength:** The BOP has maintained operational efficiency in the face of financial constraints through resourceful and innovative approaches to care delivery. Financial oversight at the institutional level is supported by the active tracking of healthcare spending by health services administrators (HSAs) and business administrators. Additionally, implementing the Uniform Financial Management System (UFMS) and using national prime vendors for pharmaceuticals and medical-surgical supplies facilitate accurate tracking and analysis of financial data.
- **Challenge:** The current financial management processes, including comprehensive medical services contracting, bill adjudication, and financial reporting, face inefficiencies due to delays in invoice processing, variations in reimbursement rates, and the separation of healthcare data and financial systems. These systems remain largely standalone, preventing a unified view of both clinical outcomes and costs. This separation hinders the

ability to scrutinize high-cost treatments effectively and limits accurate cost tracking, budget management, and informed decision-making.

- **Recommendation:** Conduct an independent evaluation of comprehensive medical services contracts to explore transitioning from a volume-based to a value-based model. Enhance the bill adjudication process by implementing standardized utilization management (UM) data collection. Improve accountability with contractor performance indicators and financial reporting processes to enhance resource management.

V. Inefficient Electronic Systems Cannot Adequately Support Current Demands

- **Strength:** Implementing internal dashboards has improved the timeliness and effectiveness of healthcare delivery by enhancing process tracking and providing real-time data access.
- **Challenge:** The current electronic health record (EHR) system (the Bureau Electronic Medical Record; BEMR) lacks modern features, reducing efficiency and increasing potential errors. Additionally, the absence of a standardized electronic medical bed management system hinders effective resource allocation and timely care transitions. Furthermore, most software systems, including BEMR, operate as standalone platforms, preventing the Bureau from integrating data across different areas.
- **Recommendation:** Enhance the EHR system by adding modern features such as clinical support tools, speech-to-text options, and better integration with other internal systems. Additionally, a medical bed management system should be implemented to ensure efficient resource allocation and that AICs are placed in facilities that are aligned with their medical needs. Lastly, software systems should be evaluated for potential integration with other BOP systems to ensure more comprehensive data analysis and improved outcomes.

VI. Medical Equipment Management Is Insufficient for Effective Care Delivery

- **Strength:** Institutions proactively approach patient safety by ensuring clear signage for radiation and other health hazards.
- **Challenge**: Despite these advancements, inconsistent management of medical equipment, including poor inventory control and irregular maintenance schedules, leads to frequent breakdowns and inefficiencies in resource use.
- **Recommendation:** Implement a comprehensive medical equipment management plan that includes rigorous inventory control, regular maintenance schedules, and contingency planning to ensure that all necessary equipment is functional and readily available, improving the overall quality of healthcare services.

Key Findings: Utilization Review (see chapter 5)

Utilization Review (UR) is a systematic process to evaluate and manage the necessity, appropriateness, and efficiency of healthcare services provided by AICs. It involves

multidisciplinary teams who assess medical cases to ensure that patient care aligns with community standards and is delivered in a timely and effective manner. The UR process also includes using tools like InterQual to support decision-making and monitor the quality of care across institutions.

VII. Utilization Review: Resource Distribution and Staffing Limit Efficiency and Effectiveness

- **Strength:** Multidisciplinary UR committee (URC) teams, which include medical personnel and employees from various departments such as Corrections, Chaplaincy, and Psychology, contribute to patient safety by providing comprehensive case reviews for complex and high-risk patients. This collaborative approach offers diverse perspectives supporting informed and patient-centered care decisions.
- **Challenges:** Limited resource allocation for UR and financial management, combined with staffing shortages—particularly the absence of specialized personnel like healthcare financial management experts and UR nurses—creates difficulties in consistently conducting URC meetings and hinders the effective management and streamlining of the UR process.
- **Recommendations:** Expand healthcare financial services by adding dedicated financial management positions at the institutional level and a healthcare actuary at the Central Office. Additionally, hire UR nurses at non-MRC institutions to enhance the effectiveness of URC meetings and improve the timeliness of care decisions.

VIII. Utilization Review: Processes Face Delays and Inconsistencies in Decision-Making

- **Strength:** The UR process benefits from well-established protocols, including multi-level reviews for high-cost, high-risk consultations, which enhance safety and ensure appropriate care for AICs. Additionally, the BOP's clear guidelines on URC timelines promote timely decision-making, helping to ensure that AICs receive necessary care without unnecessary delays.
- **Challenges:** The current UR process is hindered by inefficiencies, including delays in bill adjudication, inconsistent use of clinical decision-making tools like InterQual, and the overburdening of clinical directors (CDs) with administrative tasks. These inefficiencies impact the timeliness and accuracy of care decisions.
- **Recommendations:** Enhance the efficiency of the UR process by allowing UR authorities to independently approve or deny requests outside of URC meetings. Additionally, the bill adjudication process should produce a standardized UM data set across institutions. Partnering with third-party consult reviewers should be considered to support initial UR requests, with a long-term goal of transitioning to in-house reviews.

IX. Utilization Review: Data Utilization and Technology Warrants Enhancement for Better Outcomes

- **Strength:** The use of InterQual and a unified EHR system (BEMR) across all institutions fosters efficiency and effectiveness in the UR process. InterQual helps align treatment with community standards, while BEMR allows for seamless access to AIC medical records, improving productivity and enabling better monitoring of UR processes across institutions.
- **Challenge:** Difficulties in consistently collecting and analyzing utilization and cost data limit the ability to make informed financial decisions. Inconsistent use of InterQual and the lack of integration between financial management systems and the EHR further complicate these efforts.
- **Recommendations:** Conduct regular assessments to evaluate the consistent use of InterQual across institutions and enhance accountability through inter-rater reliability testing. Improve data management by integrating financial systems with the EHR to enable more accurate tracking of healthcare costs and utilization, thereby supporting better resource management and decision-making.

Key Findings: Telehealth (see chapter 6)

X. Telehealth Program: Staffing and Training Challenges Limit the Program's Effectiveness

- **Strength:** Facilities that implemented telehealth operations reported optimized employee time, enabling correctional employees to focus more on institutional safety and allowing health services units to prioritize consultations.
- **Challenge:** The Telehealth Program's effectiveness was impacted by the limited availability of dedicated Institutional Telehealth Coordinators (ITCs) and the need for more comprehensive training on telehealth equipment and procedures. These factors were associated with operational inefficiencies and inconsistencies in care delivery across institutions.
- **Recommendation:** Hire or designate ITCs at each institution. Consider dedicating ITCs in facilities with Care Level designations of 3 and 4 (see chapter 4: The Care Levels) solely to telehealth duties to provide consistent telehealth support for AICs and contract providers. Consider maintaining Care Level 1-2 facilities' authority to assign clinical tasks that are unrelated to telehealth to their ITCs, provided they assign such duties when telehealth coordination services are not urgently needed or backlogged. This would preserve their ability to maintain healthcare timeliness and quality when they lack the supply of health services employees to meet the demand for healthcare. Develop and implement a comprehensive training curriculum for both the clinical and technological aspects of telehealth to promote standardization of practice across the institutions and prepare employees to manage their resources effectively.

XI. Telehealth Program: Gaps in Standardized Policies and Performance Metrics Affect Consistency and Evaluation

- **Strength:** Telehealth programs observed successfully facilitated data collection on specialty provider treatment rates. Institutions used this data to inform their telehealth operations and utilization reviews, contributing to cost avoidance and optimizing resource allocation.
- **Challenge:** The absence of a unified telehealth policy and standardized performance metrics may lead to variations in how the program is implemented across institutions, making it challenging to consistently evaluate and improve the program's effectiveness.
- **Recommendation:** Develop a standardized telehealth policy that clearly defines roles, responsibilities, and procedures. Establish performance metrics to regularly assess costs, efficiency, and patient outcomes. Implement a continuous improvement process based on these metrics to guide program enhancements and justify resource allocation.

XII. Telehealth Program: Infrastructure and Technology Limitations Constrain Service Access and Delivery

- **Strength:** The Telehealth Program, when implemented and operational, broadened access to care for AICs, particularly in remote institutions, by providing specialty services that were not available on-site.
- **Challenge:** The limited availability of dedicated telehealth spaces may restrict the scope, quantity, and quality of care delivered through the Telehealth Program.
- **Recommendation:** Conduct cost-benefit analyses to assess the value of renovating institutional spaces to create dedicated telehealth areas to support high-volume, reliable telehealth operations that provide a greater level of privacy for AICs and do not disrupt other health services operations. This action would complement HSD's planned purchase of telehealth equipment for institutions. In addition, it would benefit the BOP by identifying underutilized space that can be allocated more efficiently to activities other than telehealth.

Closing

The quality of healthcare provided to AICs reflects a system that is both resilient and strained, with direct implications for fostering a culture of care. The commitment and adaptability of BOP employees are central to maintaining patient-centered care, especially in the face of resource limitations.

The persistent gaps in staffing,[3] resource allocation,[4] and technology integration[5] significantly impact the overall culture of care, leading to inefficiencies and variability in care delivery. Furthermore, inconsistent financial management, outdated electronic health records,[6] and challenges with medical equipment management contribute to delays and disruptions in care. These challenges strain the system, affect the ability to maintain a consistent, high-quality standard of care, and erode the trust and morale of both employees and AICs.

The BOP's leadership is acutely aware of many of these challenges and aims to make improvements by actively working to identify root causes while concurrently advocating for systemic change and the requisite resources. Their ongoing efforts to tackle these issues reflect a dedication to aligning practices with the highest standards, ensuring that both employees and AICs are supported in a healthcare environment that promotes well-being and positive outcomes.

Given the large number of individual recommendations, the team has divided them into priority levels, recognizing that a post-assessment transition plan is forthcoming as part of Phase 3. Sequentially, implementation efforts will require careful planning, sequencing, funding, and staffing to ensure success over time. Many of these call for changes in process or procedure, some minor in scale and others requiring greater effort. Successful implementation is dependent upon detailed planning and quality communication with employees. Some of these opportunities are low-cost and can incrementally enhance initiatives aimed at better tracking healthcare costs, which may lead to both improved stewardship of financial resources and further enhancement of the healthcare enterprise.

Just as breakfast is often considered the most important meal of the day, setting the tone for the day ahead, a strong organizational culture is essential for driving successful outcomes. As the saying goes, "Culture eats strategy for breakfast," emphasizing that even the best strategies can falter without a supportive and resilient culture of care.

Addressing these systemic challenges is crucial to fostering a culture of care that meets and exceeds the healthcare needs of AICs by making them better neighbors for tomorrow.

Next Steps

The subsequent phases of this study will build upon the assessment and recommendations of Phase 1 by expanding the focus to address broader organizational and systemic issues. Specifically, Phase 3 will focus on developing a post-assessment transition plan to guide the BOP in achieving the improvements identified by Phase 1.

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[3] Kelly, L. A., P.M. Gee, & R.J. Butler. "Impact of nurse burnout on organizational and position turnover." *Nursing Outlook*, 69, no. 1 (2021): 96-102. https://doi.org/10.1016/j.outlook.2020.06.008

[4] Shah, M. K., N. Gandrakota, J. P. Cimiotti, et al. "Prevalence of and Factors Associated with Nurse Burnout in the US." *JAMA network open*, 4, no. 2 (2021): e2036469. https://doi.org/10.1001/jamanetworkopen.2020.36469

[5] Buntin M.B., M.F. Burke, M.C. Hoaglin, et al. "The Benefits of Health Information Technology: A Review of The Recent Literature Shows Predominantly Positive Results." *Health Affairs* 30, no. 3 (2011): 464-471. doi:10.1377/hlthaff.2011.0178.

[6] Shekelle, P. G., J.D. Pane, D. Agniel, et al. "Assessment of Variation in Electronic Health Record Capabilities and Reported Clinical Quality Performance in Ambulatory Care Clinics, 2014-2017." *JAMA network open*, 4, no. 4 (2021): e217476. https://doi.org/10.1001/jamanetworkopen.2021.7476

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Chapter 1: Introduction, Scope of Work, and Report Structure

Introduction

Providing comprehensive and timely physical and mental healthcare for the approximately 158,000 adults in the custody of the Federal Bureau of Prisons (BOP, or the Bureau) requires extraordinarily skilled healthcare professionals, adequate diagnostic and procedural equipment within the 121 BOP institutions, and close working collaboration between healthcare professionals and correctional officers.

The BOP's Health Services Division (HSD) provides medical, dental, and mental health (psychiatric) services to adults in custody (AICs). One of eight BOP divisions, HSD is composed of nearly 3,000 healthcare employees, including around 550 Public Health Service (PHS) Commissioned Officers detailed by the Department of Health and Human Services (HHS) to advance its mission. It is important to note that the BOP relies on non-Bureau healthcare providers to supplement its own institutional Health Services Unit (HSU) employees. This is done by sending AICs to off-site medical facilities and/or hospitals as needed, albeit done in a secure manner with correctional officers accompanying the patient, or by bringing providers from those entities into institutions to provide care.

The BOP's capacity to provide comprehensive healthcare to AICs is impacted by (1) its ability to recruit and retain a suitable number of healthcare and custody employees; (2) adequate funding levels appropriated by Congress; (3) efficient and effective stewardship of finite resources at each institution; and (4) the need to prudently balance somewhat contradictory aims of protecting institutional safety with medically appropriate patient access to healthcare.

Further complicating the healthcare delivery imperative are the unique and sometimes deteriorated physical and mental health profiles of those in the BOP's care. The incarcerated population has many more acute psychological and physical health problems than what is expected in the general U.S. population. A 2021 published study found that "older incarcerated persons have rates of chronic illness and disability comparable to rates of non-incarcerated people who are 10 to 15 years older."[7] Concurrent mental health problems, including depression, psychological distress, and suicidal ideation, are also common. Consequently, healthcare costs for older prisoners are up to nine times higher than for younger incarcerated persons." There is no shortage of research demonstrating that the prevalence of trauma and posttraumatic stress disorder (PTSD) is higher among individuals in prison and jail than in the general population. Studies have also shown that when compared to the general population, people who are

[7] Li, Amanda, Brie Williams, and Lisa C. Barry. "Mental and Physical Health of Older Incarcerated Persons Who Have Aged in Place in Prison." *Journal of Applied Gerontology* 41, no. 4 (2021): 1101–10, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8783920/; BOP statistics indicate that about 20 percent of the roughly 1587,000 adults in custody are age 51 and older. About 6 percent of total adults in custody are age 61 and older.

incarcerated are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases such as tuberculosis, hepatitis C, and human immunodeficiency virus (HIV).[8]

Within this challenging setting of insufficient medical staffing and more acute patient care needs, the three tasks incorporated in the scope of work of this study lie.

Scope of Work

The BOP contracted with Jefferson Consulting Group[9] (Jefferson) and the National Academy of Public Administration[10] (the Academy) to work on this one-year project. Jefferson is the prime contractor, and the Academy is the subcontractor partner. The joint study team, herein referred to as "the team," consists of researchers and strategists experienced in corrections, community healthcare, and public administration (see Appendix A for short biographical information on the team's six members). The team's work benefited from active expert counsel and feedback from a five-member Panel Advisory Group (PAG) consisting of Fellows of the Academy. Each member of the PAG has extensive practical experience leading and overseeing prison systems or the provision of healthcare (see Appendix B for short biographical information on members of the PAG).

This study has the following three tasks:

1. Perform a quality assessment on the physical and mental healthcare delivery from the AIC's entry into the BOP until the point of release. This task calls for an assessment of the positive and negative impact related to the BOP's current model of providing care. This assessment includes evaluations of specialty populations such as the aging, persons with disabilities, female AICs, Nursing Care Center patients, Forensic, Seriously Mentally Ill, Memory Disorder patients, and the like.[11]
2. Assess the BOP's utilization review process, providing a detailed examination of any identified shortcomings or process oversights that could lead to delays in care, inappropriate care, unnecessary care, or unnecessary cost for the Bureau.
3. Examine telehealth processes in the BOP, including where improvements can be made and any identifiable roadblocks.

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[8] U.S. Department of Health and Human Services. "Incarceration." Healthy People 2030. Accessed August 8, 2024. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration; Notably, because of the prevalence of HIV, hepatitis C, and Medications for Opioid Use Disorder, these are treated as primary healthcare issues in the BOP context, while they would be typically treated by specialists in the community setting.

[9] Jefferson Consulting Group (Jefferson) has conducted strategic assessments and provided operational support to more than 70 federal agencies over its 28-year history. Its work has included support to the Department of Justice, the U.S. Marshals Service, the Department of Veterans Affairs, the National Institutes of Health, the Department of Health and Human Services, and more. Jefferson is a team of independent, non-partisan management consultants focused on helping the government deliver better services and achieve its important missions.

[10] Since 1967, the National Academy of Public Administration has provided expert advice to government leaders in building and managing more effective, efficient, accountable, and transparent organizations. Its national network of nearly 1,000 Academy Fellows includes former cabinet officers, Members of Congress, governors, mayors, and state and local legislators, as well as prominent scholars, business executives, and public administrators.

[11] These are the specialty populations as defined by the BOP in this project's statement of work.

The study includes a review of previous audits from the Department of Justice's Office of the Inspector General (OIG), the Governmental Accountability Office (GAO), and accreditation bodies (e.g., The Joint Commission on the Accreditation of Healthcare, American Correctional Association, and others) in additional to healthcare quality lawsuits against the BOP. Additionally, the research considers the current state and usage of HSD data analytics, including dashboards and associated infrastructure, along with Quality Management metrics and the use of findings as part of quality improvement processes. The study also includes an assessment of high-cost, high-volume, and high-risk health services operations/processes throughout incarceration with BOP.

Report Structure

This report consists of seven chapters, as detailed below:

Chapter 1: Introduction

Chapter 2: Methodology

Chapter 3: Background

Chapter 4: Healthcare Quality Assessment (Task 1)

- **Part A:** Care Dynamics
- **Part B:** Healthcare Services from Entry to Release
- **Part C:** Healthcare Operations

Chapter 5: Utilization Review Process (Task 2)

Chapter 6: Telehealth (Task 3)

Conclusion

Chapters 4 to 6 follow a consistent structure to organize the content:

- **Topic Background:** Provides essential context by describing the topic within the community (if applicable) and BOP contexts.
- **Strengths and Challenges:** An analysis categorized within the Six Domains of Healthcare Quality, as outlined in chapter 2.
    - **Topic Strengths:** Highlights positive aspects based on research, including observations, interviews, benchmarks, and literature
    - **Topic Challenges:** Identifies difficulties or gaps uncovered through research
- **Topic Recommendations:** Offers suggestions for addressing challenges and closing gaps.

Chapter 2: Methodology

This chapter explains the multifaceted five-step approach used to evaluate healthcare delivery within the Federal Bureau of Prisons (BOP, or the bureau). The five steps include the research Study Approach, Research Design, Data Collection and Instruments, Data Analysis, and Report Writing.

Step 1: Research Study Approach

Part A: Mixed-Methods Approach

This research methodology organized qualitative and quantitative data according to each of the three tasks from the study scope of work.[12] The approach accounted for qualitative and quantitative data, enabling the team to expand and strengthen conclusions to provide actionable recommendations that are informed by various frameworks (see Step 4: Data Analysis).

Part B: Formulation of Research Questions

Workgroups for the respective tasks developed pertinent research questions based on initial background research and not-for-attribution stakeholder interviews. The list of research questions is provided in Appendix D.

Part C: Study Population

Reviewing the healthcare system of Adults in Custody (AICs) from entry to halfway house release entailed a stratified and purposive sampling method, allowing for engagement with a diverse array of stakeholders, including:

- **AICs:** Individuals who have been convicted of violating federal laws and are sentenced to serve time in a federal correctional facility. This includes individuals who are awaiting trial for federal offenses and those held for civil contempt or as material witnesses. For this study, the AIC population was divided into two groups:
    - **General AIC population:** AICs under 65 years of age who do not have a physical or mental disability that would have prevented them from being interviewed or safely observed during healthcare service delivery.
    - **Specialty populations:** AICs over 65 years old, persons with disabilities, females, pregnant AICs, and the seriously mentally ill.
- **Healthcare professionals and administrators:** Health Services employees who are directly involved in healthcare delivery and decision-making at the Central Office, regional offices, and institutional level.

[12] The team uses the BOP's definition of telehealth from the April 17, 2024 Updated Telehealth Guidance memorandum throughout this report: "All healthcare provided wherein the patient and provider are separated, and delivery of care is facilitated by use of telecommunication technology."

- **Healthcare-adjacent employees:** BOP employees who indirectly affect healthcare delivery and decision-making at all levels, such as Wardens, Associate Wardens (AWs), medical trip officers, and business administrators.

Step 2: Research Design

As noted in chapter 1, the scope of work calls for comparisons with at least two other government agencies and one large non-governmental healthcare system for the utilization review and telehealth tasks. California's Department of Corrections and Rehabilitation (CDCR), Immigration and Customs Enforcement Health Services Corps (IHSC), and Massachusetts General Hospital (MGH) have been selected as the most appropriate benchmarks.[13] Their suitability for benchmarking is based on their:

- Organizational mission
- Population
- Reputation amongst stakeholders in the study and practice of correction, such as state departments of corrections and accrediting bodies
- Resources, such as the number of medical beds or the quantity of telehealth equipment.

Step 3: Data Collection Methods and Instruments

Part A: Resource Review

The BOP shared several documents to understand the historical context of its healthcare practices, primarily the Department of Justice (DOJ) Office of the Inspector General (OIG) and Government Accountability Office (GAO) audits affecting healthcare and independent reports. In subsequent literature reviews, the team reviewed additional audits, policies, and academic studies.

Interviews (see Part C below) prompted requests for additional internal materials from interviewees on a not-for-attribution basis, such as meeting minutes, recurring reports, draft policies, and training materials. Additionally, the team received multiple Health Services Division (HSD) dashboard briefings to give a fuller picture of internal technological capabilities.

Part B: Site Visits

Members of the research team visited 12 BOP sites between April and July 2024 to observe healthcare practices.[14] Sites were selected by BOP leadership and reflected a diversity of custody levels, missions, and populations. Each visit lasted approximately three days on-site, consisting of a kickoff meeting with the warden and executive leadership, a facility tour, employee and AIC interviews, and healthcare delivery observations when possible.[15] At the end of each visit, the

[13] The team would like to thank the benchmarking organizations for contributing to this study. Their willingness to share their time, data, and policies significantly enriched this research, identifying and inspiring opportunities to improve the Bureau of Prisons system.
[14] The list of sites can be found in Appendix E.
[15] Visiting teams were unable to observe primary or specialty healthcare delivery at a few sites due to lockdowns or modified operations. Under these restrictions, only essential services like pill line and

visiting team led a brief close-out meeting summarizing the strengths and challenges observed. These visits were invaluable for understanding local conditions that affect daily operations.

Part C: Interviews

Not-for-attribution interviews occurred in-person and virtually using videoconferencing platforms and followed interview guides designed for each interview. Interviews occurred with:

- **BOP Healthcare Professionals and Administrators:** The team conducted interviews with over 300 employees at the Central Office, regional, and institutional levels across a variety of departments, including and beyond HSD, such as custody, finance, and education.[16] The BOP provided initial lists of employees to interview for Central Office and regional offices, with the team identifying additional Central Office and regional interviewees and follow-up conversations as needed. At the institutional level, the team selected interviewees based on the wide array of positions critical to understanding healthcare delivery, including people such as contracting specialists, recreation employees, and correctional officers. The breadth and volume of these interviews supported the team's understanding of the scope of responsibilities and priorities that the BOP needs to juggle in order to balance AIC safety and security with health and wellness.
- **General and Specialty Population AICs:** In addition to employees, the team utilized a stratified and purposive sampling approach to interview 170 AICs in person across the 12 site visits. The team requested to speak with AICs in both representative populations: the general population and specialty population AICs, such as persons with disabilities, AICs over 65 years old, pregnant women, and others. These conversations enabled the team to conduct patient-centered research, supplementing employee interviews and clinical observations (see Part D) with patients' first-hand experiences.
- **Benchmarks:** The team met with multiple experts within benchmarking organizations to better understand policies, implementation approaches, and potential best practices. More information about benchmarking can be found in Step 2: Research Design.
- **Subject Matter Experts (SME):** The team conducted interviews with SMEs across corrections, healthcare, correctional healthcare, and government to leverage their specialized knowledge. Their unique insights and innovative approaches identified strengths and challenges within the existing structure and processes, opportunities for improved functioning, and community standards that may be relevant to healthcare delivery.

Part D: Healthcare Quality Observation Forms

A component of site visits was observing clinical encounters such as pill line, chronic care visits, and sick call. The team developed a framework to consistently and cohesively organize healthcare

emergency care were delivered. This experience highlights the unique challenges that are regularly encountered when providing healthcare within a correctional environment, where safety and security are most important.

[16] The list of BOP employee, AIC, benchmark, and subject matter expert interviewees can be found in Appendix C.

observations during site visits and to evaluate the quality of each interaction.[17] The team categorized clinical encounter notes by strengths and challenges according to the Six Domains of Healthcare Quality (see Step 4: Data Analysis), and clinical quality from the overall visit was quantified on a scale from 1-5 using a "reasonable person standard" devised by the research team. These ratings enabled systemic comparison of the quality of care across the 12 institutions for internal awareness. At the same time, the observations were cited when summarizing the strengths and challenges at each institution's close-out meeting and informing many of the strengths and challenges highlighted in chapter 4.

Step 4: Data Analysis

Part A: Analytical Approaches

The team used several techniques and frameworks to organize findings and structure recommendations, including:

Thematic Analysis

The team extracted key themes from Central Office, regional, and institutional interviews with employees and AICs and organized them in Excel by the identified strengths, challenges, and opportunities for improvement. This categorized approach facilitates a more thorough understanding of the qualitative data's content and frequency.

Six Domains of Healthcare Quality

The Institute of Medicine's (IOM) influential "Six Domains of Healthcare Quality" was used to organize clinical encounter observations and institutional interview themes by category. The team also used the domains as a framework to structure strengths and challenges, as shown in chapter 4. These domains represent six specific aims for improvement, stating that healthcare should be:

- **"Safe:** avoiding injuries to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- **Patient-Centered:** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, in particular, waste of equipment, supplies, ideas, and energy.

[17] An example of this framework can be found in Appendix F.

- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."[18]

As shown below in Figure 1, these six domains are essential for assessing the quality of healthcare services in a holistic manner. (in gold, bottom right)

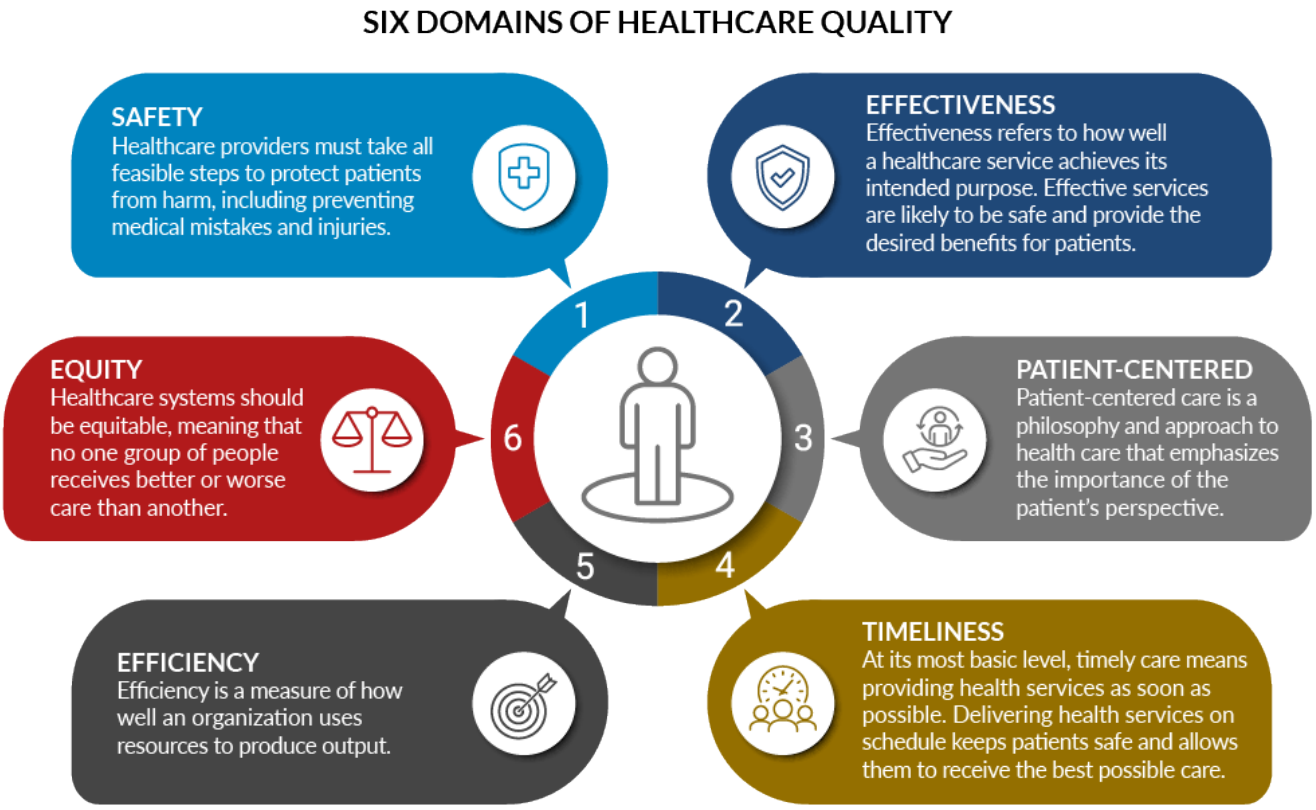

Figure 1: *Six Domains of Healthcare Quality*
(Source: Quality Gurus, 2024. Figure created by the team)[19]

People, Process, Technology

The People, Process, Technology (PPT) framework emphasizes the interconnectedness of these three key elements in achieving business objectives. The PPT structure was utilized to organize strengths, challenges, and recommendations for the utilization review and telehealth tasks. Figure 2 reflects a visual representation of this framework.[20]

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[18] Institute of Medicine (US) Committee on Quality of Healthcare in America. "Improving the 21st Century Healthcare System." In *Crossing the Quality Chasm*. National Academy Press, 2001. https://www.ncbi.nlm.nih.gov/books/NBK222265/.
[19] Quality Gurus. "Six Domains of Healthcare Quality." Accessed July 22, 2024. https://www.qualitygurus.com/six-domains-of-healthcare-quality/.
[20] Smartsheet. "Everything You Need to Know about the People, Process, Technology Framework. Last modified July 19, 2021. https://www.smartsheet.com/content/people-process-technology.

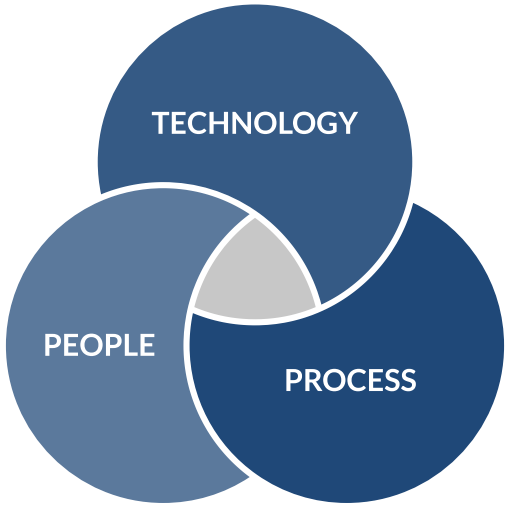

Figure 2: *People, Process, Technology framework (Source: Smartsheet, 2024)*

SMART Goals

SMART is a framework for setting objectives that are Specific, Measurable, Achievable, Relevant, and Time-bound.[21] This methodology encourages the creation of goals that are clear, focused, and aligned with the desired outcomes, increasing the likelihood of successful achievement. The SMART framework was employed to make precise, meaningful recommendations grounded in literature review, stakeholder interviews, and site visit observations.

Healthcare Recommendations Prioritization

Given the high number of recommendations, the team devised six criteria to help prioritize each recommendation:

- **Urgency**: Is immediate action necessary to prevent harm?
- **Impact**: What is the potential benefit to health outcomes and patient satisfaction? How much of the AIC population would this affect?
- **Resource Availability**: Are the necessary resources (people, process, technology) readily available?
- **Stakeholder Input**: How critical do stakeholders (e.g., interviewees, research) view the recommendation?
- **Compliance Requirements**: Is the recommendation required for compliance with legal or oversight standards [OIG, GAO, best practices in healthcare]?
- **Feasibility and Scalability**: How feasible is the recommendation in terms of complexity and required timeline? Can it be scaled appropriately to similar facilities?

[21] Forbes online. "The Ultimate Guide to S.M.A.R.T Goals." Last revised July 9, 2024. https://www.forbes.com/advisor/business/smart-goals/.

The team established priority levels by evaluating recommendations based on how many criteria they met, with each criterion contributing equally to the assessment. Recommendations that satisfied up to two criteria were initially classified as low priority, while those meeting three or four criteria were classified as medium priority. Recommendations that fulfilled five or six criteria were classified as high priority. "Initially" reflects the fact that the system is broadly intended to help categorize recommendations but is directive – not authoritative – in its usefulness. For example, after reviewing all high-priority recommendations, the team has selected 11 recommendations to classify as "top priority" based on perceived urgency, importance in laying the foundation for implementing other recommendations, and level of impact across the organization.

Part B: Stakeholder Engagement

Communication with stakeholders throughout the research and analysis process was important in guiding the team's approach. Weekly meetings with the BOP project manager and Contracting Officer's Representatives (CORs) provided regular opportunities to ask questions and gain insights as the research progressed. The team also worked to facilitate an Interim Observations briefing to review key findings from resource review and Central Office and regional interviews. Additionally, there was regular engagement with the Panel Advisory Group (PAG) to seek their perspectives.

Part C: Creating Recommendations

Recommendations drawn from this research are guided by best practices employed by benchmarking organizations, as well as BOP challenges and opportunities for improvement observed by the team, BOP interviewees, and other outside stakeholders. As mentioned, recommendations are structured around the SMART framework, reference the Six Domains of Healthcare Quality framework, and are categorized according to the People, Process, Technology framework. The team assigned low, medium, or high priority to each recommendation based on the priority framework (see Part A: Analytical Approaches) to support the implementation sequence.

Step 5: Report Writing

Please refer to the "Report Structure" section in chapter 1 for more information.

Chapter 3: Background

This chapter contains a broad and brief overview of the Federal Bureau of Prisons (BOP or Bureau) health services' organizational structure, staffing, and governance to serve as the context for subsequent chapters. This chapter is not intended to be comprehensive.

Organizational Structure

The BOP's health services operation is structured into three levels: the Health Services Division (HSD) in Central Office, regional offices, and health services units (HSUs) at institutions.

Central Office

The Health Services Division (HSD) at the Central Office plays a pivotal role in supporting and overseeing health services operations across the field, as illustrated in Figure 3 below. Its responsibilities encompass "medical, dental, and mental health (psychiatric) services provided to adults in custody [AICs] in BOP facilities, including healthcare delivery, infectious disease management, and medical designations."[22]

HSD aids operations by developing policies and clinical guidance essential for the effective delivery of health services at both regional and institutional levels. Additionally, it holds the ultimate decision-making authority over medical designations, such as determining AIC eligibility for transfer to one of the seven Medical Referral Centers (MRCs). HSD collaborates closely with the regional offices on initiatives and information-sharing, while regional offices are tasked with providing direct support to individual institutions.

Figure 3 presents an abridged version of the BOP's organizational chart for HSD situated within the Central Office in Washington, D.C. There are Central Office health services employees and institution health services employees, with some Central Office employees being assigned to specific regions to provide guidance and oversight for the institutions in that region.

[22] Federal Bureau of Prisons. "Health Services Division." Last accessed August 15, 2024. https://www.bop.gov/about/agency/org_hsd.jsp.

Figure 3 includes the following positions:

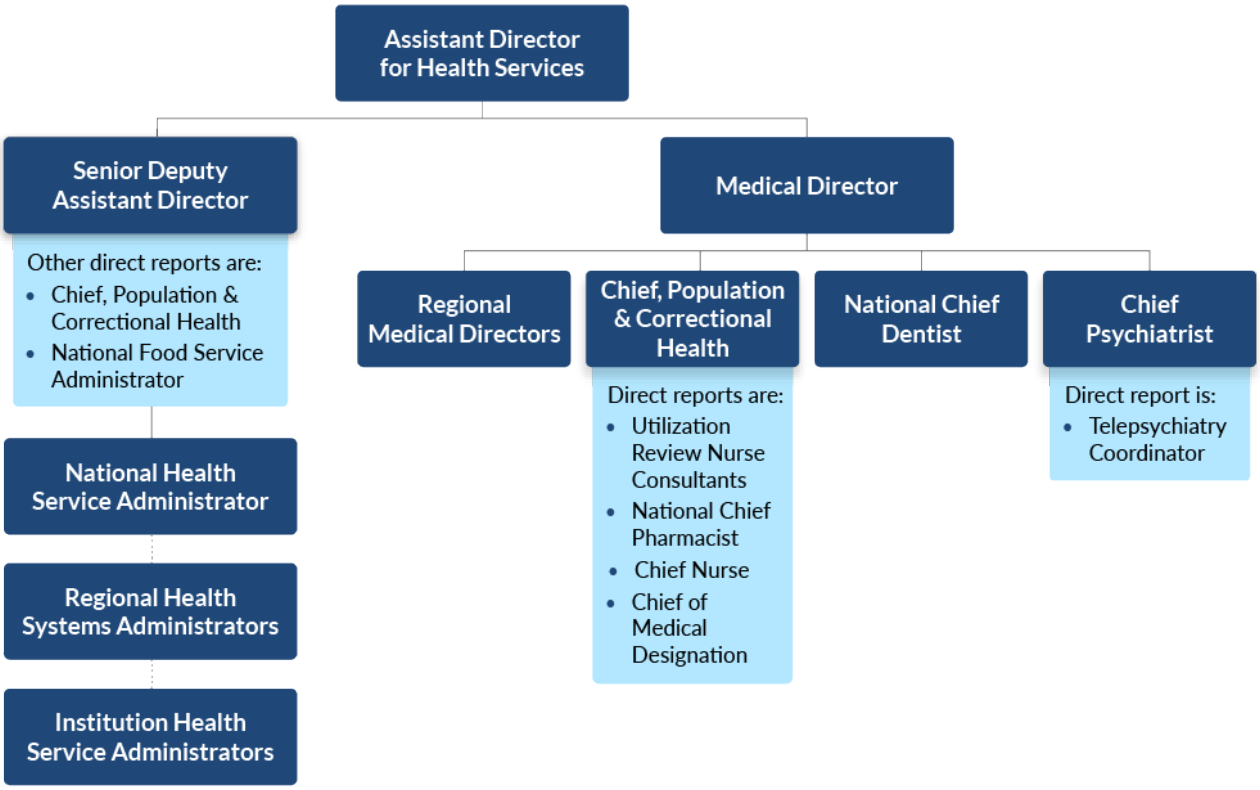

Figure 3: *Abridged BOP HSD Organizational Chart*
(Source: Figure created by the team)

- **Assistant Director (AD) for Health Services**
- **Senior Deputy Assistant Director (SDAD) for Health Services and direct reports:** Responsible for setting the direction and strategy of non-clinical medical operations, including healthcare administration, occupational and employee health.[23] Directly oversees the National Health Service Administrator, who is responsible for health services administration across the BOP.
- **Medical Director:** Responsible for providing direction, strategy, and clinical guidance for all clinical operations within the BOP. Oversees:
    - Chief of Health Programs and direct reports
    - National Chief Dentist

[23] National Academy of Public Administration et al. *Assessment of the Bureau of Prisons' Organizational Alignment with Healthcare Mission*. Washington, D.C., 2019. https://s3.us-west-2.amazonaws.com/napa-2021/studies/federal-bureau-of-prisons-medical-data-managment/BOP_NAPA_Deliverable_1_Final.pdf.

- Chief Psychiatrist and direct report

Regional Offices

The regional offices serve an advisory role, ensuring that Central Office policies, objectives, and guidance are effectively communicated and implemented at the institutional level. As stated previously, there are some Central Office employees assigned to specific regions to provide guidance and oversight for the institutions. Health services employees responsible for the regional level monitor health data reported by each institution, utilizing dashboards and viewing monthly reports to track performance on key metrics and identify areas for improvement. Additionally, they assist institutions in addressing challenges, such as backlogs in AIC chronic care visits, by providing subject matter expertise, employee training, and region-wide discussions. When institutions face key position vacancies or significant backlogs in care, regional professional officers may be temporarily deployed, either in person or remotely, to provide the necessary support. Each of the six regional offices is responsible for overseeing approximately 20 institutions within its jurisdiction. The regional offices and their corresponding states are as follows:

Mid-Atlantic Region (MXR)	North Central Region (NCR)	Northeast Region (NER)	Southeast Region (SER)	South Central Region (SCR)	Western Region (WXR)
Delaware, Kentucky, North Carolina, Maryland, Tennessee, West Virginia, and Virginia.	Colorado, Iowa, Kansas, Illinois, Indiana, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin.	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Vermont.	Alabama, Florida, Georgia, Mississippi, Puerto Rico, and South Carolina.	Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.	Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, Wyoming, and Utah.

Table 1: *Regional offices and their corresponding states.*
(Source: BOP website. "About Our Facilities." Table created by the team.)[24]

Reflecting the organizational structure, "chief" or "national" medical and administrative leadership positions in the HSD Central Office have corresponding Central Office roles assigned to the six regional offices and corresponding roles in the 121 institutions; for example, "Health Service Administrator" positions are reflected at each level with the National Health Service

[24] U.S. Department of Justice, Federal Bureau of Prisons. "About Our Facilities." Accessed August 14, 2024. https://www.bop.gov/about/facilities/offices.jsp.

Administrator, Regional Health Systems Administrators (RHSAs), and institution Health Service Administrators (HSAs).

Health Services Units at Institutions

HSUs deliver health services and implement Central Office policies at the institutional level. Institutions have some flexibility to adapt these policies to their unique circumstances, such as staffing levels and location-specific factors. Healthcare within each institution is directed and managed by a Clinical Director (CD) and an HSA, whose responsibilities mirror those of their counterparts in the regional and Central Offices. The CD oversees all clinical providers and practices within the institution and has the final authority to approve most off-site medical treatment for AICs through the utilization review (UR) process.[25] Meanwhile, the HSA is tasked with non-clinical responsibilities, such as healthcare administration, personnel management, workflow organization, and coordination with other institutional departments, including Correctional Programs. Both the CD and HSA report directly to the Associate Warden (AW) of Operations of their institution. Notably, in Medical Referral Centers (MRCs), an additional AW is specifically assigned to oversee health services operations, as described below.

Correctional Programs Division

The Central Office houses the Correctional Programs Division, which is responsible for setting policies, developing standards, and providing overall strategic direction for institutional security (correctional services) and AIC case management (correctional programs) nationwide. This division works closely with other Central Office divisions to align operations with broader agency goals.

These regional offices serve as the intermediary between the Central Office and individual institutions, ensuring that national policies and directives are implemented effectively across their respective regions. The regional directors (RDs) are supported by regional correctional employees who provide guidance, oversight, and support to the field offices within their region.

At the field level, each institution is managed by a Warden, who serves as the chief executive officer of the facility. The Warden is responsible for the overall operation of the institution, including the implementation of correctional programs and policies as set by the Central Office. The Associate Wardens (AWs) oversee operations and programming and assist the Wardens.

- **Associate Warden of Operations (AWO):** The AWO is responsible for the day-to-day functions, ensuring the safety and security of employees, AICs, and the facility itself. At most institutions, the HSU falls under the AWO's purview.
- **Associate Warden of Health Services (AWHS):** As mentioned above, certain institutions (e.g., MRCs) have an AWHS dedicated to overseeing the HSU, ensuring that medical, dental, and mental health services are provided according to BOP standards.

[25] CDs at MRCs have final authority over all treatment. However, CDs at lower care levels must seek Regional Medical Director approval for some off-site medical treatments and diagnostic procedures. While there may be opportunity to standardize approval processes across the BOP, such research is outside the scope of this report.

- **Associate Warden of Programs (AWP):** The AWP oversees all AIC programming, including educational services, vocational training, psychological services, and recreational activities.

Human Resources Management Division

The Human Resources (HR) Management Division directly supports the operational needs of the HSD by supporting that each facility is staffed appropriately to deliver comprehensive healthcare services. HR within the Central Office oversees HR policies, planning, and program development across the agency. This division handles essential HR functions such as staffing, recruitment, employee benefits, and compensation, ensuring compliance with federal regulations and alignment with the agency's strategic needs.

A Consolidated Staffing Unit located in Grand Prairie, Texas, specializes in recruiting and placing employees for all federal prisons. By centralizing these processes, this unit plays a critical role in fulfilling the staffing requirements that support the health services provided at various BOP facilities.

In addition to the Central Office and the Consolidated Staffing Unit, each institution has its own HR department tasked with implementing the Central Office's policies and managing day-to-day personnel activities, including hiring, training, performance evaluations, and employee relations. The presence of HR at the facility level helps to support local staffing needs.

Staffing

As of June 5, 2024, HSD is comprised of approximately 2,900 healthcare employees, including Public Health Service (PHS) Commissioned Officers and contractors, spread across the Central Office, regional offices, and the HSUs at institutions.[26]

Overview

Understanding the current staffing landscape within the BOP is essential, as staffing levels are a critical component of the health services system. Staffing within BOP institutions consists of direct hires by the BOP as well as personnel provided through comprehensive medical services contracting (CMSC) companies (see chapter 1: "BOP Continuum of Care" and "Outpatient Specialty Care" subsections for more information on CMSCs).

Research consistently shows that appropriate healthcare staffing levels are crucial for patient outcomes. Studies indicate that higher staffing levels, particularly in nursing, correlate with better outcomes, such as lower patient mortality and fewer medical errors.[27] Legislative and systematic reviews further support the impact of multidisciplinary staffing on reducing mortality rates and

[26] These numbers come from a June 5, 2024 data pull from the BOP Automated Staffing Tool, which is a tool that tracks the current number of employees per department per institution, identifies how many positions are currently authorized for that institutional department, and recommends a higher or lower number of employees per department based on its population and needs. This tool is currently in development and not publicly available. Once fully implemented, it is expected that the tool will still be consistently iterated upon.

[27] Aiken, L.H., D.M. Sloane, J.P. Cimiotti, et al. "Implications of the California Nurse Staffing Mandate for Other States." *Health Services Research* 45, no. 4 (2010): 904-921. doi: 10.1111/j.1475-6773.2010.01114.x.

enhancing overall patient care quality.[28] Adequate staffing not only improves patient safety and satisfaction but also enhances job satisfaction among healthcare workers, underscoring the need for well-regulated staffing policies.[29]

To fully grasp the complexities of staffing levels within the BOP, it is essential to consider not only the overall numbers but also the specific factors that affect the availability and effectiveness of the workforce. While research underscores the critical importance of adequate healthcare staffing in improving patient outcomes, the reality within BOP institutions reveals significant disparities between the number of positions filled, authorized, and recommended. These gaps, highlighted in Table 2, result from various factors, including historical hiring freezes and recent staffing shortages exacerbated by the COVID-19 pandemic.[30] These issues are outlined in the following key problem areas:

Currently Filled Positions	Authorized Positions	Recommended Positions	Gap between Filled & Authorized	Gap between Filled & Recommended
2,895	3,657	6,245	20%	53%

Table 2: *HSD Staffing Levels Across the Bureau.*
(Source: Data pulled from BOP Automated Staffing Tool. Table created by the team)[31]

- Filled: Number of positions currently occupied by employees.
- Authorized: Number of positions that have been approved for the agency to fill.

[28] U.S. Congress. Senate. Committee on Health, Education, Labor, and Pensions. *Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2021*. 117th Congress, 1st sess., 2021. S. 1567. https://www.congress.gov/bill/117th-congress/senate-bill/1567/text.

[29] Ziemek, J., N. Hoge, K.F. Woodward, et al. "Hospital personnel perspectives on factors influencing acute care patient outcomes: a qualitative approach to model refinement." *BMC Health Services Research* 24, no. 1 (2024): 805. doi: 10.1186/s12913-024-11271-x.

[30] The order instituted a 90-day hiring freeze for federal agencies and intended to be succeeded by a long-term workforce reduction plan developed by the Office of Personnel Management. It prohibited federal agencies from filling vacant positions and hiring contractors to fill positions that would otherwise be filled by full-time employees. While the hiring freeze was lifted on April 12, 2017, some restrictions for hiring remained. For example, agencies could only hire one new employee for every two vacant positions. In addition, the COVID-19 pandemic exacerbated staffing shortages across the healthcare sector. See: Politifact. "Impose a hiring freeze on federal employees." Accessed August 24, 2024. https://www.politifact.com/truth-o-meter/promises/trumpometer/promise/1352/impose-hiring-freeze-federal-employees/; and U.S. Departments of Defense, Justice, Veterans Affairs, and Health and Human Services, Pandemic Response Accountability Committee. *Review of Personnel Shortages in Federal Health Care Programs During the COVID-19 Pandemic*. September 2023. https://www.oversight.gov/sites/default/files/oig-reports/PRAC/healthcare-staffing-shortages-report.pdf.

[31] These numbers come from a data pull from the BOP Automated Staffing Tool, which is a tool in development that tracks the current number of employees per department per institution, identifies how many positions are currently authorized for that institutional department, and recommends a higher or lower number of employees per department based on its population and needs. This tool is not available to the public.

- Recommended: Number of positions suggested by internal assessments or external bodies that indicate how many positions should ideally be filled to meet operational demands.

The figures above are derived from the BOP's Automated Staffing Tool, which is a draft model in development. Therefore, this preliminary data should be understood as an indicator of staffing gaps rather than exact and fully validated actuals and estimates.

Beyond these numbers, several specific issues further complicate the staffing landscape and directly impact the ability to deliver consistent, high-quality healthcare services within the prison system, including:

- **Operational Readiness:**
  - Many "currently filled positions" are not operational due to employees being on various types of leave, including vacation, family or medical leave, administrative leave, or military deployment.
- **Interdependence of HSD and Correctional Staffing:**
  - The productivity of HSD's currently filled positions is heavily influenced by the availability of filled correctional officer positions, as security needs impact the ability to deliver health services.
    - During custody staffing shortages, facilities may go into "lockdown" or modified operations, which restricts AIC movement and complicates access to healthcare services.
    - Escorted medical appointments are frequently canceled due to custody staffing shortages, disrupting scheduled healthcare treatments.
- **Clinical vs. Support Staffing Imbalance:**
  - There is a critical distinction between clinical employees (e.g., doctors, nurse practitioners [NPs]) who provide direct patient care and support employees (e.g., medical records assistants) who perform non-clinical duties.
    - When the proportion of clinical versus support administrative employees is unbalanced, the delivery of healthcare is impacted.
- **Impact of Non-Medical Role Shortages on Healthcare:**
  - Similarly to support employees, when there is a shortage of positions filled in administrative roles (such as contracting, business administration, and human resources), it also impacts healthcare service delivery.
- **Augmentation Temporarily Reassigns HSU Employees:**
  - When there is a shortage of correctional officers, HSU employees may be reassigned to work a custody post. While some Central Office and institutional leadership interviewees stressed that augmentation is only required of non-clinical employees, institutional interviewees indicated that clinical employees also get augmented as needed. Regardless, augmenting both clinical and non-clinical employees affects the smooth operation of institutional HSUs.

Governance

To understand how staffing levels are managed and aligned with organizational objectives, this subsection will examine the governance structures and guiding policies that drive operational decision-making.

Overview

The governance of the HSD is structured around a series of program statements and clinical guidelines that establish the standards and procedures for delivering healthcare to the federal AIC population. These documents are essential for ensuring consistent, legally compliant, and aligned healthcare with recognized medical standards.

Program Statements

Program statements issued by the BOP are official policy documents that outline the rules, responsibilities, and procedures for the operation of health services across all BOP institutions. These statements serve as the primary governance tools for the HSD, providing detailed instructions on various aspects of healthcare delivery. The key program statement referred to throughout this report is Program Statement 6031.05 (Health Services Administration), which delineates the organizational structure of health services, including staffing requirements, the scope of medical care provided, and the procedures for maintaining accurate medical records. This statement ensures that all BOP facilities follow a standardized approach to healthcare administration.

Clinical Guidelines

Clinical guidelines within the BOP are developed to provide evidence-based recommendations for the treatment and management of medical conditions commonly encountered in the incarcerated population. For example, the BOP has established guidelines for the management of chronic conditions such as hypertension, diabetes, and Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS). These guidelines provide best practices for screening, diagnosis, treatment, and monitoring of these conditions within the correctional environment, ensuring that AICs receive appropriate care.

Internal Audits and Peer Reviews

The BOP's HSD governance framework also includes mechanisms for oversight and compliance. Internal audits and peer reviews are conducted regularly to ensure that healthcare services are delivered in accordance with established program statements and clinical guidelines.

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Chapter 4: Healthcare Quality Assessment

This chapter addresses current medical and mental health processes from the point at which an adult in custody (AIC) enters a facility at intake up to their release to a residential reentry center placement, home confinement, or full-term community release.

Part A: Care Dynamics

The AIC Profile

Chapter 1 of this report states that "Person for person, the incarcerated population in U.S. prisons carries a far more challenging set of mental and physical healthcare needs than the general population." The purpose of this section is to expand on that statement to convey how unique and challenging the population is. It provides a general profile of AICs, including their socioeconomic and healthcare outlook prior to and during incarceration, as well as specialty populations.

Demographics of the AIC population change daily. The following tables show the distribution of AICs in the BOP by gender identity, age, and ethnicity as of October 6, 2024.[32]

Gender Identity	Number of AICs	Percentage of AICs
Male	146,243	93.3%
Female	10532	6.7%
Other	2,257	1.4%

Table 3: *Gender Demographics of AICs*
(Source: BOP website. "Inmate Statistics- Gender". Table created by the team)

Age Range	Number of AICs	Percentage of AICs
Under 18	11	0.0%
18-21	1,356	0.9%
22-25	7,103	4.5%
26-30	17,124	10.9%
31-35	26,241	16.7%
36-40	27,376	17.5%
41-45	26,583	17.0%
46-50	19,121	12.2%
51-55	13,325	8.5%
56-60	8,508	5.4%
61-65	5,262	3.4%
Over 65	4,765	3.0%

Table 4: *Age Demographics of AICs*
(Source: BOP website. "Inmate Statistics- Age". Table created by the team)

[32] U.S. Department of Justice, Federal Bureau of Prisons. "Inmate Statistics." Last modified October 6, 2024. https://www.bop.gov/about/statistics/statistics_inmate_age.jsp.

Race	Number of AICS	Percentage of AICs
Asian	2,363	1.5%
Black	60,933	38.9%
White	89,009	56.8%
American Indian or Alaska Native	4,470	2.9%

Table 5: *Race Demographics of AICs*
(Source: BOP website. "Inmate Statistics- Race". Table created by the team)

Forty-four (44) percent of AICs are serving sentences for drug offenses, 22 percent for weapons, explosives, or arson, and thirteen (13) percent for sex offenses.[33]

Health Outlook and Patient Acuity Prior to and During Incarceration

The term patient acuity "refers to the severity of an illness or medical condition."[34] It is important to understand the factors that can impact AICs' health outlook prior to, during, and after incarceration to fully appreciate the increased patient acuity of health and mental health conditions that the BOP healthcare operation must care for. The list of social determinants of health (SDOH) below provides a useful lens through which to do so. The U.S. Centers for Disease Prevention and Control (CDC) adopts the World Health Organization's definition of the SDOH as "the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age. These forces and systems [...] that shape daily life such as economic policies and systems, development agendas, social norms [and policies], and political systems."[35]

Social Determinants of Health

1. Economic Stability
2. Education Access and Quality
3. Healthcare Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

The U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion literature summary on incarceration reports that AICs' mental and physical health and socioeconomic conditions in the community prior to and following incarceration are worse than

[33] U.S. Department of Justice, Federal Bureau of Prisons. "Offenses." Inmate Statistics. Last modified August 10, 2024. https://www.bop.gov/about/statistics/statistics_inmate_age.jsp.
[34] Definitive Healthcare. "Patient Acuity." Accessed August 13, 2024. https://www.definitivehc.com/resources/glossary/patient-acuity#:~:text=What%20is%20patient%20acuity%3F,should%20receive%20care%20before%20others
[35] Center for Disease Control and Prevention (CDC). "Social Determinants of Health (SDOH)." Last modified January 17, 2024. https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html.

those of non-incarcerated peers in the community.[36] A 2015 report from the Prison Policy Initiative found that "in 2014 dollars, incarcerated people [in state systems] had a median annual income of $19,185 prior to their incarceration, which is 41 percent less than non-incarcerated people of similar ages."[37] They are often from economically disadvantaged areas with access to fewer and lower quality opportunities to receive education, healthcare, transportation, and job opportunities.[38]

The BOP provides medical care to a population with generally worse physical and mental health compared to the non-incarcerated community.[39] Contributing factors include a history of limited access to healthcare, engagement in high-risk behaviors, and occupational hazards prior to incarceration. Many incarcerated individuals (AICs) have not routinely sought primary or specialty care before imprisonment, leading to an increased prevalence of chronic and severe conditions as they age. For instance, substance misuse and inadequate access to dental care often result in acute dental issues among AICs. These interconnected determinants of health contribute to the overall poorer health outcomes observed within this population.

The Continuum of Care

Background

Community Standard Continuum of Care

A continuum of care is a fundamental concept within healthcare. It emphasizes the need for comprehensive and coordinated service delivery to individuals over time and across various touchpoints of a robust healthcare system. The continuum includes a broad spectrum of services, from preventive and primary care to specialized services, long-term services and support, and end-of-life care, ensuring that patients receive appropriate care throughout their lifetime.

A complete continuum of care aims to facilitate seamless transitions between different health episodes and acuity levels, minimizing gaps and redundancies as patients move from one healthcare setting or service to another. A strategic approach to a continuum of care not only

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[36] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Incarceration." Healthy People 2030. Accessed August 24, 2024. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration.

[37] The Prison Policy Initiative is a non-profit, non-partisan advocacy organization that produces research to highlight harms resulting from incarceration. Its report, "Prisons of Poverty: Uncovering the pre-incarceration incomes of the imprisoned" is based on data from the Bureau of Justice Statistics. See: Rabuy, Bernadette and Daniel Kopf. Prisons of Poverty: Uncovering the pre-incarceration incomes of the imprisoned. Prison Policy Initiative. 2015. Accessed August 23, 2024. https://www.prisonpolicy.org/reports/income.html#:~:text=We%20found%20that%2C%20in%202014,incarcerated%20people%20of%20similar%20ages.

[38] Williams, David R., Selina A. Mohammed, Jacinta Leavell, et al. "Race, Socioeconomic Status, and Health: Complexities, Ongoing Challenges, and Research Opportunities." *Annals of the New York Academy of Sciences* 1186, no. 1 (2010): 69–101. https://doi.org/10.1111/j.1749-6632.2009.05339.x.

[39] Healthy People 2030. "Incarceration." Accessed October 21, 2024. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration.

improves patient outcomes but also boosts the efficiency and effectiveness of the healthcare system while maximizing value to the community in which it is located.[40]

The BOP's Continuum of Care

The BOP endeavors to align with the community standards of a comprehensive healthcare continuum, emphasizing a healthcare-first approach. The BOP's continuum of care encompasses a wide array of services that vary greatly depending on the institution's location and designated care level.

The healthcare continuum includes services such as:

- Intake screenings
- Physical examinations
- Routine care
- Pharmacy services
- Basic diagnostics
- Dental and vision care
- Chronic disease management
- Urgent sick care
- Psychology services
- Rehabilitative services such as physical, occupational, and respiratory therapy

Additional services include ancillary support like social work and restorative programs such as the Residential Drug Abuse Program (RDAP). While the Health Services Division (HSD) handles most physical and psychiatric healthcare, the Reentry Services Division (RSD) contributes to the continuum of care by providing psychological services.

HSD utilizes comprehensive medical services contracts (CMSCs) to supplement the capacity of BOP employees to provide medical services in coordination with off-site medical providers. These contracts allow AICs to access medical services in local clinics, hospitals, and on-site with specialty clinics. A CMSC varies in scope, and its service array supplements the continuum at each institution, commonly offering some specialty, laboratory, and other advanced diagnostics services. Access to community-based emergency services (e.g., hospital emergency rooms) often relies on coordination and transfer of care between the institution's emergency response team and local emergency medical services (EMS) and hospital care systems. More about CMSCs can be found in the "Inpatient Hospitalization & Outpatient Specialty Care" section later in this chapter.

Additionally, many challenges within the BOP's continuum of care have been compounded by the complex nature of policy development, which can extend the timeline for implementing systemic changes necessary to align with an integrated, patient-centered approach to healthcare delivery. For instance, the 2024 Patient Care policy, initially drafted in 2016, underwent multiple rounds of review and discussion with key stakeholders before being finalized and accepted in April 2024.

[40] Khatri, Resham, Aklilu Endalamaw, Daniel Erku, et al. "Continuity and care coordination of primary healthcare: a scoping review." *BMC Health Services Research* 23, no. 1 (2023). https://doi.org/10.1186/s12913-023-09718-8.

The Care Levels

The BOP assigns one of four levels of healthcare, including mental healthcare, to each institution and AIC.[41] Each institution's assigned care level is determined by identifying its clinical resources and capabilities and those in the surrounding community, such as proximity to a major hospital, access to emergency vehicles, and availability of certain specialists like oncologists.[42] Once a care level is determined, efforts are made to equip the institution with the appropriate staffing and equipment resources for its care level. This classification impacts the ways that institutions are organized and operated. For example, all institutions between Care Levels 1-3 are referred to as "line institutions." Additionally, there are seven Care Level 4 institutions known as "Federal Medical Centers" (FMCs) or "Medical Referral Centers" (MRCs). The term FMC is used for the name of institutions like FMC Lexington, while the term MRC is used in program statements and other official documents. The seven MRCs "provide healthcare services to [AICs] with more serious chronic or acute medical conditions."[43] Each MRC has one or more clinical specialties. Together, they provide services including but not limited to: dialysis, oncology, inpatient and forensic mental health, surgery, prosthetics and orthotics, and end-of-life care.

The following Care Level Classification Guide provides definitions for each of the four care levels:

Medical Care Levels
Care Level 1 institutions house AICs that are generally healthy but may have limited medical problems easily managed by HSU employees and supplemented by existing community resources.
Care Level 2 institutions house AICs that have stable chronic conditions managed by HSU employees and supplemented by existing community resources. Care Level 2 AICs generally self-manage their conditions and need infrequent visits to medical specialists or community facilities.
Care Level 3 institutions house AICs having more complex medical conditions and are more fragile. They require frequent clinical contact with HSU employees and more visits to community medical specialists. They may also periodically require hospitalization to stabilize their conditions.
Care Level 4 institutions are the agency's MRCs. AICs housed at MRCs may require extensive medical and nursing care. Some [AICs] may require 24-hour nursing care, including assistance with activities of daily living such as feeding, toileting, and dressing. These AICs may have frequent visits to medical specialists or hospitalizations for specialized medical care that isn't available in the MRC.

Table 6: *HSD Care Levels*
(Source: BOP Care Level Classification: Clinical Guidance, 2019)[44]

[41] Each compound at institutions that are correctional complexes are often assigned different care and mental health care levels.
[42] U.S. Department of Justice, Federal Bureau of Prisons. *Care Level Classification for Medical and Mental Health Conditions or Disabilities: Federal Bureau of Prisons Clinical Guidance.* May 2019. https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf.
[43] U.S. Library of Congress, Congressional Research Service, *Healthcare for Federal Prisoners,* by Nathan James, IF11629 (2020).
[44] U.S. Department of Justice, Federal Bureau of Prisons. *Care Level Classification for Medical and Mental Health Conditions or Disabilities: Federal Bureau of Prisons Clinical Guidance. May 2019.*

Assigning an AIC a Care Level

Upon entry, an AIC is assigned a provisional care level via the Designation and Sentence Computation Center (DSCC) or the Office of Medical Designations and Transportation (OMDT).[45] The severity level primarily considers information from an AIC's presentence investigation report, which often is incomplete with regard to health history or has contradictory information that must be corroborated when the AIC entered custody. Once an AIC arrives at their designated facility, an institutional physician reviews their provisional care level.[46] Based on information gathered during the history and physical (H&P) and/or initial chronic care clinic visit conducted at the institution, the provider then assigns the AIC a nonprovisional care level. In so doing, the provider determines the AIC's unique medical needs, considering factors such as the AIC's level of functioning, the frequency of care that may be needed, and the complexity of their healthcare needs. The provider may indicate that the AIC needs redesignation.

The care level designation for an AIC can change while they serve their sentence. Redesignations occur when an AIC's medical needs no longer fit their assigned care level. A change in care level can sometimes prompt a transfer to an institution better equipped to address a changed care level. If an AIC's care level increases to a Care Level 3 or 4, a redesignation referral request is submitted via electronic health record (EHR) after review by a physician. The regional medical professionals, OMDT, and/or the Chief of Health Programs review these submitted requests for a final decision.

Strengths of Care Level Assignments

Efficiency/ Effectiveness:

- **Considering Community Resources:** When determining the care level of an institution, community resources are taken into consideration to ensure AICs can access the appropriate care. Institutions have various strengths and challenges in the way of community resources, from differences in local emergency services response times to the ability to hire medical employees based on the facility's location. Considering local community resources when determining an institution's care level is an efficient and effective way to leverage the strengths of each institution while working around its challenges.

Patient-Centeredness:

- **Considering Patient Acuity:** Considering patient acuity aids with optimizing patient care and provider workload. The care level designation system facilitates the allocation of appropriate resources to higher care levels for more acute care, which can increase timeliness, quality of care, and patient-centered care.

Challenges of Care Level Assignments

Efficiency:

[45] DSCC is located at the Grand Prairie Office Complex in Texas. They are responsible for classifications and designations of AICs. OMDT, an office in HSD, is responsible for reviewing criteria for assigning and transporting AICs who require specific medical care.
[46] U.S. Department of Justice, Federal Bureau of Prisons, *Care Level Classification*.

- **No Defined Staffing Ratios for Care Levels:** While there are no formal staffing ratios explicitly tied to care levels, staffing and equipment guidelines are reviewed annually by the National HSA and Regional HSAs. These guidelines consider multiple factors beyond care level designations, such as the institution's healthcare missions (e.g., female healthcare, security level, bus hub operations, and detention center status). The designation of an institution's Care Level may consider the availability of community resources, which can influence initial decisions on staffing and equipment needs. However, care level alone does not determine staffing or equipment decisions; they are influenced by the broader context of the institution's needs. When an institution's care level changes, such as from Care Level 2 to Care Level 3, resource allocation—including both staffing and equipment—is reported to be part of that discussion. However, during site visits, it was reported at some institutions that care level changes occur without immediate approval for additional employees, equipment upgrades, or recognition of the community's resources and services available.

Timeliness:

- **Lengthy Wait Times After Redesignations:** Redesignating an AIC's care level throughout the sentence merits diligent review at the institutional, regional, and Central Office levels. Specifically, Care Level 3 and 4 AICs are reviewed by OMDT. Due to resource challenges such as the number of inpatient beds and staffing shortages, these wait times for transfer after redesignation by OMDT can be lengthy, often taking months to years.
- **MRC Transfers:** Only seven MRCs within the BOP are responsible for providing care to the sickest and most vulnerable populations. Patient conditions can rapidly change, but waitlists for transfers to MRCs can have lengthy wait times due to a lack of adequate bed space and staffing resources to accommodate the demand. There were 92 AICs on the waitlist for an MRC transfer by the end of July 2024.[47]

Effectiveness:

- **Patient Acuity Does Not Match Care Level:** Several institutions reported receiving patients who need more intensive care than they are equipped to provide, often due to a lack of medical information in the pre-sentence investigation report or incomplete transfer requests. Alternatively, some patients have deteriorated to a level of care that exceeds the facility's capabilities. This mismatch often complicates the delivery of quality care, as facilities are forced to handle patients with needs beyond what they can adequately support. Such inappropriate placements further strain facilities that are already struggling with limited employee capacity.

Patient-Centeredness:

- **Consideration of Mental Health:** The current care level system separates mental healthcare from medical care, resulting in a fragmented approach that minimizes the connection between physical and mental health. AICs with high mental health needs often

[47] This figure is based on a document internal to the BOP that is not public.

have higher rates of both chronic and acute physical illnesses,[48] requiring additional medical support. However, the existing siloed care level systems do not adequately address this need.

Care Level Recommendations

Recommendation 4.1 (People): Establish staffing-to-patient ratios tailored to align with the care level requirements of each institution, incorporating all relevant factors impacting both patient and staffing needs.

- ***Rationale:*** Different care level designations require varied standards of care from medical employees. As care levels increase, institutions need more employees to address their population's needs. BOP should identify the appropriate ratio and standardize it across all institutions. Additionally, it is important that the Human Resource Management Division allocates the approved positions to institutions. Furthermore, this recommendation requires adequate funding to support the staffing array. The forthcoming BOP Automated Staffing Tool (AST)[49], which is designed to assist with comprehensive staffing needs assessment beyond solely medical care levels, is expected to become a critical tool for real-time, data-driven staffing decisions, ensuring that staffing adjustments are responsive to both anticipated and emergent needs.
- ***Priority (Top Priority):*** This is an urgent, critical need that will contribute to improved patient care.

The Care Environment

Environment Background

A comprehensive continuum of care hinges on creating therapeutic environments and relationships beyond physical spaces to foster and facilitate effective treatment and recovery.[50] The BOP's aging infrastructure disrupts these therapeutic elements by hindering care coordination and privacy, complicating rapid responses to medical emergencies, and offering environments that are generally harsh and distressing—conditions that are not conducive to the physical and mental stability or recovery of incarcerated individuals.

Due to the natural setting of a correctional environment, therapeutic environments must be established within institutions. Therapeutic environments are designed to produce a positive atmosphere and improve a person's mental state by implementing sensory elements that individuals can see, touch, and smell. The team observed several positive therapeutic

[48] Fiorillo, Andrea, Ivona F. Simunovic, Oye Gureje, et al. "The Relationship between Physical and Mental Health: An Update from the WPA Working Group on Managing Comorbidity of Mental and Physical Health." *World Psychiatry 22*, no. 1 (2023): 169-170. Accessed August 13, 2024. https://doi.org/10.1002/wps.21055.

[49] This tool is currently in development and not publicly available. Once fully implemented, it is expected that the tool will still be consistently iterated upon.

[50] Sui, T. Y., McDermott, S., Harris, B., & Hsin, H. (2023). The impact of physical environments on outpatient mental health recovery: A design-oriented qualitative study of patient perspectives. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10115290/; Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse-patient relationships in mental healthcare: A systematic review of interventions to improve the therapeutic alliance. *International journal of nursing studies*, *102*, 103490.

environments at FMC Lexington, FMC Carswell, Federal Correctional Institution (FCI) Coleman, and United States Penitentiary (USP) Allenwood that could be replicated at other facilities.

Environment Strengths

Effectiveness

- **Dog Training Provides Emotional Support:** AICs participating in the dog training program are provided education on basic dog obedience and how to train service dogs for community members in need. AICs reported it helps reduce anxiety and stress by providing emotional support and companionship. The presence of dogs fosters an environment more conducive to empathy and responsibility. Animal-assisted intervention programs may lead to lower recidivism rates and violence.[51]

Patient-Centeredness

- **AICs Appreciate Sensory Elements:** Sensory elements, such as sandbox fidget sets, were present at FMC Carswell. AICs report that they like access to these items in the calm room.
- **Fish Tanks Create a Nature-Inspired Focal Point:** USP Allenwood utilized faux fish tanks in some housing units to offer alternative focal points and bring a more natural element.
- **Art Facilitates a Calming Environment:** At FMC Lexington and FMC Carswell, some walls were painted in more soothing colors, and murals were used to provide visual stimulation, which notably creates a more relaxing environment.
- **Horticulture Empowers AICs and Teaches Marketable Skills:** AICs participating in the horticulture program learn the responsibilities of growing and maintaining plants, which they reported creates a sense of normalcy and helps alleviate stress. Research shows that gardening serves several purposes, including reducing idle time, training AICs in portable skills, and giving them a sense of achievement.[52]

Equity

- **Art Access Empowers Everyone:** Arts education in correctional settings can help AICs struggle with self-worth, confidence, and empowerment issues, providing equal opportunities for personal growth and rehabilitation.

Environment Challenges

Safety:

- **Overcrowding Negatively Impacts Health and Resources**: Populations are expected to exceed capacity by 10 percent in 2024, as highlighted in the DOJ Federal

[51] Villafaina-Dominguez, Beatriz, Daniel Collado-Mateo, Eugenio Merellano-Navarro, et al. "Effects of Dog-Based Animal-Assisted Interventions in Prison Population: A Systematic Review." *Animals* 10, no. 11 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7697666/.
[52] Flinn, Nancy. "The Prison Garden Book." Burlington: National Gardening Association, 1985.

Prison System Fiscal Year (FY) 2024 Performance Budget Congressional Submission.[53] This overcrowding exacerbates mental stress, increases violence among AICs, and elevates the demand for healthcare services due to poor mental health outcomes and the spread of infectious diseases.

Efficiency:

- **Facility Design Not Conducive to Healthcare Needs:** The facilities visited were originally designed with security as the top priority, often predating the advent of advanced healthcare technology. The team and interviewees noted that their existing physical layout and square footage frequently failed to meet the growing demand for additional healthcare equipment and staffing. Observations from the team's visits indicated that some institutions have had to utilize non-clinical spaces, such as education departments, for essential medical activities like administering medications due to insufficient clinical areas.

- **Physical Infrastructure Does Not Support New Technology**: Institutional interviewees sometimes noted that the outdated physical infrastructure could not typically be retrofitted for modern electrical equipment needs, impacting the operation of crucial healthcare machinery, such as X-ray and magnetic resonance imaging (MRI) machines.

Environment Recommendations

Recommendation 4.2 (Technology): Implement therapeutic enhancements by integrating evidence-based design elements. Simple, immediate additions such as live plants, fish, strategic paint colors, mixed media artwork, and murals could start in medical and psychology service areas and expand to housing units to create a more positive healing atmosphere.

- ***Rationale:*** Research supports integrating natural elements and thoughtful design into therapeutic environments to significantly improve patient outcomes by reducing stress, improving mood, and fostering overall well-being. Incorporating live plants, natural lighting, and calming colors such as blue and green enhances the healing atmosphere and supports health and recovery. Additionally, a well-maintained and aesthetically pleasing treatment space positively influences patients' perceptions of care quality and their emotional state.
- ***Priority (Medium):*** This recommendation is feasible, and resources (AICs with artistic talents and horticultural skills) are readily available at BOP institutions.

Part B: Healthcare Services

This section examines how an AIC moves through the healthcare system, from initial entry into a facility to the point of community reentry. This report helps to determine how and whether the healthcare services provided to AICs meet the quality framework identified by the Six Domains of

[53] U.S. Department of Justice. *Federal Prison System - FY 2024 Performance Budget, Congressional Submission.* Washington, D.C.: March 3, 2023. https://www.justice.gov/d9/2023-03/bop_se_fy_2024_pb_narrative_omb_cleared_3.23.2023.pdf.

Healthcare Quality (described in chapter 2) and seeks to identify tangible short-term and long-term improvement strategies.

Intake Screenings and Physical Examination

Intake Screening

Medical intake screening, timing, and elements are codified in Patient Care Policy 6031.05. The extent of this screening varies depending on whether an AIC is newly admitted to the BOP or transferring between institutions. [54]

- **Newly Incarcerated:** According to policy, within 24 hours of arrival at an institution, AICs must undergo an initial health screening conducted by a healthcare provider. This assessment, recorded in the EHR, aims to identify urgent health needs, intoxication or withdrawal symptoms, necessary housing or work restrictions, transmissible diseases, pregnancy, disabilities requiring accommodations, substance use history, and current medication needs, including Medication for Opioid Use Disorder (MOUD), and any recent Prison Rape Elimination Act (PREA) history.[55] If an AIC is acutely ill and cannot be safely monitored by the institution, they are transferred to a local emergency department following consultation with a CD. If an AIC is medically stable but requires more acute care, then the CD can initiate a redesignation request for transfer to another institution (see "Inpatient Hospitalization & Outpatient Specialty Care" section later in this chapter).[56]
- **Bureau Intra-System Transfers Screening:** HSU employees at the receiving institution review the Bureau EHR Exit Summary to assess what AIC healthcare needs may be upon arrival, even for "in-transit" institutions that only hold AICs for a few days. The provider at the receiving institution then initiates a new intake screening as outlined above to review and update the AIC's health documentation.

Intake Physical Examination[57]

- **Newly Incarcerated**: During the initial health screening described above, each AIC's available health record is reviewed and co-signed by a Licensed Independent Practitioner (LIP). These exams occur within 14 days of incarceration for those with identified chronic medical or behavioral health conditions and within 30 days for all other AICs. This exam, which is conducted by Advanced Practice Providers (APPs) or LIPs, is essential to identifying immediate medical needs, with specifics on dental and mental health assessments outlined in separate program statements. All institutions must provide basic diagnostic services during the initial physical examination, including:
    - HIV testing is ordered for all AICs universally unless an AIC chooses to opt-out

[54] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6031.05: Patient Care*. Washington, D.C., May 14, 2024. https://www.bop.gov/policy/progstat/6031.05.pdf
[55] The intake screening does not ask explicitly about PREA history; rather, the screening asks generally about history of abuse and AICs can elaborate in a free text field if they would like.
[56] The Patient Care Program Statement does not distinguish between what acute care needs require emergency room placement vs. can be handled on site. However, BOP Central Office personnel clarified that these distinctions do exist.
[57] Ibid.

- Hepatitis testing is ordered for all AICs universally unless an AIC chooses to opt-out
- Tuberculosis screening is required for all AICs
- Sickle cell screening is offered if clinically indicated
- Sexually Transmitted Disease (STD) testing is offered if clinically indicated
- A pregnancy test is ordered for all women of childbearing age if not done during intake; an AIC may refuse screening
- Chest X-ray is offered if clinically indicated
- ECG is offered if clinically indicated

AICs with chronic conditions are subsequently enrolled in specialized chronic care clinics. Findings needing intervention are recorded in the EHR, frequently triggering the need for the CMSC to identify a provider to perform secondary testing.

- **Bureau Intra-System Transfers:** While AICs transferring between institutions need to complete another intake screening upon arrival at their new institution, they do not need to undergo another physical examination.

Intake Screening and Physical Examination Strengths

Timeliness

- **Schedule in Policy:** Scheduling frameworks are in place to ensure newly incarcerated AICs receive initial health screenings within 24 hours as mandated, demonstrating a commitment to timely healthcare access.

Equity

- **Equity in Policy:** Policies require equality for each AIC in the care provided, regardless of background or health status. Intake screening questions also target certain specialty populations to help support equitable care. This includes asking about PREA, STDs, pregnancy, and other specialty population medical needs.

Intake Screening and Physical Examination Challenges

Timeliness

- **Lags in Continuity of Care**: The process of retrieving and coordinating patient health records involves several time-consuming steps. After medical findings are entered into the EHR, the HSU must first locate previous health records from various external providers, a task that can be delayed by issues such as discrepancies in record-keeping or slow responses from other healthcare institutions. Once the necessary records are gathered, scheduling further evaluations and diagnostic tests introduces additional delays.

Patient-Centeredness

- **Culture of Compliance:** According to policy, AICs are required to accept the screening intake, as it serves as a critical safety mechanism for identifying infectious diseases and other immediate health concerns. However, AICs are not required to accept other services, such as full H&P or CCC services. While refusal of medical care is generally permitted in

most cases, refusal of the intake screening may impact housing decisions, such as placement in the general population, as a necessary safety measure.[58]

Efficiency

- **Duplicative Testing:** AICs must undergo an intake screening even if they are simply transferring between BOP institutions. Given the limited number of healthcare employees and the fact that an intake screening has already been completed for AICs at their first institution, this practice may be an inefficient use of resources.

- **Poor Allocation of Resources:** Due to limited staffing, APPs, and physicians are often the providers completing the intake process, rather than RNs or paramedics. This task assignment takes advanced providers away from their primary care duties.

Effectiveness

- **Limited Evidence-Based Practices:** While all facilities use a standardized intake screening form as mandated by policy, which serves as a critical safety mechanism for identifying infectious diseases and other immediate health concerns, there is variability in the overall effectiveness of the screening process. This inconsistency may be due to potential inadequacies of the tool itself or inconsistent application and follow-through during the assessment process. Additionally, it remains unclear whether the intake screening tool is evidence-based and validated for the specific population or if it was developed internally without an external validation process. If the tool was internally developed, it could explain its application and utility variability. Conversely, if the tool is evidence-based, further exploration of whether it is being utilized with fidelity would require additional assessment. Regardless, both the tool and its application processes observably contributed to differences in the effectiveness of care provided.

Intake Screening and Physical Examination Recommendations

Recommendation 4.3 (Process): Require HSD employees to take an AIC's height and weight during the initial intake process and during each history and physical exam.

- ***Rationale:*** While visiting institutions, the team observed that height and weight were not consistently recorded. AICs often reported changes in their weight after intake, making it critical to have accurate records of their weight and height at intake and other common touchpoints to effectively manage and assess their health.
- ***Priority (Low):*** This would be an easy, feasible recommendation to implement based on available resources and could enhance the institutions' safety and operational profiles.

Recommendation 4.4 (Process): Boost operational efficiencies by eliminating duplicative intake screening, laboratory testing, and other diagnostic assessments when transferring AICs through Bureau Intra-system Transfers.

- ***Rationale:*** Due to limited resources and low staffing, duplications and inefficiencies are more harmful than helpful. By eliminating the need to complete screening on AICs with every move among institutions, HSU employees can focus more time and resources on

[58] Ibid.

treating chronic care patients, conducting screenings for newly incarcerated AICs, and seeing patients through the sick call process.

- ***Priority (Low):*** Implementing this recommendation would be simple and not require additional resources but does not have an immediate, direct impact on improved patient outcomes.

Recommendation 4.5 (Process): Implement integrated care models such as The Comprehensive Theory of Integration to support the integration of medical, dental, vision, and mental health services to streamline and support a comprehensive continuum of care.

- ***Rationale:*** Integrated interprofessional team-based models differ from traditional team medicine structures by emphasizing greater collaboration across a broader range of disciplines. These models focus on general medical and mental health providers and incorporate specialties such as dental, vision, ancillary, and rehabilitative care professionals. This approach goes beyond simply co-locating services and emphasizes shared decision-making, care coordination, and a holistic approach to treatment. By addressing multiple health domains simultaneously, integrated models can improve healthcare quality, increase efficiency, reduce costs, and enhance health equity.[59] Adopting this model allows AICs to receive more cohesive care that addresses multiple aspects of their health, ultimately improving their overall well-being.
- ***Priority (High):*** To achieve whole-person, quality healthcare, it is necessary to adopt models that make this goal attainable, such as the integrated care model. This would require policy, system, process, technology, and personnel changes.

Recommendation 4.6 (Process): Implement standardized, evidence-based screening tools at healthcare touchpoints such as intake, annual exams, and as needed throughout the patient's care continuum.

- ***Rationale:*** Utilizing validated screening tools for mental health, substance use disorders, and infectious diseases can improve early detection and intervention. For instance, using the Patient Health Questionnaire (PHQ)-9 for depression screening and the CAGE questionnaire for alcohol use can provide valuable insights into the health status of newly incarcerated individuals and how that may change over time.
- ***Priority (Top Priority):*** This is a high priority that would require updated templates and training to ensure that medical needs are properly identified to improve care and help avoid adverse health outcomes.

[59] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Healthcare Services; Committee on Implementing High-Quality Primary Care. "Integrated Primary Care Delivery." In *Implementing High-Quality Primary Care: Rebuilding the Foundation of Healthcare*, edited by S. K. Robinson, M. Meisnere, R. L. Phillips Jr., and L. McCauley. National Academies Press, 2021. https://www.ncbi.nlm.nih.gov/books/NBK571813/.

Preventative Health Education & Literacy

Preventative Education

The community standard for preventative public health education programs includes addressing broader SDOH to support improved population health outcomes, such as anti-smoking campaigns, fitness programs, and mental health awareness. Preventative education improves the overall community health outcomes by promoting lifestyle changes. Engaging AICs in health education programs that often include peer educators has been found to improve knowledge and participation in preventative health behaviors.[60] In addition to public health education, the success of preventative health measures is contingent upon ensuring that institutions have sufficient funding to provide recommended vaccinations and other preventive services. It is recommended that budgeting considerations be aligned with preventive health guidelines to ensure that cost does not become a barrier to delivering comprehensive preventative care.

Health Literacy Services

Health literacy is crucial for ensuring patients effectively manage their health and navigate the healthcare system. It encompasses the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Enhanced health literacy leads to better patient outcomes by improving individuals' capacity to follow treatment plans accurately, access preventive services, and identify symptoms that require medical attention.

Based on conversations with employees at all levels, the term "health literacy" is not widely recognized within the BOP's education or health services departments. Addressing this gap is critical, as health literacy is directly linked to how well patients can manage their health and interact with healthcare professionals. In populations with lower educational levels, it is important to tailor health literacy efforts by utilizing plain language, interactive methods like the teach-back technique, and visual aids. Furthermore, providing culturally relevant materials and offering translation services where needed can enhance engagement and comprehension.

Preventative Health Education & Literacy Recommendations:

Recommendation 4.7 (People): Develop health promotion and disease prevention programs based on community standards that involve multi-disciplinary teams, including HSU, Psychology, recreation, food services, and chaplain services.

- ***Rationale:*** The current health promotion and disease prevention programs rely heavily on the recreation department to stay operational, with minimal collaboration with the HSU. Effective disease prevention requires a comprehensive public health approach that integrates various services and disciplines. Multi-disciplinary teams can provide more holistic care by addressing physical, mental, and social health needs, which aligns with best practices in community health standards.[61] By involving diverse departments, these

[60] Public Health England. "Engaging inmates in health education programs." *Public Health Reports* 135, no. 2 (2020): 250-261.
[61] Centers for Disease Control and Prevention. "10 Essential Public Health Services." Last accessed August 21, 2024. https://www.cdc.gov/public-health-gateway/php/about/?CDC_AAref_Val=https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.

programs can be more effective and inclusive, ensuring they are considered integral components of patient care standards.[62]

- ***Priority (Low):*** Implementing this recommendation would require existing human resources to spend more time collaborating on preventative efforts but would provide patients with a more holistic understanding of how to maintain good health.

Recommendation 4.8 (Process): Incorporate best practices in health literacy into patient care standards, employee training, and healthcare documentation and materials. Additionally, inter-department collaboration with educational services should be fostered to enhance understanding and implementation of these practices across all related sectors.

- ***Rationale:*** Increasing health literacy may generate buy-in from AICs to take more control of their health, setting them up for success during and after incarceration. To successfully make this change, HSD should follow best practices. (1) Incorporate plain language in all health communications—both oral and written.[63] (2) Implement the teach-back method, which is an interactive communication technique where patients are asked to repeat the information explained during healthcare visits to confirm their understanding. This method has been shown to enhance understanding and retention of medical instructions, significantly improving adherence to treatment plans.[64] (3) Add visual aids such as diagrams, videos, and infographics to help clarify complex medical information and procedures. Research has demonstrated that multimedia educational tools are particularly effective in improving understanding and engagement, especially among populations with lower literacy levels.[65] (4) Provide health information that is culturally and linguistically appropriate. This involves offering translation services and culturally relevant materials that resonate with diverse communities' specific beliefs, practices, and languages.[66] (5) Engaging health professionals (e.g., educators, public health professionals, nurse educators, or social workers) within the institution who can provide contextually appropriate health education will effectively increase health literacy. These individuals should be trained to deliver health education within the security

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[62] *Primary Healthcare on the Road to Universal Health Coverage: 2019 Monitoring Report*. Geneva: World Health Organization, 2019. Accessed August 21, 2024. https://www.who.int/publications/i/item/9789240029040.

[63] Kutner, M., E. Greenberg, Y. Jin, et al. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. Washington, D.C.: U.S. Department of Education, 2006. https://nces.ed.gov/pubs2006/2006483.pdf.

[64] Sudore, Rebecca L., & Dean Schillinger. "Interventions to Improve Care for Patients with Limited Health Literacy." *Journal of Clinical Outcomes Management* 16, no.1 (2009): 20-29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2799039/.

[65] Meppelink, C. S., E. G. Smit, B.M. Buurman, et al. "Should We Be Afraid of Simple Messages? The Effects of Text Complexity on The Perceptions And Comprehension Of Web-Based Cancer Information By Older Adults." *Health Communication* 30, no. 12 (2015): 1181-9. Doi: 10.1080/10410236.2015.1037425; Kripalani, S., R. Robertson, M.H. Love-Ghaffari, et al. (2007). "Development of an Illustrated Medication Schedule as a Low-Literacy Patient Education Tool." *Patient Education and Counseling* 66, no. 3 (2007): 368-377. https://pubmed.ncbi.nlm.nih.gov/17344015/.

[66] Sudore, Rebecca L., & Dean Schillinger. "Interventions to Improve Care for Patients with Limited Health Literacy." *Journal of Clinical Outcomes Management* 16, no.1 (2009): 20-29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2799039/.

parameters of the BOP, ensuring alignment with institutional policies and safety requirements.[67]

- ***Priority (Low):*** The resources are available to implement this best-practice approach Bureau-wide, and it is critical for patients to stay healthy.

Preventative and Diagnostic Services

Preventative and Diagnostic Services

An effective preventative health program within a correctional setting encompasses comprehensive vaccinations, targeted screenings for diseases such as cancer and cardiovascular conditions, and regular health checks to monitor and maintain optimal health. Evidence supports that systematic screening and vaccination programs significantly reduce disease incidence and cost-effectively manage the population's health.[68] This is partially because routine screenings allow doctors to monitor changes in test results over time, enabling providers and patients to proactively handle health issues through treatments or lifestyle modifications.[69]

The BOP utilizes its Preventative Health Care Screening Clinical Guidance from July 2022 (hence referred to as "clinical guidance" or "the guidance" in this section) to frame preventive health care services within its facilities.[70] This guidance outlines an approach throughout incarceration that includes targeted patient counseling, immunizations, and screenings for various conditions such as infectious diseases, cancer, cognitive impairments, and chronic illnesses. While tuberculosis screening is mandated, screenings for HIV and Hepatitis C follow an opt-out approach. If an AIC refuses screening for an infectious disease, they may be quarantined until further evaluation or until clinicians deem it safe to return to the general population. While this framework aligns with the U.S. Preventive Services Task Force (USPSTF) recommendations in many respects, it, in certain cases, may deviate from USPSTF recommendations, e.g., when the risk characteristics of the incarcerated patient population suggest an alternative approach.[71] It is also noted in the guidance that "recommendations from other clinical authorities may differ from the USPSTF and may sometimes be appropriate to follow, especially if they are evidence-based."

Female Screenings

- **Breast Cancer:** Per the Patient Care policy 6031.05, baseline mammography must be offered to "high-risk" females at intake.[72] The clinical guidance recommends subsequent

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[67] Kim, K., J.S. Choi, E. Choi, et al. (2016). "Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic review." *American Journal of Public Health* 106, no. 4 (2016): e3-e28. doi: 10.2105/AJPH.2015.302987.
[68] Sequera, Guillermo, Salomé Valencia, Alberto L. García-Basteiro, et al. "Vaccinations in Prisons: A Shot in the Arm for Community Health." *Human Vaccines & Immunotherapeutics* 11, no. 11 (2015): 2615-2626. https://doi.org/10.1080/21645515.2015.1051269.
[69] Johns Hopkins Medicine. "Routine Screenings." Accessed September 3, 2024. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/routine-screenings.
[70] U.S. Department of Justice, Federal Bureau of Prisons. Preventative Health Care Screening: Federal Bureau of Prisons Clinical Guidance. July 2022. https://www.bop.gov/resources/pdfs/preventive_health_care_cg_2022.pdf
[71] U.S. Preventive Services Task Force. "Home Page." Accessed September 13, 2024. https://www.uspreventiveservicestaskforce.org/BrowseRec/Index
[72] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.

mammography biennially for those high-risk patients starting at age 40, as well as for average-risk patients starting at 50. The document also indicates patients may request an annual breast exam as desired.

- **Cervical Cancer:** Per clinical guidance, female patients should be offered a Pap smear every three to five years from ages 21 to 65.

Risk Factor Screenings

- **Lung Cancer**: Annual screening for AICs aged 50-80 with a history of smoking
- **Hypertension:** Annual blood pressure check for "at-risk" populations (e.g., age ≥40, Black, overweight, or obese)
- **Type 2 Diabetes**: Fasting glucose or A1C check every three to five years in overweight or obese patients ages 35–70

Age-Related Screenings

- **Colorectal Cancer:** Annual screening for AICs aged 45-75
- **Cognitive Impairment**: Routine screening starting at age 50
- **Cardiovascular Risk and Cholesterol Levels**: Assessment conducted every three to five years for AICs aged 40–75
- **Type 2 Diabetes**: Fasting glucose or A1C check every three to five years for all patients ages 45 and older, regardless of risk factors
- **Hypertension**: Blood pressure check every three to five years starting at age 18 for patients without risk factors

Preventative Visits

Preventative Baseline Visit

Clinical guidance indicates that a preventative baseline visit is recommended for all sentenced AICs within six months of incarceration. The baseline visit may be accomplished during the newly incarcerated intake physical examination or initial chronic care visit or scheduled later as a separate preventive health visit.

Periodic Prevention Visits

Periodic prevention visits are an effective way to provide preventive health care services for all AICs, but especially for those who are not seen routinely for other medical needs, such as chronic care conditions. The clinical guidance recommends screening every three to five years for average-risk AICs under 50 and annually for AICs over 50. The specific cadence for each AIC is based on risk profiles, recommended screening type and corresponding intervals, and screening test results. Such exam frequency is not codified in the Patient Care Policy 6031.05, which states that the Medical Director will ensure the availability of age-specific preventive health examinations (e.g., cancer screening). Preventative periodic health visits and

examinations present an opportunity to establish a therapeutic relationship with AICs who are not seen routinely for other medical needs.[73]

Preventative and Diagnostic Services Strengths

Efficiency:

- **FCC Coleman Phlebotomist Team:** At the time of the team's visit, Federal Correctional Complex (FCC) Coleman had three phlebotomists to cover all of its institutions. These phlebotomists worked as a unit and could see 200 to 300 AICs a day. This allowed them to move efficiently and see more AICs to prevent a backlog.
- **FCI Aliceville Mammogram Practices:** At the time of the team's visit, FCI Aliceville had a mammography machine and contracted a mammogram technician who was able to clear out 370 backlogged screenings. Additionally, they developed record-keeping and audit practices that ensured the institution maintained its accreditation as required through the Food and Drug Administration Mammography Quality Standards Act.[74]

Safety:

- **Safety Signs on Display:** The 2024 Patient Care Program Statement requires safety signs to be clearly displayed in rooms where radiation is used. When visiting institutions, the team observed these signs clearly displayed both in the room and on the doors leading to the radiology room.
- **Dedicated Quality Improvement and Infection Prevention and Control (QIIPC) Nurse**: Many AICs report not having had regular access to healthcare – including vaccines – prior to incarceration. Assigning a QIIPC nurse to manage infection prevention and control protects public health as well as the well-being of AICs and employees.

Preventative and Diagnostic Services Challenges

Timeliness

- **Delay in Assessments:** Employee shortages and lack of available credentialed HSU employees can often delay more comprehensive follow-up assessments beyond recommended time limits, which can compromise timely medical intervention for certain conditions.
- **Long Wait Times for Results:** Various AICs voice concerns over the long wait time to receive their diagnostic results. When AICs go in for diagnostic testing, radiologists are expected to sign off on the testing within two business days; however, AICs noted that they

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[73] Gorroll, Allan H. "Toward Trusting Therapeutic Relationships – In Favor of the Annual Physical." *The New England Journal of Medicine* 373, no. 16 (2015): 1487-1489. https://www.researchgate.net/profile/Allan-Goroll-2/publication/283616470_Toward_Trusting_Therapeutic_Relationships_-_In_Favor_of_the_Annual_Physical/links/5b5f06b5458515c4b252a7fb/Toward-Trusting-Therapeutic-Relationships-In-Favor-of-the-Annual-Physical.

[74] U.S. Food and Drug Administration. "Mammography Quality Standards Act and Program." Accessed August 29, 2024. https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-and-program.

are waiting weeks to months to receive their results. This is more common when the AIC is sent to the community for testing.

- **Screenings and Periodic Visit Recommendations Not Enforced:** While preventative screenings and preventative periodic visits are recommended in the clinical guidance, there are no formal policies on preventative health. The absence of a policy framework may contribute to the variability in the application of screening intervals and limit patient access to preventative screening and periodic health examinations based on the recommended cadence, delaying critical touchpoints to meet with a provider and receive suggested screenings.

Effectiveness:

- **Staffing Challenges:** Due to staffing challenges, institutions are missing technicians to run the diagnostic equipment. Without a technician, equipment cannot be used, and AICs must be sent out to the community for testing. This leads to increased backlog, increased costs for the institution, and puts the AICs at risk. It has been suggested that the staffing challenge may be related to compensation for these roles, which could be below community rates. This may contribute to a reliance on contractors, potentially increasing costs. Further exploration of this issue could help identify ways to improve recruitment and reduce dependency on contractors.
- **Infection Control Prioritization:** The quality and infectious disease program heavily depends on the availability of a QIIPC nurse delivering all the intended services and testing to an entire facility's population. Of the 12 facilities observed, this position was commonly filled. However, this role is frequently used to supplement day-to-day nursing responsibilities and is often augmented to custody posts, indicating that quality improvement and infection control may not always be prioritized within the BOP's continuum of care compared to other institutional healthcare demands.
- **Broken Equipment:** During the site visits, the team saw numerous diagnostic machines that were broken and unusable. Medical personnel noted that when equipment, such as an X-ray machine, breaks, it is very difficult to get it repaired or replaced. This is often due to cost constraints, though one HSA stated that their X-ray machine was so old that the manufacturer would not even offer repairs.

Efficiency:

- **Resource Misallocation and Constraints:** In some institutions, resource misallocation, such as underutilized employees, lack of staffing, and inadequate and broken equipment, can lead to redundancies and inefficiencies in patient screening and assessment processes.
- **Inefficient Outside Trips for Basic Diagnostics:** When a machine is either not at the facility or broken, HSU employees must send the AICs to an outside provider to run the tests. This is costly, takes longer to get the AIC in for testing, requires more medical trips, and requires the provider to wait longer for the results.
- **Backlog of Radiology Requests:** As of March 2024, the BOP had 2,965 pending radiology requests and 390 pending results. This delay is often caused by institutions not having a technician to run the equipment, the equipment being broken, there being limited

movement for AICs within institutions, and institutions only being able to facilitate limited medical trips into the community.

Safety:

- **Mammogram Screening:** Mammogram screening for AICs is based on the USPSTF recommendations, which call for mammography every two years for average-risk patients starting at age 40. However, additional screenings may be conducted based on individual risk profiles or previous results. While the American Cancer Society suggests that women aged 40-44 may choose to start annual mammograms, and women aged 45-54 should receive annual screenings,[75] the BOP adheres to USPSTF guidelines recommending biennial screening for average-risk patients. According to the American Cancer Society, early detection is important, but current evidence suggests that biennial screening is effective for most individuals.

- **Missing Necessary Equipment:** Medical personnel noted that the BOP is missing important diagnostic equipment that could improve patient care, increase timeliness, and decrease the number of outside medical trips. Two examples of this are a bladder scanner and a portable pulmonary function test (PFT) machine, which are both common in the community. Although these devices are available to BOP institutions and can be ordered by HSAs if needed, budget constraints often impact whether the equipment or the necessary employee positions to operate them are approved. Additionally, some equipment, such as ultrasounds and computed tomography (CT) machines, is not available at every institution. AICs at institutions lacking these resources must go off-site for diagnostics.

Preventative and Diagnostic Services Recommendations

Recommendation 4.9 (Process): To improve oversight and efficiency, the tracking and monitoring of medical equipment should be centralized, particularly in high-risk, high-cost, and high-volume areas where decentralized management has caused inconsistencies. HSD should implement a standardized system for tracking equipment, including serial numbers, locations, and maintenance schedules. Additionally, HSD should develop a maintenance plan that adheres to manufacturers' recommendations and accreditation requirements, with contingency strategies in place for equipment failures or recalls. A centralized approach will help guide annual budget requests and ensure institutions are prepared to replace or repair equipment as needed. It is also important to address budgetary constraints and ensure timely contractor management to maintain effective service and maintenance. Procurement timelines may be affected by financial processes, such as continuing resolutions and internal approval steps, and these should be considered in the planning process. Each institution should consider hiring medical supply technicians to manage the equipment inventory to support this effort. Furthermore, existing

[75] American Cancer Society. "American Cancer Society Recommendations for the Early Detection of Breast Cancer." Last modified December 19, 2023. https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html#:~:text=Women%20between%2040%20and%2044,choose%20to%20continue%20yearly%20mammograms.

databases used for facility management could be integrated into this system to enhance coordination and efficiency.

- ***Rationale:*** Centralized equipment planning helps institutions prepare for replacements and repairs, reducing outside medical trips and improving patient care. However, budget constraints, including challenges in securing funding for medical equipment, can delay procurement and maintenance. Proper planning should address these challenges.
- ***Priority (High):*** This recommendation improves efficiency but may require additional resources, including new hires and funding to update and maintain equipment. Depending on facility needs, existing databases or other tools can be used for planning.

Emergency Care

Background

Emergency medical services (EMS) provide crucial assistance as the first responders to a crisis. While definitions of emergency care vary, the team embraces the Disease Control Priorities journal's definition of "health services for conditions that require rapid intervention to avert death and disability (such as shock or respiratory failure) or for which delays of hours can worsen prognosis or render care less effective…".[76] Such interventions can include cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), basic airway management, medication administration such as epinephrine, and spinal immobilization, among others.[77] These measures can help stabilize patients until they receive more comprehensive treatment from medical professionals at a hospital or other specialty facility.

When an AIC requires emergency medical services, the facility must deliver an immediate and structured response on-site. The HSU is equipped to manage emergencies directly within the facility and is primarily responsible for providing medical care; however, during an emergency, correctional employees are often the first responders. Correctional officers are annually trained in CPR, and lieutenants maintain American Heart Association CPR/AED certification.[78] Hence, they may begin administering CPR or an AED as necessary and stay with the patient while calling for health services. When healthcare personnel arrive on the scene, they stabilize the AIC and then bring them back to a designated urgent care treatment room to assess the situation, determine the next steps, and administer necessary intervention as needed.[79] If the emergency occurs at a facility that does not have 24-hour medical coverage on-site, the entirety of the emergency

[76] Reynolds, Teri A., Hendry Sawe, Andrés M Rubiano, et al. "Strengthening Health Systems to Provide Emergency Care." In *Disease Control Priorities: Improving Health and Reducing Poverty*, edited by Dean T. Jamison, Gelband Hellen, Susan Horton, et al. Washington DC: The International Bank for Reconstruction and Development/The World Bank, 2017. https://www.ncbi.nlm.nih.gov/books/NBK525279/.
[77] National Association of Emergency Medical Technicians (NAEMT). *What is EMS?* Accessed August 13, 2024. https://www.naemt.org/docs/default-source/about-ems/what-is-ems-for-web-04-17-2017.pdf.
[78] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.
[79] Institutions commonly refer to these "designated urgent care treatment rooms" as "trauma rooms." "Trauma rooms" was the terminology seen and heard during site visits and widely used in practice, including signage.

response must be managed by correctional employees until community EMS services arrive on-site to assume care.

For cases that exceed the on-site capabilities, the BOP's policy on "Escorted Trips" describes how emergency external medical care is facilitated through employee-escorted trips to nearby hospitals equipped to provide the necessary level of care. [80] During non-duty hours, approval for an emergency out-patient escorted trip is granted by the Administrative Duty Officer (ADO) or, if the ADO is unavailable, by the on-duty Lieutenant, with the Warden notified immediately. In preparation for the escorted trip, the Clinical Director or designee makes restraint recommendations based on the AIC's medical condition. The Captain makes recommendations based on security needs, and the Warden makes the final determination.

Emergency Care Challenges

Safety:

- **Advanced Cardiac Life Support (ACLS) Certification:** Several interviewees across different site visits noted that they are ACLS certified but cannot perform at that level because the BOP does not authorize stocking ACLS medications at their facilities. Interviewees lamented that being ACLS certified without access to these critical medications led to patient conditions worsening or, in some cases, loss of life while awaiting EMS support. They emphasized that the absence of ACLS medications during emergencies significantly impacted the quality of care they could provide. This issue was particularly heightened at facilities where EMS response times were prolonged and hospital distances were significant, further increasing the risk of fatal outcomes in emergency situations. Basic Life Support (BLS) is the only certification required for employment; employees who have obtained ACLS certification—either before or during their employment—have done so voluntarily and are not required as part of their position description.
- **Advanced Cardiac Life Support (ACLS) Medications:** Interviewees suggested that the BOP consider applying a harm reduction approach, allowing facilities to stock ACLS medications for their ACLS-certified employees to utilize in emergency situations. Under this model, only ACLS-certified employees would be permitted to operate at the top of their certification, maximizing their skills to provide a higher level of care. This approach could be beneficial, especially in facilities with prolonged EMS response times or those far from hospitals, without requiring full ACLS certification from all staff. The study team recognizes that stocking ACLS medications at facilities with only one or a few ACLS-certified employees may not provide a sufficient risk/ benefit ratio. Therefore, the recommendation later in this section will suggest that further analysis on the topic is needed and that the analysis recognizes that running ACLS protocols effectively requires multiple healthcare staff, which may not be feasible at non-MRC facilities during nights or weekends due to staffing shortages.
- **Equipment Shortages**: Many institutions struggle with non-electric gurneys that are challenging to maneuver. Additionally, some designated urgent care treatment rooms

[80] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5538.08: Escorted Trips*. Washington, D.C., April 8, 2024. https://www.bop.gov/policy/progstat/5538.08.pdf.

lack essential equipment like Pyxis machines or external communication lines. Interviewees sometimes explicitly linked these shortages to institutions' limited budgets.

- **Clinical Decision-Making Challenges:** When determining the appropriateness of a medical trip and the type of restraints to be used, critical decisions must be made that balance medical needs and security requirements. These decisions are ideally made with advice from licensed medical professionals in collaboration with the Captain. Sometimes, such as when the CD position is vacant, the HSA may need to serve as the primary advisor. It is important to note that while HSAs are capable in many respects, their position description does not require the depth of clinical training and insight that is provided by licensed medical employees. This situation underscores the need for clear guidelines and training to ensure that decisions about restraints and medical trips consistently align with best practices and enhance both safety and the quality of care. For example, while there have been instances where medical staff recommended safer restraints, it was reported during interviews that these suggestions may not always be heeded by correctional officers. This highlights the importance of ongoing dialogue and adherence to established protocols to prevent misunderstandings and ensure the safety of all involved**.**

Timeliness:

- **Distant Locations**: Some BOP facilities are in rural areas that are situated far from emergency medical facilities. For example, the nearest hospital to one institution visited by the team was at least 45 minutes away. In cases where an AIC requires immediate off-site medical care, this distance could result in critical delays. Patients may wait hours for an ambulance to arrive at the facility and transport them to the emergency room, significantly impacting the timeliness and effectiveness of emergency care. Life flight services are available in specific situations; however, the policies and guidelines for this were not reviewed as part of this study, and it was not a transportation method that arose during observations or interviews from site visits.

Effectiveness:

- **Nighttime Staffing Issues**: While complexes and MRCs have medical employees overnight, line institutions do not have overnight medical staffing. In the event of a nighttime medical emergency at these institutions, correctional employees, if qualified, may administer CPR, use an AED, or administer naloxone. They have access to an on-call BOP medical provider for further instructions, but this is not required before a community ambulance can be requested.
- **Dual-Use of Designated Urgent Care Treatment Rooms**: Despite having rooms designated for urgent care, some facilities use these spaces for non-emergency healthcare due to overall space limitations, impacting the readiness for emergency response (refer to the "Care Environment" section for details on facility constraints).

Emergency Care Recommendations

Recommendation 4.10 (Technology): Standardize the emergency equipment array across institutions, to include electric stretchers in the HSUs and Pyxis machines in designated urgent

care treatment rooms, across institutions, and consider centralizing the funding and approval process to ensure consistency.

- ***Rationale:*** Institutions varied with regards to their emergency – and standard – equipment array; this was true even for institutions with the same care level designation. By centralizing aspects of the funding and approval process, critical equipment, such as electric stretchers and Pyxis machines, can be consistently prioritized and procured across all institutions. This will allow for standardized, life-saving interventions, regardless of where AICs are incarcerated or the quality of local EMS services. Specifically, electric stretchers in HSUs and Pyxis machines in urgent care rooms enable the most efficient and effective emergency response during critical situations where every moment counts. This recommendation aligns with Recommendation 4.9 to centralize the tracking and monitoring of medical equipment, ensuring oversight and uniformity across the BOP.
- ***Priority (High):*** Despite initial equipment investment, these upgrades will enable healthcare personnel to deliver superior care in a crisis, potentially saving lives.

Recommendation 4.11 (Technology): Conduct a risk-benefit analysis to systematically reconsider ACLS protocols' use, including stocking ACLS medications in facilities where ACLS-certified employees are available, particularly in locations with limited/ delayed EMS response times and distant hospital locations. This analysis should assess current resources, potential benefits, and the logistics of implementing ACLS protocols across all facilities with ACLS-certified employees while prioritizing those in areas with slower or unpredictable access to emergency medical response services.

- ***Rationale:*** Implementing ACLS protocols to include the stocking of ACLS medications for use by ACLS-certified employees could improve outcomes during cardiac emergencies, where timely access to advanced care is critical**.** Evidence suggests that early ACLS interventions, such as the administration of medications like epinephrine and amiodarone, can improve survival rates and neurological outcomes in cardiac arrest cases.[81] Additionally, rural healthcare facilities that have adopted ACLS capabilities have shown improved emergency response times and patient outcomes.[82] A tiered plan would allow for phased implementation, verifying that employees who are ACLS certified—since it is voluntary—are willing to participate and that resources are appropriately allocated.
- ***Priority (Top Priority):*** Access to ACLS protocols, including the stocking of ACLS medications for use by ACLS-certified employees, particularly in locations with limited or delayed EMS response times and distant hospital locations, would enhance patient safety and outcomes by providing timely, life-saving interventions in critical situations. ACLS is

[81]Okubo, Masashi, Sho Komukai, Clifton W. Callaway, et al. "Association of Timing of Epinephrine Administration With Outcomes in Adults With Out-of-Hospital Cardiac Arrest." *JAMA Network Open* 4, no. 8 (2021): e2120176. doi:10.1001/jamanetworkopen.2021.20176.; Panchal, Ashish R., Jason A. Bartos, José G. Cabañas, et al. "Part 3: Adult Basic and Advanced Life Support: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care." *Circulation* 142, no. 16 (2020): S337-S357. https://doi.org/10.1161/CIR.0000000000000916.

[82] Rural Health Information Hub. "Emergency Medical Services and Trauma Care in Rural Areas." Last updated July 18, 2024. https://www.ruralhealthinfo.org/topics/emergency-medical-services.

a community best practice that some of the ACLS-certified interviewees were eager to adopt.

Sick Care

Background

The sick care (typically referred to as "sick call") process is designed to address AIC health concerns that vary in severity and acuity of illness. AICs may request medical attention for acute illnesses such as infections, colds, flu, or injuries resulting from accidents or altercations within the facility. Sick call is also frequently used for skin infections, rashes, and other dermatological issues. Prompt medical evaluation and treatment help prevent complications and promote recovery.

AICs can request sick call care through the following ways, which usually require an AIC to detail symptoms and the nature of the health concern:

- **In-Person Requests:** Institutions typically have walk-in sick call timeframes several days per week (generally in morning hours) where an AIC with a health care request presents and completes a sick call form detailing the nature of the complaint.
- **Written Requests:** An AIC can submit a written request using a BP-A0148 "Inmate Request to Staff" form (widely referred to as a "cop-out" form), which they place in either a medical request box or hand-deliver to medical services. This is commonly used in segregated housing units when AICs cannot physically come to the HSU for an in-person request and do not have access to a computer kiosk for an electronic request.
- **Electronic Requests:** In most facilities, AICs may use an electronic kiosk linked to the Trust Fund Limited Inmate Computer System (TRULINCS) to submit sick call requests.
- **Verbal Requests**: In cases where an AIC prefers to or cannot use written or electronic methods, they may verbally request medical attention from correctional officers or during daily interactions with the HSU. This method is particularly important for urgent or immediate health concerns.

Based on these methods, HSU may schedule an initial sick call visit with the patient to better understand their complaint and then determine the next steps.

In the community, many different triage protocols are used for reviewing a patient's medical condition. One triage tool, created by the Agency for Healthcare Research and Quality (AHRQ), uses the Emergency Severity Index (ESI) to prioritize patients in emergency room settings based on acuity and resource needs. There are five levels of patient assignment: ESI levels 1 to 5. To determine which level the patient should be assigned, a triage nurse considers four decision points:

- **A:** Does this patient require immediate life-saving intervention?
- **B:** Can this patient wait? Are they in a high-risk situation, experiencing new confusion, lethargy, or disorientation, and are they in severe pain?
- **C:** How many resources will treating this patient take?

- **D:** What are the patient's vital signs?[83]

Utilizing this triaging tool allows patients to be seen appropriately and quickly while also limiting overtaxing the providers' resources.[84]

Sick Care Strengths

Patient Centeredness:

- **Provided Patient Education:** Some providers mentioned that they are aware of and engaged in their patients' health literacy discrepancies. They spend additional time explaining the root causes of the patient's symptoms, the underlying meaning behind vital numbers, potential courses of action, and information about prescribed medications. Such education informs patients about their situation and equips them to be more active participants in their care moving forward.

Timeliness:

- **AICs Seen in a Timely Manner:** AIC perception of sick call varied greatly depending on the institution visited. However, AICs at institutions with a principal mental or physical health mission, such as MRCs and USP Allenwood, most frequently praised their institutions for "immediate," "same-day," and "timely" sick call delivery.

Sick Care Challenges

Safety & Timeliness

- **AIC Health Literacy:** The accuracy of AIC requests for care often depends on the AIC's ability to understand their symptoms and communicate them effectively. Many requests require forms or written documentation, but the ability to accurately complete these forms is strongly tied to the AIC's health and language literacy. This presents a safety risk, as AICs with low literacy may miscommunicate the severity of their condition. For example, a request for abdominal pain may be due to indigestion or, in more severe cases, acute pancreatitis. This risk could be mitigated if all sick call requests were triaged in person by a healthcare professional on the same day, allowing for a more accurate assessment of the AIC's condition.
- **Delays in Care:** Delays and inconsistencies in the sick call process were also observed. In the 2023 Patient Perception of Care Survey, 65.3 percent of AICs who completed the survey noted that they were not seen in a timely manner by medical employees.[85] Delays are reported to have led to serious health risks, especially for AICs with acute conditions or multiple chronic care diagnoses in addition to their sick call ailment. AICs at most

[83] Gilboy, Nicki, Paula Tanabe, Debbie A. Travers, et al. *Emergency Severity Index, Version 4: Implementation Handbook*. Agency for Healthcare Research and Quality, 2005. https://www.sgnor.ch/fileadmin/user_upload/Dokumente/Downloads/Esi_Handbook.pdf.
[84] Ibid.
[85] The Patient Perception of Care Survey is administered annually to all AICs and includes questions about medical and dental care. These survey results are from 2023 when the survey got a response from 23.5% of all AICs for the medical portion; By comparison, in the community, 31% of patients state discontent for having to wait too long to get an appointment. American Academy of Physician Associates. *The Patient Experience - Perspectives on Today's Healthcare*. March 2023. https://www.aapa.org/download/113513/?tmstv=1684243672.

facilities visited, specifically those that struggle with constant population turnover, modified operations,[86] and high HSU position vacancy rates, said that sick call can take weeks or multiple requests to finally be addressed.

- **Sick Call Disparities:** There are disparities in how quickly and thoroughly AICs' health concerns are addressed, which can be influenced by factors such as whether the AIC is in special housing or the general population, lockdowns, or employee availability.
- **Limited Access to Urgent Care:** At two institutions visited, there was no 24/7 access to a mechanism for reporting health issues because the call button system inside each housing unit was broken or AICs reported that correctional officers in their housing unit were unresponsive to their needs.
- **Medical Needs Not Tracked:** Determining whether the needs were being met and the timeliness of care received, apart from a point-in-time evaluation, is nearly impossible. This difficulty arises because Inmate Request to Staff forms, TRULINCS requests, and verbal requests are frequently not recorded in BEMR and are not reconciled for duplicate entries and requests.

Efficiency

- **Inefficient Practices:** Inefficiencies in the sick call process often lead to inefficient use of resources and increased healthcare costs due to delayed treatments and worsening health conditions. At one facility, an HSU employee noted over 1,900 unopened TRULINCS messages, a standalone system that lacks integration with other healthcare systems. Employees and AICs further reported that it was assumed that if a condition became severe enough, an AIC would resort to verbal requests by asking a correctional officer or pressing the call system button in the housing unit for assistance. Also, it should be noted that the call system button was not operational at this facility.

Sick Care Recommendations

Recommendation 4.12 (Process): Implement a standardized triage protocol categorizing health concerns and sick call requests by urgency. This should include clear criteria for urgent, routine, and non-urgent categories to guide health service prioritization.

- ***Rationale:*** Implementing a standardized triage protocol such as the Emergency Severity Index (ESI) in correctional facilities can greatly enhance healthcare delivery efficiency and effectiveness.[87] By categorizing health concerns into urgent, routine, and non-urgent categories, this protocol ensures that patients with the most severe needs receive immediate care, reducing the risk of complications and the necessity for more complex interventions later. Clear criteria for each category help healthcare employees make

[86] Modified operations limits movement into and around the institutions. Internal movement for AICs is suspended with exceptions for certain work and medical details. Additionally, visitors are prevented from entering the institution.

[87] The ESI protocol, in particular, offers a nuanced five-level system that assesses patients based on severity and anticipated resource needs. This level of detail aids in more precise staffing and resource distribution, crucial for managing the diverse healthcare demands in a correctional environment. Structured training, coupled with tools like ESI algorithm posters and electronic health record (EHR) integrations as recommended by the Agency for Healthcare Research and Quality (AHRQ), ensures consistent application and facilitates ongoing evaluation of the triage process.

consistent, objective decisions, improving patient outcomes and optimizing resource allocation. This approach is validated by research suggesting that structured triage systems can significantly improve health service prioritization and outcomes in prison settings. [88]

- ***Priority (Top Priority):*** Adopting a standard community triaging process is needed to improve the efficiency of employees and increase patient care.

Recommendation 4.13 (Process): Maintain comprehensive records of all sick call requests and outcomes, including the AIC's complaint, triage decision, and any follow-up actions taken.[89]

- ***Rationale:*** Inconsistent and duplicative sick call requests impede the ability to predict healthcare needs accurately. Comprehensive documentation ensures that each request is recorded, enabling better analysis and planning. This systematic approach helps distinguish between actual need and service capability, improving resource allocation and patient care quality.[90] Accurate record-keeping also supports continuity of care and can highlight patterns that inform preventive measures and policy decisions.
- ***Priority (High):*** This recommendation would improve patient care and data collection but would require a large lift for employees using the current sick call system.

Chronic Disease Management

Background

The Chronic Care Model (CCM) has been the community standard for almost 20 years. It focuses on a patient-centric approach to disease management. Two factors contribute to the CCM: evidence-based chronic illness management and the patient acting as a self-manager. Care must be "proactive, planned, population-based, and patient-centered."[91]

There has been a shift towards more patient-centered care in the community by adding goal-oriented care to the CCM. Goal-oriented care focuses on the whole person and not just their chronic disease. Goal-oriented care starts with the patient identifying personal goals and then collaborating with the physician or provider to meet these desired outcomes. This approach requires the provider to establish a strong relationship with the patient, address social determinants of health, and treat the whole person to be effective.[92]

The 2024 Patient Care Program Statement states that when an AIC with a chronic condition enters an institution, an APP or LIP must see the AIC within 14 days for their H&P and enroll them in a chronic care clinic (CCC) if their diagnosis requires medications or routine follow-up. All AICs in a CCC are to be seen at least once every 12 months by a physician or more frequently

[88] Gilboy et al., *Emergency Severity Index, Version 4.*
[89] Venters, Homer. (2019). *Life and Death in Rikers Island.* Johns Hopkins University Press: 2019.
[90] Centers for Disease Control and Prevention. "Guidelines for Health Services in Correctional Institutions." Last accessed August 21, 2024. https://www.cdc.gov/correctional-health/about/inde.g.html?CDC_AAref_Val=https://www.cdc.gov/correctionalhealth/guidelines.html.
[91] Grudniewicz, Agnes, Carolyn S. Gray, Pauline Boeckxstaens, et al. "Operationalizing the Chronic Care Model with Goal-Oriented Care." *The Patient* 16, no. 6 (2023): 569-578. Accessed August 13, 2024. https://doi.org/10.1007/s40271-023-00645-8.
[92] Ibid.

if clinically indicated. Physicians are allowed to delegate CCC follow-up visits to an APP when the patient is seen more than once a year, but the physician is still required to review and cosign all documentation. During each CCC, the healthcare professional must reassess the AIC's care level designation to determine if more or less care is indicated. If the AIC's condition has improved to the extent they achieve remission or no longer require routine follow-up for a disease state, only a physician can remove them from the CCC.[93]

Chronic Disease Management Strengths

Patient-centeredness

- **Autonomy for AICs:** Many AICs with chronic conditions have autonomy when it comes to medication and wellness. AICs are allowed to self-carry medications that are not controlled substances or otherwise restricted by the National Formulary.[94] They are also responsible for managing their illness in their daily lives through exercise, diet, and overall lifestyle.
- **Patient Education:** During one observation of a CCC, the physician printed off the commissary list for the patient and discussed the food options that were best for their health. This allowed the AIC to make a more informed and conscious decision about their wellness and provided them with the tools to help manage their condition.

Equity:

- **Equitable Treatment of AICs:** When interviewing AICs currently enrolled in a CCC, most of them stated that they perceived their care as equitable to other AICs. They expressed little to no concern that race, age, gender, or crime impacted the providers' treatment of their condition.

Chronic Disease Management Challenges

Safety:

- **Late or No CCC:** Chronic care visits are backlogged and delayed at several facilities due to low staffing levels, high demand, and inefficient practices. Alongside the challenges faced by the HSU providers, low custody staffing ratios frequently lead to facility lockdowns or modified operations (collectively called "restricted operations"), which results in the automatic suspension of CCC. These frequent and prolonged restricted operations exacerbate the backlog, increasing the potential harm to AICs who need ongoing treatment.
    - Several facilities reported that during periods of restricted operations, all compound movements, including medical services, are halted, regardless of the nature of the restriction. Furthermore, depending on the facility layout and housing unit design, the HSU providers sometimes attempted creative solutions, such as expressing an interest in setting up temporary care rooms within the units

[93] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.
[94] The National Formulary is "s a list of medications that are considered by the organization's professional staff to ensure high quality, cost-effective drug therapy for the population served." U.S. Department of Justice, Federal Bureau of Prisons. *Federal Bureau of Prisons Health Services National Formulary: Part 1*. May 2022. https://www.bop.gov/resources/pdfs/2022_winter_formulary_part_1.pdf.

or suggesting to correctional officers that they escort the AIC to the HSU. However, the HSU interviewees reported these approaches are often met with refusal.

Patient-Centeredness

- **AICs Have Limited Control:** Although AICs experience some autonomy in their choices and their health, there are limitations. They can only access the food provided by the institution, which many AICs report negatively impacts their health. Additionally, they have restricted access to health services, limited opportunities to ask questions of providers, and limited access to educational materials about their condition. While some providers give printed educational materials, the team observed many medical professionals not providing verbal or written education, dismissing patient concerns, and prioritizing shorter visits over longer visits spent setting and achieving health goals with the AICs.

Effectiveness:

- **CCC is Too Infrequent:** BOP's program statement requires AICs to be seen for CCC annually unless otherwise indicated by the physician.[95] The community standards emphasize the importance of regular chronic care visits every three to six months until stability is achieved to ensure high-quality care and timely treatment adjustments.[96] Due to this policy and staffing limitations, AICs are not seen as frequently as community standards recommend.
- **Untreated Chronic Pain:** A common theme expressed by numerous AICs is the desire for care for their chronic pain. Many described how their lifestyles have contributed to physical and mental injuries that, when left untreated and unrehabilitated, result in daily, debilitating chronic pain.

Timeliness:

- **Delay in Chronic Care Visits:** During interviews, some AICs noted that they were not seen for their CCC visits in a timely manner. In March 2024, there were over 1,400 internally delayed chronic care visits with AICs waiting to meet with a physician. This delay in care can impact disease management, pain management, and medications.

Chronic Disease Management Recommendations

Recommendation 4.14 (Process): Establish interdisciplinary medical teams at each facility that are comprised of a physician, an APP, a clinical pharmacist with a collaborative practice agreement, and an RN to promote continuity of care for patients with chronic conditions. A member of this team should meet with the patient every three to six months until their condition is under control and then transition to annual meetings once stability is achieved. In the meantime, chronic care visits conducted by institutional providers should be converted to telehealth appointments with Central Office telehealth employees in institutions with limited clinical capacity.

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[95] Ibid.
[96] American Academy of Family Physicians. "Clinical Practice Guidelines." 2024. https://www.aafp.org/family-physician/patient-care/clinical-recommendations.html.

- ***Rationale:*** Evidence-based standards emphasize the importance of regular chronic care visits to manage conditions effectively, with the American Academy of Family Physicians (AAFP) recommending planned visits every three to six months until stability is achieved to ensure high-quality care and timely treatment adjustments. Regular follow-ups are crucial for managing chronic diseases, preventing complications, and improving health outcomes; research shows that consistent intervals between primary care visits reduce hospitalizations and mortality.[97] Interdisciplinary teams would leverage diverse expertise to enhance patient outcomes and maintain high-quality care.[98]

  In the short term, for institutions lacking clinical capacity, converting chronic care appointments to telehealth would allow institutional providers to focus on more urgent medical issues while improving timeliness for chronic care visits. HSD is also adding centralized positions dedicated to telehealth, as discussed in chapter 6 of this report, which might help to meet the increased demand for chronic care visits.
- ***Priority (Medium):*** Establishing interdisciplinary teams will require more resources at most institutions but will support continuity of care. Offering centralized telehealth appointments in the short term requires little to no resources to implement and would ease the strain on institutional employee workloads. However, it is not a sustainable solution to institutional staffing shortages because the regions have limited capacity to take on their workloads.

Recommendation 4.15 (Process): Enhance patient education and empowerment during chronic care visits by ensuring health professionals and patients have increased access to educational materials. Implementing best practices for therapeutic patient education can notably improve chronic care management.

- ***Rationale:*** Improving patient education and the ability to self-manage their chronic conditions can help improve the overall health of the population. Increased education can also decrease the workload of medical personnel since it limits the worsening of conditions and the need for drastic medical intervention.
- ***Priority (Medium):*** This recommendation requires training, additional resources, and more involvement from the healthcare providers, but these resources will pay off in the end and will improve the overall population health. There are many free resources that HSD can utilize to improve patient education.

Recommendation 4.16 (Process): Assess and implement a multidisciplinary and multimodal approach using evidence-based programming and clinical guidelines to better treat AICs experiencing chronic pain. Offer chronic pain evaluation and treatment that is inclusive of identifying pain mechanisms, performing pain assessments, and examining the impact of psychosocial factors and mental health on the pain experience.

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[97] Khazen Maram, Wiessam Abu Ahmad, Faige Spolter, et al. "Greater temporal regularity of primary care visits was associated with reduced hospitalizations and mortality, even after controlling for continuity of care." *BMC Health Services Research* 23, no. 1:777. doi: 10.1186/s12913-023-09808-7.

[98] Center for the Study of Healthcare Innovation, Implementation & Policy, VA Greater LA Healthcare System, Los Angeles, CA, USA, et al. "Teaming in Interdisciplinary Chronic Pain Management Interventions in Primary Care: A Systematic Review of Randomized Controlled Trials." *Journal of General Internal Medicine* 37, no. 6 (2022): 1501-1512. doi: 10.1007/s11606-021-07255-w.

- ***Rationale:*** Patients with acute and chronic pain in the United States face a crisis due to significant challenges in obtaining adequate care, resulting in profound physical, emotional, and societal costs. According to the Centers for Disease Control and Prevention (CDC), 50 million adults in the United States have chronic daily pain, with 19.6 million adults experiencing high-impact chronic pain that interferes with daily life or work activities. [99]
- ***Priority (Medium):*** This recommendation will require additional resources and staffing but will significantly improve the quality of life for AICs and decrease repetitive sick call visits for pain.

Dental Care

Background

Oral health is an essential component of overall healthcare. Good oral health stems from access to and uptake of three types of dental care: preventative, basic, and major. Preventative dental care consists of regular exams, cleanings, and X-rays and identifying potential problems before they increase in severity. Basic restorative dental services are non-surgical procedures that fix the damage that has already occurred, such as fillings, extractions, and root canals. Major restorative dental services are lengthy, complex procedures such as crowns, bridges, and oral surgery.[100] Research shows that consistent preventative dental care results in significantly lower restorative dental care costs; one study indicates that for every dollar spent on preventative care, $8 to $50 can be saved in restorative and emergency treatments.[101]

Besides the connection between preventative dental care, improved oral health outcomes, and the reduced need for restorative dental care, preventative dental care also plays a critical role in physical healthcare. Dentists can screen for chronic illnesses like hypertension and diabetes during regular exams and counsel patients on the next steps if findings are abnormal.[102] Regular cleanings can also remove the bacteria that may lead to cardiovascular disease, endocarditis, and lung infections.[103] Hence, preventative dental care significantly contributes to maintaining whole-person health.

Notably, the majority of AICs entering the BOP have lacked quality dental hygiene or preventative dental services for several years prior. Additionally, many have sustained enamel damage due to

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[99] Dalhamer, James, Jacqueline Lucas, Carla Zelaya, et al. "Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016." *MMWR Morbidity and Mortality Weekly Report 2018*, no.36: 1001–1006. http://dx.doi.org/10.15585/mmwr.mm6736a2

[100] Humana. "How does dental insurance work?" Dental FAQs. Accessed August 13, 2024. https://www.humana.com/dental-insurance/dental-resources/how-does-dental-insurance-work.

[101] University of Illinois Chicago College of Dentistry. "The Value of Preventative Oral Healthcare." Published November 2, 2016. https://dentistry.uic.edu/news-stories/the-value-of-preventive-oral-health-care/.

[102] Nasseh, Kamyar, Barbara Greenberg, Marko Vujicic, et al. "The Effect of Chairside Chronic Disease Screenings by Oral Health Professionals on Healthcare Costs." *American Journal of Public Health* 104, no. 4 (2014): 744-750. https://doi.org/10.2105/AJPH.2013.301644.

[103] Cleveland Clinic. "How Your Oral Health Affects Your Overall Health." Published October 20, 2022. https://health.clevelandclinic.org/oral-health-body-connection.

the use of illicit substances prior to their incarceration. Hence, patients often have intensive dental care needs to be addressed once they are within the BOP system.

Dental care is provided across the BOP's 121 institutions, with each institution authorized by policy to have one dentist and one dental assistant per 1000 AICs.[104] An AIC's first interaction with a dentist occurs during the Admissions and Orientation (A&O) examination within 30 days of their arrival. During this examination, the dentist takes a dental history, conducts a head/neck and soft tissue evaluation, examines teeth and gums, and takes X-rays and intraoral photos as necessary.[105] Subsequently, patients may receive comprehensive and emergency dental care as needed. Preventative and basic comprehensive care, such as routine cleanings and procedures, is accessed by AICs joining the Routine Treatment list, where they are seen in order based on when they signed up. Major dental services such as implants and oral surgery often occur off-site and require the utilization review committee's approval (see chapter 5) before scheduling.[106] Dentists assess and handle urgent dental needs through dental sick call (see the "Sick Care" section earlier in this chapter).

Dental Care Strengths

Patient-Centeredness

- **Provided Patient Education:** Interviewed dentists stressed the importance of enhancing patient literacy during care touchpoints such as the A&O examination and routine procedures. In one dental procedure that the team observed, the dentist explained the potential medical consequences of removing only one infected tooth rather than both. The provider also educated the patient on post-operative care. Such an approach empowers the patient to decide on their desired approach to care.
- **Effective Pain Management:** During an observed tooth extraction, the dentist checked the patient's pain levels before proceeding with the procedure. Based on patient feedback, the dentist adjusted the dose to better support the patient's comfort.

Efficiency

- **AIC Dental Assistant Training Program:** At certain institutions, AICs can apply to and enroll in an educational job training program for dental assistants. They are trained in how to clean lines, sterilize equipment, and organize tools. Upon completion, they receive a Department of Labor Dental Assistant Apprentice Program certificate. This productive activity empowers AICs to learn workplace skills and gain certification, offering pathways to employment after release.

Dental Care Challenges

Timeliness

- **Lengthy Preventative Care Waitlists:** One National Performance Measure (NPM) the BOP strives to fulfill for dentistry is that 90 percent of AICs on routine care lists are

[104] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6400.003: Dental Services*. Washington, D.C., June 10, 2016. https://www.bop.gov/policy/progstat/6400_003.pdf.
[105] Ibid.
[106] Ibid.

seen within two years.[107] However, several dental employees and AICs noted that routine care lists are considerably backlogged; at one institution, the patients receiving routine dental care had been on the list as far back as 2015. This delay in care restricts patients' ability to seek assistance in a timely manner for minor oral health concerns and causes chances of untreated smaller problems becoming larger, more complex situations.

Efficacy

- **Mismatched Directives Compared to Reality:** Several dentists noted a disconnect between Central Office directives emphasizing the importance of preventative and routine care and the reality of urgent care needs. While dentists would like to conduct more preventative care appointments, dental sick calls and the resulting procedures often require much more of the provider's attention. Dentists are challenged by current resourcing and patient acuity to address these competing priorities, causing them to focus on urgent needs over preventative care.
- **Lack of Training Manual**: While there is clinical practice guidance for dental services that describes how providers should treat certain ailments, there is no standardized, vetted training manual across the institutions. This lack of a standard manual can lead to gray areas for providers, particularly when it comes to decisions on triaging patients. For instance, Routine Treatment lists are typically simple lists of patients in the queue. This hinders dental services' ability to triage patients within classifications like preventative, basic, and major. In turn, it compounds the issues with patient acuity and employee capacity in addressing backlogs for preventative care.
- **Preventative Resources Not Freely Provided**: AICs must purchase their own oral hygiene products (e.g., toothbrush, toothpaste, floss) at the commissary with personal funds.[108] Not providing patients with these resources – which are often given freely during preventative care appointments in community settings – disincentivizes patients from purchasing them on their own, which can perpetuate the cycle of poor oral health, leading to acute problems and costly intervention.

Efficiency

- **Hiring Difficulties**: Several institutions visited specifically struggle with hiring dental assistants, who often come to institutions through CMSCs. Without dental assistants, dental hygienists or other dentists must work below their scope to perform dental assistant duties during procedures. Such an approach is an inefficient use of resources that prevents providers from effectively completing their primary duties.
- **Personnel Gaps**: Despite policy stating that each institution should have one dentist and one dental assistant per 1000 AICs, institutions do not always have the appropriate number of positions authorized by HR or the Administration Division. Such gaps can lead to overworked providers, providers operating above or below scope, and a delay in care.

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[107] National Performance Measures (NPMs) are benchmarks developed by HSD based on community standards. There are currently seven NPMs: diabetes management, HIV viral load suppression, atherosclerotic cardiovascular disease risk reduction, hypertension management, antipsychotic treatment adherence, screenings, and dental routine treatment.

[108] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6400.003: Dental Services*. This statement notes that "indigent" AICs are provided these resources as needed.

Patient-Centeredness

- **Gaps in Restorative Care:** The BOP generally does not offer a complete continuum of restorative dental services (dental bridges, crowns, or implants). The BOP defaults to tooth extractions, and while tooth extractions are considered a basic restorative dental procedure deemed safe and effective, this does not align with the community's standard of using extraction as a procedure of last resort. AICs who had received tooth extractions reported an impact on their self-esteem and reduced chewing functionality, as implants to replace extracted teeth are not a readily available option.
- **Capacity to Provide Assistive Equipment:** AICs reported long wait times for dentures and a general lack of access to dental implants. Dental employees recognized this issue and reported it was because of an absence of internal manufacturing capabilities and the lack of contracts with external suppliers for dental medical equipment and supplies.

Dental Care Recommendations

Recommendation 4.17 (People): Reduce dental routine care backlog by deploying BOP hygienists and volunteers with community dental organizations to institutions through mechanisms like health fairs and mobile dentistry and partnerships with dental hygiene programs.

- ***Rationale:*** BOP dentists recognize the importance of routine care but are often overwhelmed by more urgent dental care needs, which can delay patients accessing preventative services for years. Assembling a team of volunteer hygienists from community dental organizations and other BOP institutions to host clinics at institutions with the greatest backlog of routine care could be a timely method for addressing daunting waitlists.
- ***Priority (High):*** Providing institutions with resources needed to reduce their routine care lists allows providers to reset and reprioritize competing care needs and supports better oral and physical health outcomes for patients. However, this would require temporary reassignments of existing personnel and relationship building with community partners; these logistics take time to arrange.

Recommendation 4.18 (People): Address institutional dental assistant vacancies at hard-to-hire facilities by transitioning contractor positions to direct hires and setting up the dental assistant AIC training program at eligible institutions, which could further support providing routine preventative dental cleaning services while concurrently supporting reentry job readiness.

- ***Rationale:*** Transitioning contractor positions to direct hires and establishing a dental assistant AIC training program can address staffing shortages at hard-to-hire facilities while enhancing continuity of care. Direct hires are more likely to provide consistent service, reducing turnover and improving patient outcomes. Additionally, training programs within institutions can help fill vacancies and equip AICs with marketable skills, supporting both their reentry and the delivery of routine dental services.
- ***Priority (Medium):*** The human resources for the AIC dental training program are available through the AIC population, though dentists and hygienists would need to dedicate time to facilitating their training. Transitioning contractor positions to BOP full-

time equivalents would be a more complex and lengthy process but would require less on-the-job training than the AIC program.

Recommendation 4.19 (Process): Develop and implement a standardized, evidence-based training manual for dental services employees across all institutions, with a focus on clear protocols for patient triage and classification.

- ***Rationale:*** A standardized training manual specific to dental services can ensure that all employees have access to consistent guidelines for triaging patients according to clinical need, improving the prioritization of care and reducing backlogs, particularly for preventative services. Recent studies underscore the importance of standardized protocols in dentistry for improving the quality and consistency of care, reducing treatment variability, and ensuring that patients receive appropriate and timely interventions. Such a manual would align with current best practices in dental care, enhancing both operational efficiency and patient outcomes across institutions.
- ***Priority (Low):*** Implementing this recommendation will help improve healthcare quality and produce marginal efficiency benefits. However, it does not address other factors that contribute to backlogs of care within dental services.

Recommendation 4.20 (Process): Explore the feasibility of developing an internal manufacturing program for dental equipment such as dentures and dental implants and possibly expanding to other durable medical equipment through UNICOR (Trade name for "Federal Prison Industries," which employs and trains AICs in practical work) while concurrently securing contracts with reliable external suppliers to address immediate shortages.

- ***Rationale:*** Establishing an internal manufacturing program for dental devices and other durable medical equipment via UNICOR could provide a sustainable solution to long wait times and limited access to dental implants, creating job training opportunities for AICs while reducing dependency on external suppliers. This approach aligns with UNICOR's mission of providing valuable skills and work opportunities to incarcerated individuals, potentially improving reentry outcomes.[109] Conducting a feasibility study would allow the institution to assess the potential costs, benefits, and implementation challenges of this initiative. Meanwhile, securing contracts with reliable vendors ensures that patient care is maintained without interruption during the transition period.
- ***Priority (Low):*** The recommendation, while potentially beneficial in the long term, may have a low immediate impact on patient care and quality due to the significant resources, time, and logistical challenges required to develop an internal manufacturing program. The feasibility study and setup process could delay the realization of benefits, making this a resource-intensive solution with limited short-term impact on addressing current patient care needs.

[109] UNICOR. "About UNICOR." Accessed August 13, 2024. https://www.unicor.gov/.

Vision Care

Vision Care Background

Vision care is an important part of holistic healthcare for patients of all ages. Comprehensive eye examinations allow eye care professionals to detect vision-impairing conditions like glaucoma and vision-related side effects of chronic diseases, such as diabetic retinopathy, which affects 29 percent of U.S. adults over 40 who have diabetes.[110] Without these exams, patients may go years without noticing any eye disease symptoms, which can lead to irreversible vision loss. Additionally, eye exams can help detect early signs of several common chronic diseases, including hypertension, cardiovascular disease, and multiple sclerosis, among others.[111] Thus, like comprehensive dental exams, comprehensive eye exams are an essential component of the healthcare spectrum.

According to clinical guidelines and confirmed by site observations, AICs undergo a vision screening as part of the intake physical.[112] If they are indicated for eyeglasses based on BOP standards, they are referred for refraction. Refraction and other vision care is delivered through third-party optometrist and ophthalmologist contractors who visit institutions at a standard interval, often weekly or monthly. AICs note that being scheduled for a vision acuity test can take weeks but seem generally satisfied with the four-to-six-week turnaround for receiving glasses. In the meantime, readers are available for purchase from the commissary.

The BOP does not have vision care codified in their Patient Care policy that governs physical healthcare, dentistry, and durable medical equipment, among other topics. Ophthalmology clinical guidance recommends regular risk-based eye examinations for patients with Type 1 and Type 2 diabetes, hypertension, and HIV; however, institutional employees mention they are unable to consistently fulfill these recommendations. Additionally, no clinical guidance exists for screening AICs who are 65+ for glaucoma, cataracts, or other age-related vision disorders.

Vision Care Recommendations

Recommendation 4.21 (Process): Implement a policy for evidence-based vision screening for chronic conditions and age to support patient safety.

- ***Rationale:*** The American Optometric Association recommends biannual eye exams for asymptomatic or low-risk patients ages 18-64 and annual eye exams for patients 65+, though at-risk patients (e.g., those with family history of ocular disease, patients with systemic health conditions with potential ocular manifestations, etc.) are recommended for at least annual visits.[113] While the BOP similarly recommends this health conditions

[110] American Optometric Association and Association of Clinicians for the Underserved. *Integrating Eye Health and Vision Care for Underserved Populations into Primary Care Settings*. Published December 2020. https://clinicians.org/wp-content/uploads/2020/11/Integrating-Eye-Health-and-Vision-Care-FINAL.pdf.
[111] Ibid.
[112] U.S. Department of Justice, Federal Bureau of Prisons. *Ophthalmology Guidance: Federal Bureau of Prisons Clinical Guidance*. October 2018. https://www.bop.gov/resources/pdfs/ophthalmology_guidance201810.pdf.
[113] American Optometric Association. "Comprehensive Eye Exams." Accessed August 13, 2024. https://www.aoa.org/healthy-eyes/caring-for-your-eyes/eye-exams?sso=y.

screening guidance, it does not systematically follow this guidance or provide any guidance on age-related vision screenings. Codifying a screening schedule for patients who are 65+ and certain patients with chronic diseases is a community best practice that would enhance patient safety.

- ***Priority (Medium):*** Writing policy around eye exams for high-risk patients would likely improve health outcomes and mirror community standards. For many institutions, the contract optometrist already comes on-site regularly, so this change would simply require increasing their patient load rather than bringing in an entirely new provider.

Pharmacy Services

Pharmacy Services Background

Pharmacists in community settings are integral members of the healthcare team through a variety of services they provide. Community pharmacists' primary responsibilities encompass verifying, filling, and validating prescriptions, ensuring drug interactions and contraindications are carefully considered, and providing patient education on the safe and effective use of medications. Additionally, they are involved in conducting health screenings, administering immunizations, and offering guidance on over-the-counter products.[114] Clinical pharmacists are more utilized for direct patient care, working collaboratively with physicians and other healthcare professionals to identify and tailor treatments to individual patient needs.[115] They also assist with managing chronic disease by providing patient education, handling medications, and collaborating with the patient's primary healthcare provider on the next steps.[116] Through these multifaceted roles, pharmacists contribute significantly to improving patient health outcomes and the overall quality of care.

Pharmacy services play a key role in the process of medication administration, dispensing, distribution, and, to a limited extent, prescribing and patient counseling.[117] HSD is responsible for promulgating policies for pharmacy services, maintaining the BOP-wide National Drug Formulary, and addressing recent directions from Congress related to the treatment and services for Opioid Use Disorder (OUD).[118] The program statement on pharmacy services calls for each institution to maintain a pharmacy directed by pharmacists, pharmacy technicians, and medication technicians and support employees as needed. Some institutions, particularly large ones, operate a central pharmacy. For example, a complex the team visited had a central pharmacy in a standalone building on the institution's property that ordered, filled, and distributed medications for each of its three institutions on-site.

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[114] Cleveland Clinic. "Pharmacist." Accessed August 13, 2024. https://my.clevelandclinic.org/health/articles/24786-pharmacist.
[115] U.S. Bureau of Labor Statistics. "Pharmacists." Occupational Outlook Handbook. Accessed August 13, 2024. https://www.bls.gov/ooh/healthcare/pharmacists.htm#tab-2.
[116] Direct Relief. "Clinical Pharmacists Significantly Improve Patient Outcomes, Advance Health Equity." Accessed August 13, 2024. https://www.directrelief.org/2022/07/clinical-pharmacists-significantly-improve-patient-outcomes-advance-health-equity/.
[117] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6360.02: Pharmacy Services*. Washington, D.C., October 24, 2022. https://www.bop.gov/policy/progstat/6360_002.pdf.
[118] Ibid.; U.S. Library of Congress. Congressional Research Service. *The First Step Act of 2018: An Overview,* by Nathan James. R45558. 2019.

Most medications are considered safe enough for AICs to keep in their cell to administer on their own schedule ("self-carry medications"). For medications that must be administered by an HSU employee, AICs are administered these medications during pill line, which is usually scheduled once in the morning and once in the evening at line institutions. The specific times and locations vary across the institutions due to factors including provider discretion, employee capacity, and operating status. For example, HSU employees need to administer pill-line medications directly to the housing units when institutions are on lockdown.

One medication that requires supervised administration is medications for the treatment of OUD. As aforementioned, pharmacists are intimately involved with medications for OUD, though their role in the broader OUD treatment service array can vary by institution. They can be responsible for some or all of the following components of providing OUD services:

- Ordering medications for OUD
- Conducting initial medical screenings for AICs to determine their eligibility
- Ordering blood tests
- Initiating treatment
- Adjusting doses
- Managing side effects

Pharmacy Services Strengths

Safety

- **Leaving with Medication Supply**: When an AIC's institutional sentence finishes, pharmacy policy dictates that they must be sent with a 30-90-day supply of chronic condition medications. The supply depends on their next location, whether they are transferring to a reentry center/community program or released from custody. This policy supports continuity of care, allowing AICs to continue taking prescribed treatment while they find a community provider.
- **Verification of Patient Identity:** The team observed that providers running pill line verified patient identity by checking patient identification cards before administering treatment, checking that the right patient received the right medication.

Timeliness

- **Timely Prescription Fills**: AICs interviewed were generally satisfied with how quickly new scripts and refills are prepared. A couple specifically noted the helpfulness of the electronic system automatically notifying them to request a refill.

Effectiveness

- **Collaborative Practice Agreements Promote Interdisciplinary Approach**: BOP policy on practice agreements enables pharmacists to enter a one- to two-year agreement with a licensed physician to deliver direct patient care through chronic care clinics.[119] Such an arrangement allows interested pharmacists to practice their clinical skills, which can

[119] U.S. Department of Justice, Federal Bureau of Prisons. *Healthcare Provider Credential Verification, Privileges, and Practice Agreement Program, Report Number 6027.02*. Washington, D.C., October 12, 2016. https://www.bop.gov/policy/progstat/6027_002.pdf.

alleviate the care burden on physicians and potentially give patients more face-to-face time with a provider.[120]

Efficiency

- **Central Pharmacies Enhance Productivity:** Sites with multiple institutions (e.g., complexes, MRCs) often create central pharmacies to consolidate medication deliveries and distribution to their own facilities. Additionally, the BOP has one Central Fill and Distribution (CFAD) pharmacy that provides medications to 22 institutions without pharmacists on-site. Operating at a larger scale allows them to reduce the number of employees responsible for such duties. In addition, institutions use the central pharmacies for enterprise risk management by acting as temporary storage or a backup supply for other institutions in the event of service interruption, such as staffing shortages and extreme weather events.
- **Self-Carry Medications Optimizes Resources**: Medications deemed by the BOP as safe for AICs to keep on their person (e.g., low potential for harm if misused) can be provided to AICs in a one-month to three-month supply to self-administer. Entrusting these medications to AICs reduced the volume of patients needing medication administration daily for the pill line.

Pharmacy Services Challenges

Safety

- **Documentation and Follow-up Practices for Medication Safety:** Current procedures for documenting medication administration and the follow-up on medication errors and near misses were reported to exhibit variability and may not consistently meet best practice standards. This variability can impede effective monitoring and management of medication safety, posing challenges to ensuring consistent and reliable practices across the healthcare system. Enhanced efforts to standardize and improve these processes are essential to better safeguard patient outcomes and uphold the integrity of healthcare services.

Timeliness

- **Lockdowns Delay Medication Administration:** HSU employees are challenged to administer medications to AICs in a timely manner during lockdowns and modified operations because they need to visit each housing unit individually rather than all AICs coming to the central pill line window.

Efficiency

- **Underutilized Licenses:** Pharmacists, physicians, RNs, and APPs are underutilized when they are pulled from clinical and counseling duties to administer pill line in response

[120] For detailed statistics on the number of Collaborative Practice Agreements certified pharmacists, their proportion within the BOP, and the clinics conducted by BOP pharmacists, please consult with the Chief Pharmacist. Additionally, there was mention of a national award from the American Pharmacists Association in 2018 recognizing the Collaborative Practice Agreements approach; however, this was not verified as part of this study and should be confirmed with the BOP or the American Pharmacists Association directly.

to support technician vacancies. The opportunity cost for this practice is an inefficient allocation of employee skillsets and salaries to tasks and improvement in patient outcomes.

Patient-Centeredness

- **Evening Pill Lines Too Early:** Evening pill lines are typically scheduled around dinner time. However, due to staffing shortages at numerous facilities, the timing has been moved as early as 2:00 p.m., though more commonly to around 4:00 p.m., just before dinner. This shift complicates medication management for AICs, particularly those with diabetes who require precise insulin administration. Many AICs reported that this earlier schedule leads to the premature administration of sleep-inducing medications, disrupting their sleep patterns and potentially interfering with blood sugar control. Additionally, AICs employed in UNICOR programs often miss the pill line altogether due to conflicts with their work schedules, further exacerbating the issue.

Pharmacy Services Recommendations

Recommendation 4.22 (Process): Conduct an assessment to determine the potential value of establishing central pharmacy services at institutions other than complexes and MRCs, such as institutions that are in close proximity to others.

- ***Rationale:*** Assessing the value of enhancing central pharmacy services at sites in close geographic proximity to one another could further reduce the number of health services employees needed for medication logistics. The expansion of services could facilitate more integrated and efficient pharmacy operations, enhancing medication safety and availability. Consultation with the BOP Chief Pharmacist regarding pending proposals related to central fill and distribution pharmacy services should be considered to align this assessment with existing initiatives and explore expanded roles for pharmacists in patient care management. This expansion could save staff time, manage enterprise risk, and optimize resources across a broader network.
- ***Priority (Low):*** This recommendation would not encompass complexes and MRCs that have already implemented central pharmacy services. Although this approach may not solve underlying challenges such as staffing shortages, it could significantly improve operational efficiency and enhance patient care outcomes by leveraging existing resources and infrastructure across a larger area.

Recommendation 4.23 (Technology): Provide wireless access to the EHR when administering pill line on the units to support better verification and documentation of medication administration.

- ***Rationale:*** Providers are unable to connect to the EHR while on the unit as they do not carry a portable device (e.g., laptop, iPad). This hinders real-time confirmation of what the patient should be administered, which could lead to medication errors. Furthermore, providers must log what was administered once they returned to the HSU, which creates a backlog of administrative tasks.
- ***Priority (Medium):*** While providing wireless access to the EHR during pill line administration on the units would enhance real-time verification and documentation,

reducing medication errors, the resource investment and infrastructure upgrades required lend this a medium priority initiative.

Recommendation 4.24 (Process): Develop a mandatory educational program for all HSU employees on the rights of medication administration and medication error reporting process.

- ***Rationale:*** While existing policies may require site-specific training, there is a need for a standardized educational program that encompasses all aspects of medication management, particularly focusing on error reporting. Recognizing the distinct and critical nature of medication error reporting, this training will particularly emphasize protocols for effectively reporting errors, assessing incidents, and implementing corrective actions. This standardized approach will ensure all personnel, regardless of their current roles, are equipped to handle pill lines and understand the importance of accurate error reporting, contributing to a shift in constructive responses to error management. Implementing comprehensive training on medication administration and proper error reporting for all personnel involved in pill lines would support a standardized practice and enhance overall care quality.
- ***Priority (Low):*** Given the limitations of the "Five Rights" in significantly reducing medication errors, particularly in high-pressure environments, prioritizing an educational program on these protocols may have a limited impact on improving patient safety. Recognizing the importance of medication error reporting, this aspect of the training is emphasized as a critical component, despite the overall low priority of the educational program. This distinction is crucial as error reporting directly impacts patient safety and healthcare outcomes. However, expanding the scope of this training to include all employees will foster a more uniform understanding and adherence to safety protocols, potentially improving the culture around error reporting and patient outcomes. Focus should be placed on addressing systemic issues such as workload, staffing, and interruptions, which are more critical factors in ensuring safe medication administration.[121]

Recommendation 4.25 (Process): Develop a comprehensive contingency plan incorporating innovative long-term strategies and effective short-term solutions to address ongoing medication management challenges. Consider the adoption of emerging technologies such as automated medication dispensing cabinets to enhance accuracy and security in medication delivery. For immediate relief during periods of critical staffing shortages, secure funding and contracts with locum tenens healthcare professionals to maintain consistent access to medication at established pill line times. Further, policy adjustments that allow for controlled self-administration of insulin using needle-free injection systems, especially at facilities where staffing and frequent disruptions in evening pill lines, should be considered. For medications with an increased risk of misuse, such as sedatives, consider the use of pre-dispensed blister packs that can be securely distributed in the morning for self-administration

[121] Hanson, Angela, and Lisa M. Haddad. "Nursing Rights of Medication Administration." In *StatPearls [Internet].* StatPearls Publishing, 2023. https://www.ncbi.nlm.nih.gov/books/NBK560654/; Martyn, Julie-Anne, Penny Paliadelis, and Chad Perry. "The safe administration of medication: Nursing behaviours beyond the five-rights." *Nurse Education in Practice* 37 (2019): 109-114. doi: 10.1016/j.nepr.2019.05.006.

under supervision later in the day. This approach could mitigate the risks associated with delayed or missed doses but also aligns with best practices in patient-centered care. Additionally, pharmacy access for AICs engaged in the UNICOR program should be enhanced by establishing flexible, designated pick-up points or mobile medication carts that deliver directly to work areas. This ensures that AICs can access their medications without compromising their work responsibilities or the facility's security.

- ***Rationale:*** Revising medication management strategies in correctional facilities highlights the importance of incorporating technology and adapting policies to enhance operational efficiency and security. By considering the integration of Automated Medication Dispensing Cabinets[122], the BOP can explore ways to minimize errors and unauthorized access while streamlining medication distribution processes. The deployment of locum tenens healthcare professionals could temporarily bridge staffing gaps, ensuring that essential healthcare services remain consistent, especially during staffing shortages. Policy adjustments, such as facilitating needle-free self-administration of insulin[123] and using blister packs for controlled dosages of sedatives offer avenues for the BOP to test safer and more flexible medication management practices under varied supervisory conditions. Additionally, customizing pharmacy access for UNICOR participants addresses the specific challenges of their schedules, enhancing adherence to treatment protocols without compromising their work commitments. This broad-based approach encourages the BOP to conduct thorough research and reviews to ensure that these proposed changes meet the dynamic needs of the correctional environment, align with best practices, and enhance the overall care and safety of the incarcerated population.
- ***Priority (Medium):*** Implementing a comprehensive contingency plan for medication management is crucial for enhancing operational efficiency and ensuring consistent patient care in correctional facilities. This strategy incorporates both innovative long-term solutions, such as automated medication dispensing cabinets, and immediate measures, including the engagement of locum tenens during staffing shortages, to maintain uninterrupted access to medications. The integration of flexible medication delivery systems for UNICOR participants and needle-free insulin administration further aligns with best practices in patient-centered care, improving safety and adherence to treatment.

Mental Healthcare Services

Background

This section explores the delivery and processes of mental healthcare, focusing on the services and programs available, with additional attention given to AICs experiencing a serious mental illness. Mental health services commonly include assessment, crisis intervention, therapy, counseling, and medication management. Broadly, services aim to support the needs of individuals facing challenges such as stress, anxiety, depression, substance use disorders, and other behavioral or psychological conditions that impact daily life and functioning. The BOP

[122] Burton, Samantha J. "Automated Dispensing Cabinets Can Help or Hinder Patient Safety Based On the Implementation of Safeguard Strategies." *Journal of Emergency Nursing* 45, no. 4 (July 2019): 444-449. https://doi.org/10.1016/j.jen.2019.05.001.

[123] American Diabetes Association, "Standards of Medical Care in Diabetes—2023," *Diabetes Care* 46, no. 1 (2023): S1-S270, https://doi.org/10.2337/dc23-S001.

defines mental illness as a "clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."[124]

In the community, mental health services are provided by a range of professionals who can diagnose and treat mental health conditions. Psychiatrists, Psychiatric Mental Health Nurse Practitioners (PMHNPs), psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Marriage and Family Therapists (MFTs) all play vital roles in diagnosing and treating mental illness. Psychiatrists and PMHNPs often focus on medication management alongside therapy, while psychologists, LCSWs, LPCs, and MFTs provide therapy, assessments, and case management, addressing both psychological and environmental factors. Peer Support Specialists, with lived experience, provide mentorship, and Case Managers coordinate care across various settings, such as clinics, hospitals, and community centers.

Unlike the diverse range of mental health service provider types available in the community, the BOP restricts who can provide services to a narrower group of licensed professionals. In the BOP, psychiatrists, PMHNPs, and Physician Assistants with a Certificate of Added Qualifications (PA-Cs with a CAQ in Psychiatry) are authorized to provide both medication management and therapy. Additionally, forensic psychologists and psychologists are approved to deliver therapy and assessments. Other professionals, such as pharmacists with collaborative practice agreements, may also manage medications for mental health disorders. However, the absence of professionals like LPCs, LCSWs, and peer support specialists may reduce the diversity of therapeutic approaches and limit the breadth of supportive services offered. Additionally, relying solely on providers with higher-level credentials, such as psychiatrists, PMHNPs, and psychologists, can affect access to care due to a shortage of these professionals, potentially leading to longer wait times and limited availability of services. These factors combined could impact the overall comprehensiveness and timeliness of mental health care within the federal prison system.

The psychiatry and psychology providers are managed by two separate divisions: HSD, which is responsible for psychiatry and social work services, and the RSD, which oversees Psychology and recidivism reduction programs, including drug treatment. This division of responsibilities can create silos within the mental healthcare continuum, leading to challenges in coordination and continuity of care.

Mental Health Care Levels

Similar to medical care levels, mental health requires its own care level to distinguish the unique needs of each AIC. The mental healthcare levels are not impacted by medical care levels and are determined through a process very similar to determining medical care levels (see "The Care Levels" section earlier in this chapter). The mental health care level designations consider the severity and acuity of an AIC's condition, such as those experiencing personality disorders or intellectual disabilities, as well as the long-term impact of these diagnoses on their ability to perform activities of daily living. [125] However, unlike medical care levels, mental healthcare levels

[124] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5310.16: Treatment and Care of Inmates with Mental Illness*. Washington, D.C., May 1, 2014. https://www.bop.gov/policy/progstat/5310_16.pdf.
[125] Ibid.

are determined by both clinical impressions and AIC's willingness to participate in mental healthcare treatment. Consequently, if the AIC refuses to engage, their MH care level may be reduced to CARE1-MH (Mental Health) or CARE2-MH, indicating an unwillingness to participate.

- **CARE1-MH:** No significant Mental Healthcare is needed.
- **CARE2-MH:** Routine Outpatient Mental Healthcare or Crisis-Oriented Mental Healthcare. Brief, crisis-oriented mental healthcare of significant intensity, e.g., placement on suicide watch or behavioral observation status.
- **CARE3-MH:** Enhanced Outpatient Mental Healthcare or Residential Mental Healthcare. Weekly mental health interventions. Placement in psychology treatment program
- **CARE4-MH**: Inpatient Psychiatric Care. Require acute care in a psychiatric hospital. The AIC cannot function in a general population.

Mental Healthcare Strengths

Effectiveness

- **AIC Companion Programs:** The use of AIC companion programs is continually cited as a strength at institutions by both employees and AICs. The utilization of AIC companions is seen as a constructive and cost-effective way to assist AICs with mental health-related issues, as well as AICs with physical disabilities, in carrying out activities of daily living. For example, the RISE program, which is a mental health program focused on substance misuse, includes AIC companions and has largely been a success to not only the AIC in need but also the companions who are gaining valuable skills to support them in seeking potential employment opportunities in a peer support role.
- **Communication Between Psychology and Health Services**: Enhancing coordination between the HSD and RSD divisions can significantly improve care for patients with comorbid behavioral health and medical conditions by fostering collaboration across siloed divisions. To address the challenges, psychological providers hold "coordinated care" meetings to collaboratively discuss and develop comprehensive treatment plans for these patients. These meetings are intended to ensure that patients receive an integrated approach to care rather than being fragmented across different divisions. Unfortunately, some institutions reported that these meetings are infrequent or are only attended by one department, which undermines the intended purpose and effectiveness of a truly coordinated approach.

Mental Healthcare Challenges

Safety

- **AICs Experiencing Suicidal Ideations:** The risk of suicide in custody is a large concern. A 2024 DOJ OIG audit found that staffing shortages in Psychology, among a list of other issues, hinder the quality of care possible for AICs with suicidal ideations, leading to preventable suicides in custody.[126] Institutions are often left to create their own

[126] U.S. Department of Justice Office of the Inspector General. *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions.* OIG-24-041. Washington, D.C., February 2024. https://oig.justice.gov/sites/default/files/reports/24-041.pdf.

solutions to minimize the safety threat of suicide in custody, creating further inconsistencies in how care is delivered. The current measures, according to the program statements that outline suicide prevention programs, are often unrealistic, especially if an institution is not appropriately staffed or equipped. For example, institutional employees noted that when there is a shortage of correctional employees in a housing unit, the correctional officer may be required to wait for additional employees to arrive to intervene in a situation where an AIC is reporting suicidal ideation or actively pursuing self-harming behaviors.

Patient-Centeredness

- **Mental Health Training for Medical Employees:** Mental health training for medical employees is not part of medical employee training, even in institutions where AICs with Care Level 3 and 4 MH levels are housed. Severely mentally ill patients often have a unique set of needs that are likely not accounted for without the ability of medical employees to properly communicate with them. Stigmatization of mental health-related issues sometimes exists in the medical field and can, in part, be traced to the lack of training, skills, and patient-centered intervention approaches. This dynamic can negatively impact medical outcomes for the severely mentally ill.[127]
- **Mental Health Training for Custody and Administration:** Observations and interviews revealed that some correctional officers and administrative professionals lacked understanding of mental health and substance use disorders and exhibited stigmatizing attitudes, which negatively impacted the equity and patient-centeredness of care for AICs.

Effectiveness

- **Communication Between Psychology and Health Services:** The effectiveness of communication between the psychology and HSU employees varied from institution to institution. This inconsistency can, at times, serve as an obstacle to providing integrated, high-quality care while disproportionately affecting AICs experiencing a mental illness. Proper and frequent means of communication between HSU and Psychology, as well as joint initiatives focused on patient-centeredness, will benefit these AICs.
- **Mental Health Care Levels Not Assigned to Institutions:** According to the 2014 Program Statement 5310.16 "Treatment and Care of [AICs] with Mental Illness," and interviews conducted during this study, mental health care levels are only assigned to AICs but were not consistently observed to be assigned to institutions.[128] Although OMDT has a list of institutions with mental health care level assignments, our observations showed that not all institutions visibly operate under an official mental health care level designation, even when they serve populations with more serious mental health needs. Some institutions with mental health missions appeared to be better equipped to accept AICs with more serious and persistent mental health needs, but the lack of a clear

[127] Knaak, Stephanie, Ed Mantler, and Andrew Szeto. "Mental Illness-related Stigma in Healthcare: Barriers to Access and Care and Evidence-based Solutions." *Healthcare Management Forum* 30, no. 2 (2017): 111-116. https://doi.org/10.1177/0840470416679413.
[128] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5310.16: Treatment and Care of Inmates with Mental Illness*.

designation may still lead to inconsistencies in placement. Further exacerbating this issue is that an AIC's mental health care level can be reduced if they are unwilling to participate in their treatment. This contrasts with medical care levels, which are assigned to both AICs and institutions and are more clearly recognized by employees. The absence of distinct mental health care level designations per facility and frequent changes in care levels due to variability in an AIC's willingness to engage in mental health treatment complicates the determination of effective staffing ratios and the placement of AICs within the institution. This lack of consistency also hampers the institution's ability to effectively advocate for the necessary resources.

Mental Health Recommendations

Recommendation 4.26 (Process): Conduct a baseline organizational assessment to explore expanding trauma-informed care practices across the entire AIC population, as evidence highlights the positive impact of these practices on patient outcomes and organizational effectiveness. [129]

- ***Rationale:*** Trauma-informed care is a tool that extends to all incarcerated populations and can be expanded using the current women-focused trauma-informed care model.
- ***Priority (High):*** The tools required to implement this recommendation already exist.

Recommendation 4.27 (People): Implement comprehensive training programs for correctional officers and administrators that aim to increase empathy and reduce bias, such as Mental Health First Aid and Crisis Intervention Training (CIT).

- ***Rationale:*** To provide equitable care to all AICs, incidences evidencing employee bias must be identified and addressed to avoid interfering with an AICs ability to receive quality care. Evidence suggests that such training programs, such as Mental Health First Aid and CIT for correctional officers, administrators, and executive management, enhance employee understanding of mental health issues, improve crisis management skills, and foster more compassionate interactions with AICs. For instance, CIT programs have been shown to reduce the use of force and improve safety outcomes in correctional settings.[130] Additionally, Mental Health First Aid training helps employees recognize and respond appropriately to mental health crises, thereby promoting a more supportive and less biased correctional environment. [131] By equipping employees with these critical skills, correctional facilities can ensure better care and support for vulnerable populations, ultimately leading to improved overall outcomes.
- ***Priority (Medium):*** Increased training and accountability can only go so far when there is an element of personality and culture that can influence the full implementation of this

[129] Substance Abuse and Mental Health Services Administration. *Practical Guide for Implementing a Trauma-Informed Approach*. 2023. https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf.
[130] Compton, Michael T., Roger Bakeman, Beth Broussard, et al. "The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills." *Psychiatric Services* 65, no. 4 (2014): 517-522. https://doi.org/10.1176/appi.ps.201300107.
[131] Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health First Aid." Last updated September 23, 2021. https://www.samhsa.gov/resource/dbhis/mental-health-first-aid.

recommendation. BOP should work towards the long-term goal of eliminating employee bias, beginning with increased training around employee bias towards AICs.

Recommendation 4.28 (Process): Develop and implement a standardized core curriculum and training program for all HSU provider types who provide care to patients who experience mental, neurological, and substance use disorders. This program should ensure consistent knowledge, attitude, and practices (KAP)[132] across all providers, focusing on facilities caring for Care Level 3 and 4 patients. The curriculum should include ethical guidelines and standards to prevent variations in care based on provider type or individual ethical differences, thereby advancing the integration of mental health into primary care settings.

- ***Rationale:*** To accommodate for the high volume of mental illness in custody, especially at higher mental health care level facilities, medical professionals should be given the appropriate training and tools to adequately care for these patients.
- ***Priority (High):*** The resources for implementing this recommendation are largely available and can be appropriately applied.

Substance Use Services

Substance use disorder (SUD) services were not initially identified as a focal area within the study's scope.[133] However, during site visits and interviews, the team observed the critical importance of SUD services as an integral component of the holistic "whole-person care" model, which addresses both mental health and substance use disorder treatment. While the information presented in this section is not exhaustive, it aims to provide a foundational understanding of the significance of SUD services in this context.

Background

SUD is a prevalent condition among many AICs. According to the Bureau of Justice Statistics, 31.8 percent of federal AICs in 2016 qualified for a SUD classification, meaning they had depended on or excessively used alcohol or drugs for the 12 months prior to their admission to prison.[134] Such a high percentage indicates an opportunity to offer treatment to AICs motivated to make a change in their lives.

Treatment modalities are diverse and require an individualized approach for each patient, depending on their situation. The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2023-2026 Strategic Plan emphasizes the importance of a comprehensive approach to SUD, including prevention, harm reduction, evidence-based treatment, and recovery support.

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[132] Ayano, G., D. Assefa, K. Haile, et al. "Mental Health Training for Primary Healthcare Workers and Implication For Success of Integration of Mental Health Into Primary Care: Evaluation of Effect on Knowledge, Attitude And Practices (KAP)." *International Journal of Mental Health Systems* 11, no. 63 (2017). https://doi.org/10.1186/s13033-017-0169-8.

[133] SUD services refer to a range of medical, psychological, and social interventions designed to help individuals who struggle with substance misuse.

[134] U.S. Department of Justice, Bureau of Justice Statistics. "Federal prisoners, 2016 – substance use disorder." Chart describing the percentage of federal AICs in 2016 who qualified for a SUD diagnosis. Created August 13, 2024. Survey of Prison Inmates Data Analysis Tool. https://spi-data.bjs.ojp.gov/dashboard.

Notably, these services are targeted to "meet people wherever they are on the behavioral health continuum."[135] To identify these specific services that would be most appropriate for an individual patient, healthcare organizations often turn to The American Society of Addiction Medicine: *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 4th ed (the ASAM Criteria), which is the "most widely used and comprehensive set of standards" for managing patients with a substance use disorder. Its multidimensional assessment holistically assesses a patient's situation to determine the appropriate level of care on the care continuum.[136]

Besides medical and mental health treatment administered by professionals, peers play a critical non-clinical role in assisting individuals who are recovering from substance use challenges. These peers have lived experience with recovering from SUD and can meet individuals along their recovery process to support their improved quality of life, decrease in or abstinence from substance use, and increased self-empowerment, among other outcomes.[137] Integrating peer support services alongside clinical treatment extends the reach of treatment beyond the provider's office, supporting a more sustained recovery process.[138] Many states have begun embracing trained peer and community recovery resources as part of their continuum of care for people recovering from SUD.

Substance Use Services Care Levels: Community

The SUD care levels in the community typically align with the ASAM Criteria's strength-based multidimensional assessment, which considers a patient's needs, challenges, and liabilities alongside their strengths, resources, and support structure to determine the appropriate level of care. The care continuum consists of four broad levels, numbered 1 through 4, with decimal numbers used within each level to indicate varying intensities and types of care. Additionally, the ASAM Criteria is further divided into subdimensions that inform the level of care.

[135] Substance Abuse and Mental Health Services Administration. *2023-2026 SAMHSA Strategic Plan*. 2023. https://www.samhsa.gov/sites/default/files/samhsa-strategic-plan.pdf.
[136] American Society of Addiction Medicine. "About the ASAM Criteria." Accessed August 13, 2024. https://www.asam.org/asam-criteria/about-the-asam-criteria.
[137] Reif, Sharon, Lisa Braude, D. Russell Lyman, et al. "Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence." *Psychiatric Services* 65, no. 7 (2014). https://psychiatryonline.org/doi/10.1176/appi.ps.201400047?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.
[138] Substance Abuse and Mental Health Services Administration. "Peer Support Workers for those in Recovery." Accessed August 13, 2024. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

The following figure depicts the subdimensions in **bold and blue.**

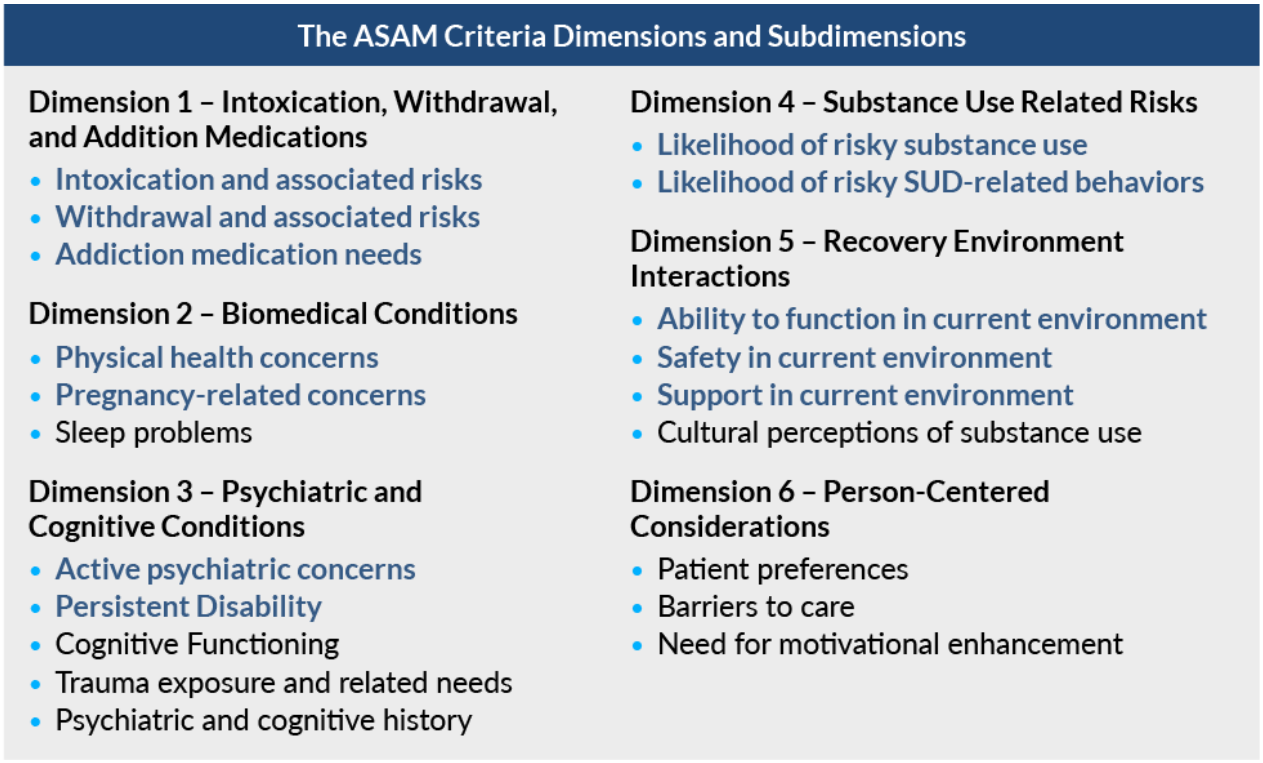

Figure 4: *The ASAM Criteria Dimensions and Subdimensions (Source: The American Society of Addiction Medicine, 2024)* [139]

[139] American Society of Addiction Medicine. "The ASAM Criteria, 4th Edition." Accessed August 13, 2024. https://www.asam.org/asam-criteria.

The following figure depicts the ASAM Criteria's care levels:

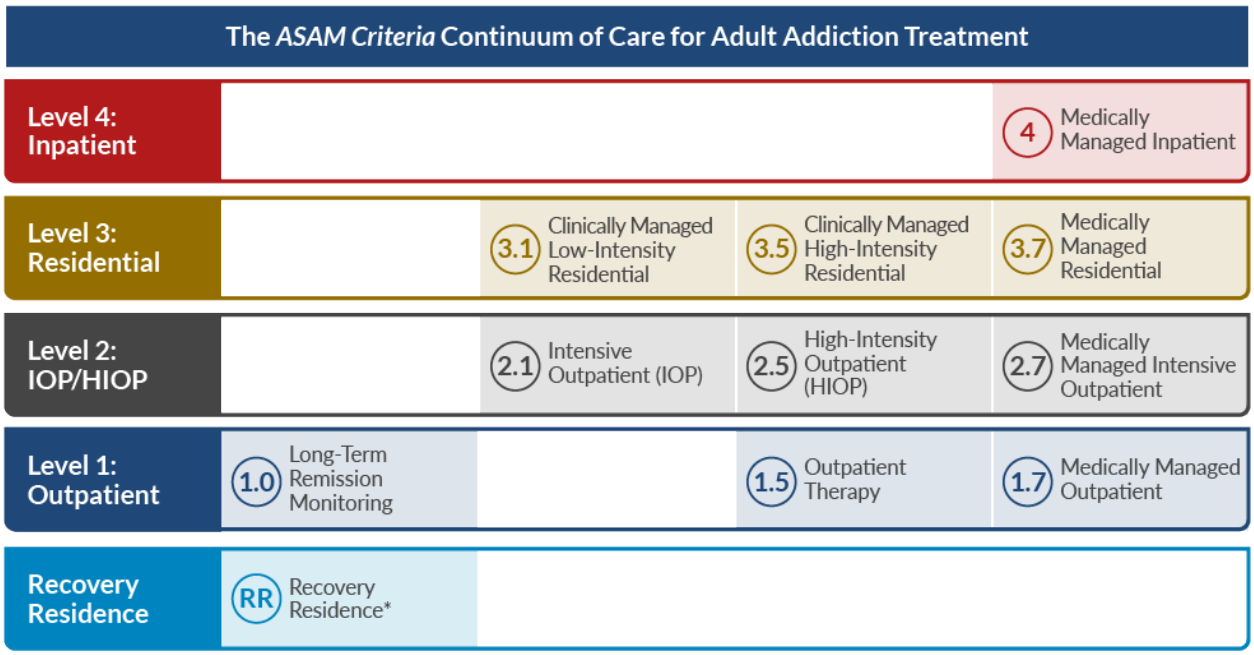

Figure 5: *The ASAM Criteria Continuum of Care for Adult Addiction Treatment (Source: The American Society of Addiction Medicine, 2024)*[140]

Substance Use Services Care Levels: The BOP

The BOP's SUD services continuum diverges from the standard definitions and tiered approach outlined by SAMHSA and the ASAM Criteria. This divergence highlights gaps in the levels of care offered, which can lead to either undertreating an individual's SUD or, conversely, providing excessive treatment. Several studies emphasize that inadequate treatment durations are linked to poor outcomes, underscoring the need for sustained and appropriate intensive care to achieve long-term recovery.[141] However, it is not just insufficient treatment that poses risks. The British Medical Journal's (BMJ) "Too Much Medicine" initiative brings attention to the dangers of overdiagnosis and overtreatment. This reinforces the importance of finding a balance in care, ensuring that individuals receive neither too little nor too much treatment.

Moreover, the inclusion of recovery supports, particularly through peer support, is crucial for sustaining long-term sobriety and improving outcomes. Without these ongoing supports, individuals face a significantly higher risk of relapse, as consistent engagement with a peer community reinforces positive behaviors and provides necessary accountability.

[140] American Society of Addiction Medicine. "The ASAM Criteria Continuum of Care for Adult Addiction Treatment." Accessed August 21, 2024. https://www.asam.org/asam-criteria/about-the-asam-criteria.
[141] Beaulieu, Myriam, Joël Tremblay, Claire Baudry, et al., "A Systematic Review and Meta-Analysis of the Efficacy of the Long-Term Treatment and Support of Substance Use Disorders." *Social Science & Medicine* 285 (2021). https://www.sciencedirect.com/science/article/abs/pii/S0277953621006213.

Without standardized screening and placement on a robust continuum of care that includes recovery supports, AICs may not be receiving access to a tailored treatment approach to support long-term recovery.

The BOP's SUD treatment strategy includes:

- **Medically Supervised Withdrawal Clinical Guidance:** Clinical guidelines indicate Psychology (under the Reentry Services Division [RSD]) and the HSU collaborate during the withdrawal process to provide psychological support and symptomatic treatment, particularly for patients with psychiatric co-morbidities.[142]
- **Medications for Opioid Use Disorder Treatment Services (MOUD):** Please see the "Medication for OUD" subsection later in this section.
- **Substance Misuse Education:** Every institution must provide a series of classes regarding substance misuse and its consequences that serve to motivate AICs to seek further treatment while incarcerated and after release.[143]
- **Nonresidential Drug Abuse Program** (NRDAP): This is a 12-week, Cognitive-Behavioral Therapy (CBT) group treatment program that all institutions are required to offer. It addresses criminal lifestyles and provides skill-building opportunities in rational thinking, communication, and adjusting to institutions and the community.[144]
- **Residential Treatment Programs:**[145]
    - **Residential Drug Abuse Program (RDAP)** is an evidence-based recidivism reduction (EBRR) program utilizing CBT in a modified therapeutic community model, which lasts approximately nine months. The program takes a comprehensive approach by combining activities focused on substance use disorder recovery and relapse prevention, applying a targeted relapse prevention approach and helping to address criminality through cognitive-behavioral challenges to correct criminal thinking. Group sessions, individual counseling, and meetings with RDAP coordinators are conducted to help AICs learn coping skills and address opportunities for relapse that they may face in the community environment that are not present in an institution's setting. Eligible AICs can earn

[142] U.S. Department of Justice, Federal Bureau of Prisons. *Medically Supervised Withdrawal for Inmates with Substance Use Disorders: Clinical Guidance*. February 2020. https://www.bop.gov/resources/pdfs/medically_supervised_withdrawal_cg.pdf.

[143] U.S. Department of Justice. *Title 28, Chapter V, Subchapter C, Part 550*. Electronic Code of Federal Regulations. Accessed August 13, 2024. https://www.ecfr.gov/current/title-28/chapter-V/subchapter-C/part-550.

[144] U.S. Department of Justice, Federal Bureau of Prisons. "Substance Abuse Treatment." Accessed August 13, 2024. https://www.bop.gov/inmates/custody_and_care/substance_abuse_treatment.jsp.

[145] U.S. Department of Justice, Federal Bureau of Prisons. *First Step Act Approved Programs Guide*. September 2023. https://www.bop.gov/inmates/fsa/docs/fsa_guide_eng_2023.pdf; AICs and employees noted that residential programming often had waitlists, some of which had hundreds of AICs. Additionally, certain residential programs are only offered at select institutions. AICs struggling with addiction reported waiting months to years to get into a program at their institution or transfer to an institution that has space for them.

up to 12 months off their sentence following successful course completion. This is a unique benefit that is not offered by the BOP's other reentry programs.

- **Challenge Program** is a CBT-based program operating within a modified therapeutic community for male AICs in USPs with SUD and/or behavioral health conditions. AICs live separately from the general population and participate in programming designed to treat SUD and address criminality.
- **Female Integrated Treatment Program (FIT)** is a CBT-based program operating within a modified therapeutic community in a trauma-informed, gender-responsive environment for female AICs with SUD, behavioral health conditions, and trauma-related disorders. Similar to RDAP and Challenge, this program addresses criminal thinking through the identification of criminal thinking errors. However, FIT uniquely emphasizes vocational training, prosocial interactions, and community partner collaborations to prepare these women for successful reentry. Similar to RDAP, women with SUD who qualify for RDAP but complete FIT may be eligible for the sentence reduction incentive.

- **Companion Program:** The BOP utilizes AIC companions for behavioral health and physical health conditions (see "Mental Healthcare Strengths" later in this section for more information about companions). However, no visited institution offered peer support as a tool for SUD treatment. AICs with lived recovery experience reported they informally support their peers in the SUD recovery process on their own initiative, but such a service is not supported or guided by the BOP.

Substance Use Services Recommendations

Recommendation 4.29 (Process): Enhance the quality and effectiveness of substance use disorder treatment by adapting The American Society of Addiction Medicine (ASAM) levels of care framework to the unique in-patient setting correctional facilities. Consider the development of specialized housing units for patients at the highest risk of SUD negative outcomes, leveraging existing proposals where feasible.

- ***Rationale:*** To enhance the quality and effectiveness of substance use disorder treatment within the correctional facility, it is recommended to adapt and implement the ASAM's levels of care. ASAM's comprehensive framework provides a continuum of care that includes assessment, treatment planning, and delivery of services tailored to patients' individual needs. This approach ensures that individuals receive the appropriate intensity of treatment, which has been shown to improve outcomes and support long-term recovery.[146] The ASAM criteria, which encompass early intervention, outpatient services, intensive outpatient/partial hospitalization services, residential/inpatient services, and medically managed intensive inpatient services, offer a structured method for delivering care. In non-medical correctional settings, the expectation is to provide services within the available resources and levels of care that align with ASAM's framework, such as early intervention or outpatient services. By adopting these levels of care, the correctional facility can ensure that AICs with substance use disorders receive evidence-based, person-

[146] *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (3rd ed.)*. Edited by David Mee-Lee. Carson City: The Change Companies, 2013.

centered treatment, ultimately reducing relapse rates and improving overall health outcomes.

- ***Priority (Medium):*** While adapting and implementing the ASAM criteria will support better health outcomes by aligning with best practices in healthcare, adapting this community-based framework to the correctional setting will present significant resource challenges. Given these considerations, this recommendation is categorized as a "medium" priority to allow for careful planning with a tiered implementation approach and resource allocation.

Recommendation 4.30 (People): Incorporate peer recovery support into the current array of behavioral health treatment by training and certifying AICs with lived experience. Look to SAMHSA's Peer Recovery Center of Excellence for implementation practices for additional guidance.

- ***Rationale:*** Peer support is an area of untapped potential within the BOP's treatment arsenal. By leveraging the power of peer support, the BOP can further its efforts to aid in substance use recovery with a more holistic approach. This programming would promote rehabilitation efforts for both the patient and the peer, improving quality of life and aiding in reentry efforts.
- ***Priority (Medium):*** This recommendation is a community best practice that would improve patient experience and be mutually beneficial to patients and peers. The personnel resources are already available across the Bureau and would not require additional financial investment. The Bureau could begin piloting a peer certification program by integrating it into the RDAP, which already incorporates peer support elements.

Medications for Opioid Use Disorder Treatment

As indicated above in the SUD Services subsection, medications and other services for Opioid Use Disorders were not an identified area within the study's scope. Thus, the information presented in this section is not comprehensive but is intended to add value by highlighting insights and considerations relevant to the treatment of OUD. These observations are meant to inform future discussions and decisions around the integration and optimization of Medications for the Treatment of Opioid Use Disorder (MOUD) within the broader continuum of care.

Background

Treatment for OUD may include the use of Food and Drug Administration (FDA)-approved medications (buprenorphine, methadone, and naltrexone) combined with counseling and behavioral therapies. Notably, successful treatment of OUD emphasizes the use of both pharmaceutical and behavioral interventions to lead to the best outcomes. While critics may view medication as a 'substitute' for addictive substances, it is important to recognize that these medications do not produce the euphoria associated with opioid misuse. Instead, such treatments relieve withdrawal symptoms and opioid cravings, reduce the risk of overdose, normalize brain

function, and allow the brain to heal.[147] Meanwhile, behavioral interventions address the root causes of substance use disorders and teach coping skills to respond to triggers and maintain sobriety.[148] Research shows that providing MOUD in prisons and jails has wide-ranging impacts post-release, increasing community treatment engagement and decreasing illicit opioid and injection drug use.[149]

The First Step Act (FSA) in 2018 required the BOP to treat OUD by, among other approaches, expanding access to MOUD; in 2019, the BOP started its in-house MOUD services.[150] Providing MOUD is a joint effort between HSD and RSD (Psychology), with both departments conducting their own screenings for eligibility and collaboratively providing pharmaceutical and behavioral interventions, respectively. All 12 institutions visited had patients receiving MOUD; while institutions are approved to offer all three FDA-approved medications, employees interviewed indicate that most patients are on buprenorphine. Extended-release buprenorphine, despite its higher cost, is often the preferred option in correctional settings due to several key benefits. It notably reduces the risk of diversion, as it is administered by healthcare professionals, limiting opportunities for misuse and enhancing overall safety within prisons.[151] Additionally, its extended-release formulation leads to improved treatment retention, resulting in higher abstinence rates and a reduced risk of relapse compared to daily sublingual buprenorphine.[152] These factors contribute to its long-term cost-effectiveness by reducing the need for emergency medical interventions and ensuring continuity of care post-release, promoting sustained recovery.[153] With this said, extended-release is not the right medication for everyone, and thus, MOUD pill lines occur daily. Medical personnel primarily facilitate medication administration, and although correctional officers are sometimes present, these are not standard correctional officer posts as seen in other health systems (e.g., California Department of Corrections and Rehabilitation [CDCR]).

Opioid Use Disorders Treatment Services Strengths

Effectiveness:

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[147] Substance Abuse and Mental Health Services Administration. "Medications for Substance Use Disorders." Accessed August 13, 2024. https://www.samhsa.gov/medications-substance-use-disorders.
[148] Illinois Department of Public Health. "Medication-Assisted Treatment FAQ." Accessed August 13, 2024. https://dph.illinois.gov/topics-services/opioids/treatment/mat-faq.html.
[149] Moore, Kelly E., Walter Roberts, Holly H. Reid, et al. "Effectiveness of Medication Assisted Treatment for Opioid Use in Prison and Jail Settings: A Meta-Analysis and Systematic Review." *Journal of Substance Abuse Treatment* 99, (2019): 32-43. https://doi.org/10.1016/j.jsat.2018.12.003.
[150] U.S. Government Accountability Office. *Improved Planning Would Help BOP Evaluate and Manage Its Portfolio of Drug Education and Treatment Programs*. GAO-20-423. Washington, D.C., May 2020. https://www.gao.gov/assets/d20423.pdf.
[151] National Commission on Correctional Health Care. *Position Statement: Opioid Use Disorder Treatment in Correctional Settings*. Adopted March 2021. https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021/.
[152] Greenwald, Mark K., Katharina L. Wiest, Barbara R. Haight, et al. "Examining the benefit of a higher maintenance dose of extended-release buprenorphine in opioid-injecting participants treated for opioid use disorder." *Harm Reduction Journal* 20, no. 173 (2023). https://doi.org/10.1186/s12954-023-00906-7
[153] O'Connor, Alane B., Catherine Gelsinger, Sadie M. Donovan, et al. "Community buprenorphine continuation post-release following extended release vs. sublingual buprenorphine during incarceration: a pilot project in Maine." *Health and Justice* 12, no. 28 (2024): 12-28. https://doi.org/10.1186/s40352-024-00281-w.

- **Integrated OUD Treatment:** Psychology and HSUs work together to provide MOUD to AICs who meet the criteria for OUD treatment.[154] At facilities, Psychology often conducts an assessment first before the HSU assesses the severity of the OUD diagnosis. Additional OUD treatment services combined with the HSU-provided MOUD and psychology-provided behavioral therapy. Such a multi-pronged approach to OUD treatment provides AICs with various avenues toward positive outcomes.
- **Increased Participation in MAT:** Since 2019, the number of AICs who have participated in MAT while in custody has increased exponentially. In 2019, only 116 AICs received medication-assisted treatment while in a BOP facility, and by 2022, 2,412 AICs were involved in the MAT program.[155]

Patient-Centeredness:

- **Medication Cost for OUD Not Highlighted by Interviewees:** Providing MOUD requires financial investment; the National Institute on Drug Abuse reported in 2014 that the annual per-person cost of long-term methadone treatment was approximately $4,700.[156] While BOP employees did not cite medication costs for the treatment of OUD as a primary barrier to expanding access, it's important to recognize the substantial budgetary impact. Despite these financial challenges, the continued expansion of MOUD highlights its value in improving health outcomes and reducing recidivism, aligning with broader correctional healthcare goals.
- **Broad Institutional Access to MOUD:** As aforementioned, MOUD was delivered on-site at every visited institution. This breadth of access allows patients across the BOP to receive care without needing to relocate to a different institution or regularly travel off-site.
- **Shared Decision-Making of MOUD**: The BOP utilizes three primary FDA-approved medications for AICs. While institutions indicated a preference for prescribing extended-release injectable buprenorphine, treatment decisions are based on a shared decision-making process. This process considers both the clinical judgment of the provider and the preferences of the patient, ensuring that the selected medication is clinically appropriate while also considering patient preferences, such as the choice between buprenorphine, naltrexone, or different modalities (e.g., injectable vs. film). This approach fosters patient involvement while ensuring safe and effective care.
- **MOUD Continuity of Care**: If a patient comes into the BOP or switches BOP facilities and is already on a MOUD, they are allowed to continue their treatment with their prescribed medication. At one visited facility, a newly incarcerated AIC was scheduled to meet the day after his intake with a BOP provider to prescribe a continuation of the

[154] U.S. Department of Justice, Federal Bureau of Prisons. *Opioid Use Disorder: Diagnosis, Evaluation, and Treatment*. August 2021. https://www.bop.gov/resources/pdfs/opioid_use_disorder_cg.pdf.
[155] *Federal Prisoner Statistics Collected under the First Step Act, 2023*. Office of Justice Programs, Bureau of Justice Statistics, Nov. 2023. https://bjs.ojp.gov/document/fpscufsa23.pdf.
[156] National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. National Institutes of Health. Revised January 2018. https://archives.nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf.

methadone that he had started in the community, ensuring timely care to avoid extended withdrawal symptoms.

Opioid Use Disorders Treatment Services Challenges

Timeliness:

- **Delayed OUD Assessment:** The requirement for a Psychologist to conduct a behavioral assessment prior to initiating MOUD has been removed from official guidance; however, observations and interviews across multiple institutions indicated that these assessments are still frequently conducted in practice. This often results in delays, as institutions are waiting for both the Psychology assessment and the medical history and physical examination performed by HSU. Institutions reported that the continuation of these assessments, despite the updated guidance, contributes to patients not starting MOUD in a timely manner due to the screening delays by either department.
- **Restricted MOUD Access:** AICs and employees noted accessing MOUD can be challenging as the providers often have waitlists, some of which have hundreds of AICs. While they wait, AICs may still be using opioids, potentially creating a dangerous situation for themselves and others.

Patient-Centeredness:

- **Lack of Education and Support for MOUD:** Custody interviewees reported they rarely receive education on the benefits of MOUD. As a result, some expressed skepticism about its utility in addressing the needs of the patient population despite ongoing concerns about drug contraband and overdoses in the facility. This perspective leads to stigmatization for AICs who are on or would benefit from MOUD.

Effectiveness:

- **Perceived Issues with MOUD Eligibility:** During interviews, employees across institutions expressed frustration regarding the criteria used to determine AIC eligibility for MOUD. They reported concerns that some AICs may be requesting MOUD without sufficient confirmation of having a clinical diagnosis of OUD. Staff indicated that eligibility determinations appeared to rely heavily on general histories of opioid use and patient self-reports rather than on thorough clinical assessments. This perception has led to concerns that some AICs may be accessing MOUD for reasons other than clinical necessity, potentially limiting access for those who are most appropriate and motivated for treatment.
- **Behavioral Programming Not Integrated with MOUD:** Despite the natural overlap between MOUD and behavioral programming (described in the strengths section above), the team found that more can be done to enhance integration between these treatment modalities. AICs may have participated in both offerings but at different times in their sentences. This piecemeal approach impairs the opportunity to simultaneously reinforce the education and skills gained in these programs.

Equity:

- **Inconsistent MOUD Prioritization:** Institutions have the flexibility to determine how to manage patients seeking MOUD. Given the limited staffing resources to offer MOUD to

all eligible AICs, many institutions offer MOUD as part of the release-planning process; AICs can receive MOUD if prescribed, starting around 90 days from release. However, this approach does not always consider the severity of the OUD and could cause AICs who need more immediate care to wait until release – which may never happen – for treatment.

Opioid Use Disorders Treatment Services Recommendations

Recommendation 4.31 (Process): Impose timelines for medical and psychology evaluations to facilitate patients being cleared to start Medications for Opioid Use Disorder (MOUD) care in a timely manner.

- ***Rationale:*** MOUD access is determined in part by clearance from the medical and psychological screenings. Setting deadlines for each department to complete their screenings may ensure patients are not lost in the process and have the approval to start treatment as soon as a spot becomes available.
- ***Priority (Medium):*** While this recommendation has several of the resources in place, there is significant potential to treat a higher number of patients. To treat a higher number of patients, a timely screening process and staffing to conduct the screening will be critical.

Recommendation 4.32 (Process): Enhance and expand structured training programs focused on the principles of empathy, the science behind substance use disorders and MOUD, and the impact of language on stigma and recovery. Encourage a culture of accountability where employees are responsible for their language and attitudes, supported by clear policies and consequences for the use of shaming language. Furthermore, consider making the training, especially around MOUD, mandatory for all BOP employees, including correctional officers and non-medical staff.

- ***Rationale*:** Institutional employees, particularly in custody, often express confusion about the benefit of MOUD and how MOUD can address drug-seeking behavior. Provide opportunities for local individuals with MOUD success stories to educate employees on the disease model of substance use disorders, covering genetic influences, neurochemical changes in the brain, co-occurring medical and psychiatric disorders, and the positive effects of MOUD. Providing a comprehensive overview of the science and outcomes and explicitly connecting this to enhanced safety and security for employees, AICs, and the community may generate buy-in and strengthen cooperation relating to OUD treatment services, including MOUD, across departments. Additionally, employees sometimes use stigmatizing language (e.g., "junkies," "addicts") to talk about individuals receiving or trying to access MOUD, contributing to a more hostile environment for AICs with OUD. Shifting to language with less negative connotations (e.g., "substance misuse") will help reduce the critical tone and can move the BOP closer to an enhanced culture of care.
- ***Priority (Low):*** Existing resources can drive this educational and cultural change at each facility and may enable patients to seek help while incarcerated, potentially curbing their substance use and thereby driving better health outcomes.

Nutrition Management

Nutrition Management Background

Nutritional management represents a vital component of preventive healthcare, particularly within correctional settings where dietary choices are often limited. The BOP's nutrition management program is led by the Chief Dietician at the Central Office and is supplemented by dieticians stationed at each MRC. The Chief Dietician works with Food Services (under HSD) to develop and assess the National Menu each year, which is a standardized list of meals offered at all institutions that rotate on a five-week cycle; these meals are designed for AICs to not exceed 2300 milligrams of sodium daily as advised by the Dietary Guidelines for Americans.[157] The National Menu provides a meat option and a plant-based option as the baseline meal that all AICs are served unless an AIC qualifies for a religious diet or special diet due to health concerns. To determine if an AIC is eligible for a special diet, they must be evaluated by an MRC dietician if they are at an MRC or by a Central Office dietician if they are elsewhere.[158] Additionally, Central Office and institutional dieticians provide nutritional counseling as part of the treatment regimen when clinically indicated,[159] meaning that AICs receive counseling to address existing health conditions and general guidance on selecting foods that promote a healthy lifestyle and aid in the prevention and management of medical issues.[160]

Nutrition Management Strengths

Patient-Centered:

- **Opportunities for Counseling During Chronic Care**: Some providers reviewed commissary lists and purchases with AICs during their chronic care check-ups that the team observed, educating them on the negative nutritional impacts of certain items and encouraging them to make healthier choices.
- **Patient Choice in National Menu:** Every year, AICs are invited to participate in a National Menu preference survey. Their feedback on their favorite and least favorite meals is accounted for while planning the National Menu for the upcoming year. This approach allows AICs to have some menu choices in an often-restricted institutional environment.

Effective:

- **National Menu is Healthy by Default**: In recent years, Food Services (under HSD) transitioned to offering a "heart-healthy" option as the default meal for all AICs unless they are on a special diet. Such standardization enables the BOP to streamline meal planning and supports AICs having access to health-conscious meals that support overall health goals.

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[157] U.S. Departments of Health and Human Services and Agriculture. *Dietary Guidelines for Americans 2020-2025*. 2020. https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf.
[158] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.
[159] Ibid.
[160] Vasiloglou, Maria F., Jane Fletcher, and Anna Poulia. "Challenges and Perspectives in Nutritional Counselling and Nursing: A Narrative Review." *Journal of Clinical Medicine* 8, no. 9 (2019). https://doi.org/10.3390/jcm8091489.

Nutrition Management Challenges

Effectiveness:

- **Limited Access to Nutritional Counseling:** Nutritional counseling, like disease prevention education, is often relegated to the recreation department instead of registered dieticians, a situation brought about by the minimal number of dietician positions. This practice can dilute the effectiveness of the dietary advice provided, impacting the overall quality of care.
- **Commissary Offers Unhealthy Choices:** While the National Menu offers low-sodium, "heart-healthy" meals, AICs have access to a commissary where they can spend about 90 dollars a week on food, clothes, and other material goods. Commissary offerings vary by institution, but a review of commissary lists across site visit institutions indicates that most food available for purchase is high in sugar, salt, calories, and fat (e.g., chips, ramen, soda). There are no fresh fruits or vegetables available for purchase through the commissary.

Nutrition Management Recommendations

Recommendation 4.33 (Process): Expand the dietetics program to enhance nutritional counseling services by including other professionals, such as Nutritionists, Certified Nutrition Specialists (CNS), and others. This expansion will increase access to essential preventive health information, providing broader support for individuals seeking to improve their nutritional health. Additionally, structured educational programs, such as certified health coaching, should be explored to equip AICs with knowledge about nutrition and healthy eating habits while also offering skills and certifications that can be valuable in community employment settings.

- ***Rationale:*** Nutritional counseling should be a proactive component of healthcare, serving as a preventive measure to mitigate the onset of diet-related diseases such as diabetes, hypertension, and obesity, which are prevalent in incarcerated populations.[161] To address staffing challenges, consider alternative solutions, such as hiring nutritionists, who do not need the same level of education and training as registered dieticians.[162] These measures can help fill gaps caused by vacant positions and ensure AICs have access to qualified nutrition professionals. Additionally, implementing structured educational programs that teach AICs about nutrition and healthy eating habits can empower them to make informed choices within the constraints of available food options, enhancing overall health and well-being.[163] This approach addresses immediate nutritional needs and supports long-term health and well-being, reducing the future burden of chronic diseases associated with poor diet.
- ***Priority (Low):*** Broadening services will require additional resources and may take longer for AICs to see results than with other services and interventions.

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[161] Brown, A. D. and B.L. Smith. "Impact of dietary interventions on the prevalence of chronic disease in prison populations: A systematic review." *Journal of Correctional Healthcare* 25, no. 3 (2019): 250-262.
[162] Lee, J. K., & T. M. Jenkins. "Telehealth Efficacy in Correctional Facilities: Bridging the Gap in Healthcare Delivery." *Journal of Telemedicine and Digital Health* 7, no. 1 (2023): 45-56.
[163] Carter, D. E., & Foster, E. J. "Nutritional Education Reduces Health Disparities in Prison Populations." *American Journal of Public Health* 110, no.4 (2020): 489-495.

Social Work

Background

Social workers are a vital part of healthcare in community settings, improving healthcare outcomes through their administrative and clinical support. Administratively, social workers carry out case management, which involves assessing, planning, implementing, and monitoring the care needed by patients. They assist patients with navigating SDOH, such as linking patients to stable housing, healthy foods, and affordable care. Patient advocacy is another critical element of their role, promoting patient rights and assisting with appeals processes. LCSWs provide direct patient care by assessing, diagnosing, and treating individuals with behavioral, mental, and emotional conditions. Collectively, social workers facilitate patients receiving comprehensive, coordinated, and compassionate care.

As of December 2023, the BOP has 84 full-time social work positions authorized. Of these positions, 77 are assigned to 36 institutions, with a 25 percent vacancy rate across the Bureau. Social workers are primarily concentrated at MRCs, Medical Care Level 3 institutions, institutions with intensive behavioral health programming, and institutions with female populations. They primarily focus on reentry planning for AICs with "significant medical and mental health issues," meaning all medical Care Level 3 and 4 AICs and select Care Level 2 AICs.[164] The reentry planning may entail setting up community appointments, addressing durable medical equipment and medication needs, coordinating with AIC families, and supporting Medicare and Medicaid applications for eligible AICs. Occasionally, social workers run select FSA programs. More about social workers and their role in release planning can be found in the "Reentry Services and Supports" section later in this chapter.

Social Work Strengths

Effectiveness:

- **Clinical Skillset:** Approximately 90 percent of the BOP's social workers are licensed, equipping them to deliver direct care to patients with behavioral, emotional, or mental conditions.
- **MOUD Focus:** Institutional social workers often focus on supporting the AICs seeking MOUD, a hybrid initiative between Psychology and HSD (see the "Medications for OUD" subsection for more information). Having a professional employee dedicated to administratively managing this interdisciplinary effort while AICs are incarcerated and ensuring continuity of care after release facilitates access to an important resource.

Efficiency:

- **Engaging Regional Resources:** Despite the lack of social workers at every institution, AICs with an identified need can be referred by an institution to connect remotely with a regional social worker. Utilizing regional resources broadens social work access for AICs at institutions without a social worker on-site, enabling them to receive critical individualized attention.

[164] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.

Equity:

- **Prioritized Assignments**: Given the number of social workers, these resources are intentionally assigned to institutions with high-need populations. Such placements provide crucial healthcare support to the most vulnerable AICs as they face the overwhelming reentry process.

Social Work Challenges

Effectiveness:

- **Limited Scope of Practice:** Despite having a high percentage of LCSWs, social workers report they rarely deliver behavioral healthcare. Restricting social workers to administrative duties despite possessing clinical skills is an inefficient and ineffective use of resources, limiting AICs from accessing useful behavioral health programming that overburdened psychological providers cannot always deliver.
- **Lack of National Policy:** Policies are critical for informing employee behavior, setting expectations, and holding the Bureau accountable. However, social work has never had its own national policy approved, and the drafted policy has been stalled since 2021; currently, the policy references around social work only exist as part of the Patient Care Program Statement 6031.05. The absence of social work policy can hinder effective rehabilitation and reintegration of AICs into society, potentially jeopardizing the safety of AICs and the public.

Patient-centeredness:

- **Restricted Social Work Access:** While social worker placements are prioritized based on institutional and individual AIC needs, SDOH affects most AICs. Limited social work resources mean many AICs may not connect with a social worker prior to release, leaving them to navigate challenging reentry conditions on their own.

Social Work Recommendations

Recommendation 4.34 (People): Increase the effectiveness and reach of behavioral health services by broadening the staffing credentials beyond psychiatrists and psychologists to include a diverse array of professionals such as LCSWs, Licensed Professional Counselors (LPCs), Marriage and Family Therapists (MFTs), Substance Use Disorder Counselors, and Peer Specialists. Each type of provider brings unique skills and perspectives, facilitating comprehensive care through interdisciplinary teamwork.

- ***Rationale:*** Around 90 percent of the BOP's social workers are licensed independent practitioners and should be permitted to practice to the fullest scope permitted in accordance with their State license.
- ***Priority (Top Priority):*** Opening behavioral health programming leadership opportunities to LCSWs – many of whom have expressed an appetite for this kind of work - would increase patient access to critical behavioral healthcare and be well-received by overburdened Psychology employees and underutilized LCSW employees alike.

Recommendation 4.35 (People): Implement position tiers in social work to promote cost-effective administrative and case management duties that can be performed by associate or

bachelor-level (unlicensed) social workers. Then, authorize each institution to have at least one social worker of any tier.

- ***Rationale:*** LCSWs currently spend much of their time doing non-clinical activities. Introducing tiers would enable social workers without a license to enter the BOP and provide administrative support, which would also be more affordable than hiring LCSWs. The affordability of lower-tier social workers would also make hiring one social worker for every institution a more attainable goal. These unlicensed social workers could handle simpler release planning cases, saving more complex coordination assignments for more advanced social workers. Then, offering social workers in lower tiers support to grow their skills through practicum hours or financial contributions towards licensure may serve as a retention strategy.
- ***Priority (Medium):*** Given the importance of release planning for all AICs – not just complex patients – increasing access to social workers is essential for improving continuity of care. Embracing social workers of varying licensure status increases the pool of qualified applicants, making this recommendation more feasible to implement across the Bureau.

Rehabilitative Services

Rehabilitative services are designed to help individuals regain, maintain, or enhance skills and functioning necessary for daily living that may have been compromised due to illness, injury, or disability. These services can include physical, occupational, and respiratory therapy and speech-language pathology, and within a community setting, they are offered within both inpatient and outpatient settings.[165] Within the BOP, approximately 50 rehabilitative specialists provide physical therapy (PT), occupational therapy (OT), and respiratory therapy (RT). The leadership role overseeing these specialists is currently titled the "Chief Physical Therapist," and the oversight is performed as a collateral duty.[166]

Physical Therapy

PT addresses patients' physical rehabilitation and mobility needs. PT is administered by a licensed physical therapist who assesses, diagnoses and treats individuals suffering from acute injuries and chronic pain. Additionally, they help patients avoid surgery and prescription drugs such as opioids for pain management, maximize mobility, decrease pain, and support the prevention of future problems by improving physical function and fitness.[167] Additionally, physical therapy assistants, under the supervision of physical therapists, contribute to treatment by assisting with executing therapy plans.[168] Physical therapists also have the critical role of guiding patients who need assistive devices. Assistive devices, prosthetics, and device training are necessary for AICs who

[165] HealthCare.gov. "Glossary- Rehabilitative/Rehabilitation Services." Accessed August 6, 2024. https://www.healthcare.gov/glossary/rehabilitative-rehabilitation-services/.
[166] To better reflect the comprehensive scope of these services, the BOP is considering transitioning this position to a full-time equivalent and is contemplating a title change to Chief of Rehabilitative Services.
[167] American Physical Therapy Association. "Becoming a Physical Therapist." Accessed August 6, 2024. https://www.apta.org/your-career/careers-in-physical-therapy/becoming-a-pt.
[168] U.S. Bureau of Labor Statistics. "Physical Therapist Assistants and Aides." Last modified April 18, 2024. Accessed August 6, 2024. https://www.bls.gov/ooh/healthcare/physical-therapist-assistants-and-aides.htm.

may be quadriplegic or paralyzed, and physical therapists can assist in appropriately fitting these devices.

The BOP has physical therapists stationed at select facilities, primarily complexes and MRCs. Physical therapists within the BOP assist with a variety of issues, including chronic pain management, post-surgery rehabilitation, wound care, and incontinence. If an AIC at an institution without a physical therapist requires PT, they may be seen via telehealth by a regional physical therapist, seen by a physical therapist in the community through the CMSC, or be considered to transfer to a higher level of care.

Occupational Therapy

OT is a service array delivered by occupational therapists and occupational therapy assistants aimed at helping individuals of all ages perform daily tasks and activities independently despite physical, mental, or cognitive limitations. OT services focus on a person-centered approach to teaching new ways of approaching tasks, recommending adaptive equipment, and altering environments to better accommodate an individual's needs. Common services for adults may involve rehabilitation from injury, adaptations for aging-related conditions, and strategies for managing chronic health issues. Occupational therapists can develop and implement programs that promote healthy behaviors or address particular issues such as older driving, community transitions for returning soldiers, homelessness, troubled youth, mental health, and addictions.[169]

Like PT, the BOP offers OT at a minority of institutions, primarily those with Care Level 3 or 4 designations. Occupational therapists assist AICs with managing activities of daily living (ADLs), particularly AICs who have mental health challenges.

Respiratory Therapy

RT services involve the assessment, diagnostic evaluation, treatment, and care of patients with deficiencies and abnormalities associated with pulmonary disease.[170] These services are provided by licensed respiratory therapists, who are trained to administer treatments like aerosol medications, chest physiotherapy, and mechanical ventilation, as well as to conduct pulmonary function tests and provide emergency respiratory care.

The BOP has two institutional respiratory therapists located at separate MRCs. The primary focus for RT is testing for and managing diseases such as chronic obstructive pulmonary disease (COPD), asthma, and sleep apnea with the aid of equipment like nebulizers, continuous positive airway pressure (CPAP), and oxygen tanks. The aging AIC population often requires timely and effective treatment for chronic respiratory conditions. However, the limited availability of full-time, round-the-clock care and a comprehensive medical team, as typically found in community settings, can hinder the management of severe respiratory episodes.[171]

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[169] American Occupational Therapy Association. "What is Occupational Therapy?" Accessed August 13, 2024. https://www.aota.org/-/media/corporate/files/practice/manage/presentation-resources/brochure/what-is-ot-brochure.pdf.
[170] American Association for Respiratory Care. "What is an RT?" Accessed August 13, 2024. https://www.aarc.org/your-rt-career/what-is-an-rt/.
[171] CDC. "Respiratory Viruses and Older Adults." Last modified March 1, 2024. https://www.cdc.gov/respiratory-viruses/risk-factors/older-adults.html.

Speech-Language Pathology

Speech-language pathologists (SLPs or speech therapists) diagnose and treat various communication and swallowing-related issues to improve vocal communication (e.g., apraxia of speech, cognitive-communication disorders, aphasia, and expressive disorders). Some conditions treated by SLPs develop following a stroke or traumatic brain injury.[172] Treatment consists of speech-therapy techniques; some examples include tongue and mouth exercises, facial movements, reading, and word exercises.

Community standards include the option to seek out care from an SLP specialist via physician's offices, private practices, hospitals, and rehabilitative centers.[173] Although the BOP does not directly offer speech-language pathology services within the institution, it supports access to speech-language pathology services through CMSCs in the community (see "Finances" later in this chapter for challenges related to CMSCs). This arrangement is made available when clinically indicated. However, this external provisioning can create a gap in immediate and consistent care, potentially impacting the timely treatment and rehabilitation of AICs needing these services.

Rehabilitative Services Strengths

Effectiveness

- **Carswell Pelvic Health Wellness Program**: Institutions that do have rehabilitative specialists can develop innovative programming. At FMC Carswell, physical therapists have created a unique 8-week program to address pelvic health concerns, covering diet, nutrition, posture, and sleep hygiene. At the time of writing this report, the therapists hope to expand the program from urinary and fecal incontinence to postpartum concerns and seek to have the program evaluated for evidence-based status.
- **Carswell Chronic Pain Management Program:** Chronic pain is an issue with which AICs frequently grapple (see "Chronic Disease Management" earlier in this chapter). Carswell has designed a seven-week interdisciplinary chronic pain course to teach AICs tools for managing chronic pain, such as breathing techniques.
- **Breadth of Board Certification**: As of December 2023, approximately 75 percent of BOP physical/occupational therapists are board-certified. Certification enables therapists to specialize in particular areas, such as cardiovascular rehabilitation, neurology, or geriatrics. Such competency equips therapists to provide superior care tailored to the unique needs of their patients.

Efficiency

- **Carswell AIC Training Program**: As of June 2024, Carswell runs a physical therapist technician training program for AICs. Additionally, Carswell has one PT orderly who is being trained as a medical assistant. Both tracks increase Carswell's capacity to provide more patient care while teaching marketable job skills and promoting reentry efforts.

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[172] Cleveland Clinic. "Speech Therapy." Last reviewed May 3, 2023. https://my.clevelandclinic.org/health/treatments/22366-speech-therapy.
[173] American Speech-Language-Hearing Association. "Who are Speech-Language Pathologists and What Do They Do?" Accessed August 13, 2024. https://www.asha.org/public/Who-Are-Speech-Language-Pathologists/.

- **Telehealth Utilization:** Given the limited number of rehabilitative specialists across the Bureau and the desire to provide as much in-house care as possible, the BOP must be creative to address AIC needs in a resource-efficient manner. The utilization of telehealth for rehabilitative services is an effective way to minimize challenges associated with providing timely and quality care.

Rehabilitative Services Challenges

Timeliness

- **Demand Outpaces Capacity:** According to the Bureau of Labor Statistics, demand for PT is anticipated to grow by 15 percent over the next 10 years due to the trajectory of the growing aging population.[174] If an institution has on-site PT, it is often not enough to fulfill the demand of its population, causing long wait times for care. Alternatively, for institutions without on-site PT, the wait times maybe even longer as AICs must access PT via outside medical trips or wait for a BOP telehealth provider to have availability.

Effectiveness

- **Limited PT Access Hinders Treatment**: Several AICs mentioned difficulties with accessing PT despite it being recommended or prescribed as part of a treatment plan. For those who received surgery, this means the post-surgery healing process was negatively impacted. For those who had yet to undergo surgery, this means they received no intervention at all. In both cases, patients were restricted from maximizing their recovery potential.
- **Inadequate Equipment:** Physical and respiratory therapists noted they require more functional equipment to deliver more efficient and effective care. Several pieces of respiratory equipment were non-functional, requiring patients to be sent out for tests that could be conducted with working equipment in-house. Assistive devices such as hoists can be detrimental to patients and providers, inhibiting patient mobility and autonomy and causing injuries to employees. Gaps in the equipment array inhibit care optimization.

Equity:

- **Speech-Language Pathology:** While the BOP supports the provision of speech-language pathology services through CMSCs outside the institution when clinically indicated, it does not offer these services in-house. This practice meets some needs but may not fully address the immediacy and consistency of care required for all AICs, particularly those with chronic conditions like traumatic brain injuries (TBI). To enhance care equity, integrating speech-language pathology services within BOP facilities could significantly improve accessibility and outcomes.

Rehabilitative Services Recommendations

Recommendation 4.36 (People): Allocate one respiratory therapist per MRC, with additional RTs allocated to facilities as needed based on patient volume. Enhance patient care by increasing coordination among contract pulmonologists and consider establishing a system for dedicated

[174] U.S. Bureau of Labor Statistics. "Physical Therapists." Occupational Outlook Handbook. Accessed August 21, 2024. https://www.bls.gov/ooh/healthcare/physical-therapists.htm.

clinical supervision by a centralized pulmonologist who supports comprehensive care tailored to the needs of the patients while maintaining consistency across facilities.

- ***Rationale:*** Having respiratory therapists at each MRC enhances access to specialized treatment for AICs, who generally have a higher prevalence of respiratory conditions.[175] Increasing coordination among contract pulmonologists ensures that RTs follow the best practices tailored to the needs of each patient. If established, a centralized pulmonologist could support consistency across facilities, leading to comprehensive care and improved patient safety while also reducing potential errors.
- ***Priority (Medium):*** Allocating one respiratory therapist per MRC, with adjustments based on patient volume, and enhancing coordination among contract pulmonologists will improve patient care. However, the complexity of hiring specialized staff and managing coordination across MRCs makes this a medium-priority initiative. If a centralized pulmonologist is implemented, careful consideration will be needed to ensure it complements the existing structure without adding undue burden.

Recommendation 4.37 (Process): Equip MRCs with updated and standardized pulmonary function testing equipment, such as lung diffusion DLCO machines, portable peak flow meters, and respiratory gas analyzers, with an implemented maintenance plan to ensure comprehensive on-site testing and reduce equipment breakdowns and patient transfers.

- ***Rationale:*** On-site pulmonary function testing can reduce the need for off-site hospital care, improving both efficiency and health outcomes. This method facilitates immediate clinical decision-making by enabling rapid diagnoses and the quick formulation of treatment plans at the point of care, thereby avoiding the delays often associated with external testing. Such prompt intervention is essential for effectively managing chronic conditions and preventing severe complications that could lead to emergency situations or hospital admissions.[176]
- ***Priority (Low):*** While updated pulmonary function testing equipment is valuable, prioritizing the hiring of specialized employees, such as respiratory therapists, and ensuring proper clinical supervision is more critical. Without the necessary personnel to operate and interpret these tools, the impact of investing in new equipment would be limited, making this a lower priority until staffing needs are adequately addressed.

[175] During the draft review for this report, the BOP suggested that the study team consider the use of tele-respiratory services for outpatient sleep studies. Based on their observations of current cost expenditures for external sleep studies, it was noted that this approach could potentially reduce costs. Further research and analysis would be required to validate this approach and assess its feasibility within the BOP context.
[176] Ndd Medical Technologies. "Point of Care PFT Testing: Important Now, More Than Ever." Published January 20, 2022. https://nddmed.com/blog/2022/point-of-care-pft-testing-important-now-more-than-ever.

Long-Term Services & Supports, Palliative, End-of-Life Care- and Compassionate Release

Background

Long-term Services & Supports (LTSS)

Long-term services & supports (LTSS) include a variety of services, including (but not limited to) assistance with daily living, facilitation of daily medications, wound care, and providing rehabilitative services. LTSS aims to serve patients who have any condition that would impede them from performing ADLs. The need for long-term services can arise suddenly following a medical emergency, such as injury or stroke, or become required due to a chronic medical condition. Treatment associated with long-term care can vary depending on the condition and take place in the form of home-based care or community and residential care.[177]

Palliative Care

Palliative care provides specialized critical support to patients living with serious illnesses such as cancer, heart disease, or other chronic health conditions.[178] Depending on the associated condition being treated, palliative care includes various types of support, from medical and symptom relief to social and emotional assistance. Palliative care can be provided at any stage of an illness and is not the same as end-of-life (or hospice care), which has a larger focus on prioritizing the comfort and quality of life of the patient, with the understanding that the patient's condition will not be curable.[179]

End-of-Life Care

End-of-life care refers to the support and medical care given during the time surrounding death, typically when a patient is in the final weeks or months of life. It focuses on providing comfort, managing symptoms, and ensuring the patient's quality of life is as good as possible during their remaining time. End-of-life care may include decisions about withdrawing or withholding treatments that are no longer beneficial or might cause more harm than good. It also involves addressing emotional, social, and spiritual needs, as well as supporting family members.

Community standards include LTSS, palliative, and end-of-life care through both home-based and community care. The BOP currently does not highlight the expectations for LTSS, palliative, and end-of-life care in program statements, creating a potential gap in standardized care for AICs needing these service arrays. This gap is further compounded by the limited use of compassionate release, as described below, which could provide a critical alternative for AICs in need of specialized care beyond what is available within the BOP.

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[177] National Institute on Aging. "What Is Long-Term Care?" Last reviewed October 12, 2023. www.nia.nih.gov/health/long-term-care/what-long-term-care.
[178] Cleveland Clinic. "Palliative Care: What It Is & What's Included." Last reviewed April 22, 2022. my.clevelandclinic.org/health/articles/22850-palliative-care.
[179] National Institute on Aging. "What are Palliative Care and Hospice Care?" Last reviewed May 14, 2021. https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care.

Compassionate Release

Compassionate release was established by the Sentencing Reform Act of 1984 as a part of the Comprehensive Crime Control Act of 1984. This legislation reformed the federal sentencing system and included provisions that allowed for the early release of AICs under certain conditions, such as terminal illness or extraordinary circumstances.[180] In today's correctional setting, compassionate release is often associated with both palliative and end-of-life care for elderly AICs who are no longer seen as a threat to the community. However, the growing challenges of an aging AIC population, increased deaths in custody, overcrowding, and escalating healthcare costs within the criminal justice system have led to calls for more extensive application of compassionate release.[181]

The BOP's criteria for compassionate release apply to AICs 65 or older who have served 50 percent of their sentence and:[182]

- Suffer from chronic or serious medical conditions related to the aging process.
- Experience deteriorating mental or physical health that substantially diminishes their ability to function in a correctional facility.
- Have medical conditions for which conventional treatment promises no substantial improvement to their mental or physical condition.

According to BOP data posted in August 2024, 4,740 compassionate releases have been ordered by the Courts since the passage of the FSA; 67 releases have been denied, and 17 have been granted in 2024.[183]

Long-Term Services & Supports, Palliative, End-of-Life Care and Compassionate Release Strengths

Efficiency:

- While every MRC ideally has a specialized nursing care unit with local policies for end-of-life care, these units can be challenging to operate with consistent staffing.[184] The study team observed FMC Lexington's separate housing unit, which was reported to be a best

[180] U.S. Senator for Hawai'i Brian Schatz. "Schatz Legislation on Compassionate Prison Release Passes Senate in Sweeping Criminal Justice Reform Bill." Press release. December 18, 2018. https://www.schatz.senate.gov/news/press-releases/schatz-legislation-on-compassionate-prison-release-passes-senate-in-sweeping-criminal-justice-reform-bill.

[181] At the time of writing this report, it was noted that the medical criteria for reduction in sentences (RIS) were being reexamined due to new sentencing guidelines. However, this process is not determined by the Health Services Division (HSD), as the policy falls under the responsibility of the Office of General Counsel (OGC).

[182] U.S. Department of Justice, Federal Bureau of Prisons. *Compassionate Release Criteria for Elderly Inmates with Medical Conditions: Clinical Guidance*. June 2019. https://www.bop.gov/resources/pdfs/2019_compassionate_release_cpg.pdf.

[183] U.S. Department of Justice, Federal Bureau of Prisons. *Federal Bureau of Prisons Fact Sheet*. August 12, 2024. www.bop.gov/about/statistics/docs/bop_fact_sheet.pdf?v=1.0.14.

[184] During the draft review of this report, the BOP reported that the FMC Butner had a similar specialized housing unit that was closed due to nursing staff shortages. Further verification is required to determine how many MRCs have specialized housing units for Long-Term Services and Supports (LTSS), palliative care, and end-of-life care.

practice due to its specific features, including 24-hour nursing care and fully equipped hospital-style beds aligned with community standards.

Long-Term Services & Supports, Palliative, End-of-Life Care and Compassionate Release Challenges

Effectiveness:

- **Inconsistencies with Compassionate Release:** The compassionate release process relies heavily on medical assessments to determine eligibility, which places significant responsibility on healthcare professionals. Research supports that both clinical inaccuracies and procedural hurdles impact the effectiveness of this process.[185] Clinically, instances of medical neglect, delayed diagnoses, and inadequate care have been documented, such as cases where treatable conditions were misdiagnosed or allowed to worsen due to a lack of timely intervention. Procedurally, delays in reviewing applications, inconsistent application of medical criteria across different jurisdictions, and slow administrative response times have contributed to missed opportunities for compassionate release.[186] Interviewees also reported frustrations with the inconsistency in applying these medical and procedural standards, further complicating the compassionate release process and leading to delayed or denied release even for those who reportedly met the criteria.

Long-Term Services & Supports, Palliative, End-of-Life Care and Compassionate Release Recommendations

Recommendation 4.38 (Process): Expand MRC capacity and services to enhance the continuum of care. This expansion should include long-term services and supports (LTSS), palliative, and end-of-life care, alongside streamlined provisions for compassionate release that are consistent with evidence-based standards for correctional health.

- ***Rationale:*** Expanding LTSS within correctional facilities addresses the aging population's increasing needs, promoting dignity and reducing long-term healthcare costs. Palliative and end-of-life care are critical as they provide necessary comfort and moral consideration, supporting a humane approach to incarceration.[187] Furthermore, streamlining the compassionate release program can help alleviate the financial and ethical burdens on the system by allowing terminally ill AICs to receive care in a more

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[185] Williams, Brie A., Rebecca L. Sudore, Robert Greifinger, et al. "Balancing Punishment and Compassion for Seriously Ill Prisoners." *Annals of Internal Medicine* 155, no. 2 (2011): 122–126. doi: 10.7326/0003-4819-155-2-201107190-00348; U.S. Sentencing Commission. *U.S. Sentencing Commission Compassionate Release Data Report*. Washington D.C., March 2024. https://www.criminallegalnews.org/news/2024/oct/1/us-sentencing-commission-publishes-data-report-compassionate-release-fy-2023/.

[186] Ciaramella, C.J. "Medically Neglected Inmates Could Get Relief Under Compassionate Release Changes." Reason. Published January 23, 2023. https://reason.com/2023/01/23/federal-inmates-suffering-from-unconstitutional-medical-neglect-could-get-relief-under-rule-change/; Thompson, Christie. "Old, Sick, and Dying in Shackles." The Marshall Project. Published March 7, 2018. https://www.themarshallproject.org/2018/03/07/old-sick-and-dying-in-shackles.

[187] Wilper, Andrew P., Steffie Woolhandler, J. Wesley Boyd, et al. "Health and Healthcare of US Prisoners: Results of a Nationwide Survey." *American Journal of Public Health* 99, no. 4 (2009): 666-672. doi: 10.2105/AJPH.2008.144279.

appropriate setting, thus aligning with best practice standards for correctional healthcare and reducing overcrowding.[188]

- ***Priority (Medium):*** The expansion of LTSS, palliative, and end-of-life care, alongside streamlined provisions for compassionate release, would align BOP with the community standard for care, but many of the resources needed to fully implement this recommendation are scarce.

Specialty Population Care

Background

Policies and care guidelines within the BOP play a crucial role in shaping the care provided to AICs, particularly those in specialty populations. The Women and Specialty Populations Branch (WASPB) operates independently of the HSD in the Central Office and resides within RSD. WASPB aims to optimize and ensure the development of provisions and services geared towards specialty population care. WASPB defines specialty populations as (but not limited to) AICs over 65 years old, persons with disabilities, females, pregnant AICs, and the seriously mentally ill.[189] This branch has a unique and often overlooked mission that can drastically improve the quality of care for many AICs.

It was reported that WASPB had previously launched and/ or withdrawn initiatives for specialty populations without sufficient collaboration or consultation from the HSD. These actions were reported to have led to challenges, particularly in integrating health services initiatives into aging clinical care, which was viewed as being not adequately considered by WASPB. Highlighting these historical background challenges is essential to foster an understanding of the critical need for enhanced collaboration and communication between RSD and HSD when providing care for specialty populations in custody.

This section first offers recommendations for specialty populations in general, then expands on the intricacies encountered while providing care for specialty populations in custody.

Recommendations

Specialty populations within the BOP have unique needs that require tailored approaches to care and management. Addressing these needs effectively necessitates general strategies and recommendations that apply across various groups as well as specific interventions targeted at particular populations. By distinguishing between broad recommendations and those designed for specific specialty populations, the BOP can more effectively allocate resources and provide the appropriate level of care and support for each group.

Recommendation 4.39 (People): Create a Specialty Population Coordinator position, prioritizing position placement at facilities with a higher prevalence of specialty populations. This

[188] Brie Williams et al., "Balancing Justice and Health in the Release of Elderly, Infirm, and Terminally Ill Inmates: A Survey of US State Policies," *Journal of Correctional Healthcare* 21, no. 1 (2015): 37-49.
[189] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5200.07: Female Offender Manual*. Washington, D.C., May 12, 2021. https://www.bop.gov/policy/progstat/5200.07b.pdf.

role will ensure comprehensive and continuous care, advocate for specific health needs, and implement tailored programs for these populations.

- ***Rationale:*** Due to staffing shortages and inadequate resources, institutions do not always have the trained personnel to focus on specialty population programming. A specialty populations coordinator at each institution would ensure the prioritization of these programs.
- ***Priority (Low):*** This position would be beneficial to specialty population care; however, staffing is a challenge, and it may take some time to implement. Beginning with the female population is a good starting point.

Female Population

Background

Female AICs make up roughly seven percent of the total population and are housed at 27 institutions, including one all-female medical center.[190] Unique accommodations must be made to properly provide quality care for the female population, acknowledging the importance of psychological resources such as trauma-informed care as a necessity for this population. Detailed guidance is highlighted in the Bureau's "Female Offender Manual" on additional programming to target special needs associated with the female population, as well as employee training specific to the female population.[191]

Pregnant females constitute an additional specialty population within female AICs, requiring further care and accommodation. BOP acknowledges that incarcerated women are often the sole providers for their infants and offers opportunities for mothers to adequately plan and prepare for this. The pregnant population has access to the following two pregnancy programs:

- **Mothers and Infants Together (MINT)**: A community residential program that houses pregnant AICs for two months and then postpartum AICs for six months with their infant.[192]
- **Residential Parenting Program (RPP):** A program through the Washington State Correctional System (WADOC) where BOP has an inter-governmental agreement to place pregnant AICs in a minimum-security pregnancy program for up to 3 months. This program allows AICs to reside with their infants for up to 30 months post-delivery.[193]

In addition to these programs, accommodations such as regular obstetrics and gynecological care, bottom bunk assignments, birth arrangements, and counseling are available.[194]

Female Care Strengths

Patient Centeredness

[190] Federal Bureau of Prisons. "List of BOP Locations." Accessed August 14, 2024. www.bop.gov/locations/list.jsp.
[191] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5200.07: Female Offender Manual.*
[192] Ibid.
[193] Ibid.
[194] Ibid.

- **Trauma-Informed Care:** Utilization of trauma-informed care with female populations has been well received and effective. BOP recognizes that women in custody are more likely to have experienced trauma and has facilitated employee training as well as increased programming to support the need.[195]

Effectiveness

- **Specialty Populations Coordinator Position:** The newly created specialty populations coordinator position solely focuses on programming and allocating resources to AIC specialty populations. This coordinator position is staffed in only a few primarily female institutions. Employees view it as a successful way for institutions to focus on specialty population care without removing resources from other initiatives. As this position is new, it is expected to be an effective way of making sure that policies and programming dedicated to specialty population care are being followed and reviewed.

Female Care Challenges

Patient-Centeredness

- **Domestic Violence Support and Traumatic Brain Injury (TBI):** Evidence-based screening and programming for domestic violence support, TBI, or both does not currently exist within the BOP. However, incarcerated women would benefit from a form of domestic violence support, as nearly 75 percent of incarcerated women have experienced a form of domestic violence.[196] A consequence of increased levels of domestic violence history is the presence of TBIs in incarcerated women; over 75 percent of women who have experienced domestic violence suffer repeated TBIs.[197] Additionally, studies have found a link between TBIs and mental health problems (such as severe depression or anxiety, substance use disorder, impulsive behavior, and self-harm).[198]

Efficiency

- **Access to MINT and RPP** Participation in both MINT and RPP can be untimely, inefficient, and inaccessible to certain pregnant AICs. From 2017 to 2019, only 124 out of 524 (24 percent) of pregnant AICs participated in either MINT or RPP.[199] Employees may

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[195] Despite this section's emphasis on the female population, trauma affects men as well. Previous studies show that up to 87 percent of incarcerated men experience a form of trauma as well. Additionally, a study using the Adverse Childhood Experiences (ACES) Questionnaire found that a sample of violent AICs experienced childhood adversity, on average, at four times the rate of the general population.

[196] Alessi, Gabriella, Katy Kaskolunas, Jocelyn Braxton, et al. *Implementing Domestic Violence Peer-Support Programs in Jail: A Starting Point*. Safety and Justice Challenge, 2023. https://safetyandjusticechallenge.org/wp-content/uploads/2023/07/2023DomesticViolencePeerSupportReport.pdf.

[197] American Brain Foundation. "Domestic Violence and Traumatic Brain Injury: The Chilling Truth of *This Hits Home*." Published June 30, 2023. www.americanbrainfoundation.org/domestic-violence-and-traumatic-brain-injury-the-chilling-truth-of-this-hits-home/.

[198] Center for Disease Prevention and Control. "TBI and Correctional Facilities." Traumatic Brain Injury & Concussion. Accessed August 21, 2024. www.cdc.gov/traumatic-brain-injury/health-equity/correctional-facilities.html.

[199] United States Government Accountability Office. *Pregnant Women in DOJ Custody: U.S. Marshals Service and Bureau of Prisons Should Better Align Policies with National Guidelines*. GAO-21-147. Washington, D.C., January 2021. https://www.gao.gov/assets/gao-21-147.pdf.

inconsistently inform a pregnant AIC of the option to participate in the MINT or RPP program. In addition, RPP is only available through Washington State corrections, making it far away for most female institutions. Pregnant women often want to be close to their families, so this program is often not a viable option.

Female Care Recommendations

Recommendation 4.40 (Process): Incorporate domestic violence support and TBI support into programming for the female population.

- ***Rationale:*** Trauma-informed programming focused on domestic violence support paired with increased screening and support for TBI in the women population could increase the quality of care and assist with addressing a multitude of issues associated with TBI.
- ***Priority (Medium):*** This recommendation would provide necessary support to female AICs with a history of Domestic Violence and TBI. However, especially in the case of TBI, this is largely a new area and may take time and resources to develop.

Aging Population

Background

The aging population is defined as any AIC over 50 years old, and the elderly population is defined as any AIC over 65 years old. This population is quickly growing as AICs age in custody at higher rates than in the past. From 2007 to 2010, the share of AICs over the age of 65 grew 94 times faster than the overall population.[200] The aging population often requires additional medical care and attention due to an increase in chronic conditions, mental impairments, and decreased mobility and functionality.[201] The cost to house an AIC 55 years or older in a federal prison is around five times more expensive than an AIC under the age of 55 due to the increased medical needs listed above. [202] Circumstances such as the physical infrastructure of an institution, staffing levels, and quality of needed equipment to provide care heavily impact the quality of care that an institution can provide its aging population.

Aging Population Care Strengths

Efficiency

- **AICs 70+ Cannot Be Care Level 1:** When an AIC becomes 70 years old, they can no longer be considered a Care Level 1,[203] even if they would otherwise meet the other criteria for a Care Level 1. This automatic transition is a strength that can shift necessary additional medical attention to an aging AIC. It can also be beneficial to focus on preventative care and diagnose any potential chronic conditions related to aging.

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[200] Human Rights Watch. "U.S.: Number of Aging Prisoners Soaring." Published January 26, 2012. www.hrw.org/news/2012/01/26/us-number-aging-prisoners-soaring.
[201] McKillop, Matt, and Alex Boucher. "Aging Prison Populations Drive up Costs." *Pew Trust*. Published February 20, 2018. www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs.
[202] Ibid.
[203] U.S. Department of Justice, Federal Bureau of Prisons, *Care Level Classification*.

Aging Population Care Challenges

Patient-Centeredness

- **Preventative Age-Related Care:** There is not a large focus on preventative care for the aging population. While AICs can access preventative care when an institution is appropriately equipped, preventative care is not prioritized until a health issue increases in severity. Additionally, there is limited access to on-site OT and PT, which increases risks associated with falling or other physical accidents and decreases overall mobility.

Safety

- **Physical Infrastructure:** Some institutions lack the physical infrastructure to safely house an aging population. Conditions such as lack of air conditioning, inadequate air flow, or stairs in or around housing units can vary from institution to institution and pose a safety risk for the aging population.

Aging Population Recommendations

Recommendation 4.41 (Process): Implement comprehensive, evidence-based standards for aging populations, focusing on integrated care models, falls prevention programs, engagement initiatives, and aging-in-place programs to enhance overall well-being and functional ability.

Rationale: A focus on preventative care as it pertains to aging is not only a patient-centered approach to healthcare, which will improve quality of life but also a cost-effective one. Costly chronic care conditions can be largely avoidable when appropriate preventative measures are taken place.[204] Comprehensive care models, such as the Age-Friendly Health Systems' 4Ms framework, ensure that older adults receive personalized, effective care that addresses what matters most to them, alongside managing medications, mentation, and mobility. Evidence-based fall prevention programs like CAPABLE and the Otago Exercise Program significantly reduce fall risks and improve the ability of older adults to perform daily activities, enhancing their independence and quality of life.[205] Furthermore, initiatives supported by the World Health Organization emphasize the importance of fostering environments that support healthy aging, promoting functional ability and well-being through integrated health and social services.[206]

- ***Priority (Medium):*** This recommendation could save the BOP resources in the long term and improve the quality of care for aging AICs; however, it can only be applied to institutions that are appropriately resourced.

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[204] A CDC study found that when preventative care is leveraged, 70 percent of costly chronic care conditions are avoidable. See: Institute of Medicine (US) Roundtable on Evidence-Based Medicine. "Missed Prevention Opportunities." In *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, edited by Pierre L. Yong, Robert S. Saunders, and LeighAnne Olsen. National Academies Press: 2010. https://www.ncbi.nlm.nih.gov/books/NBK53914/.

[205] American Hospital Association. "Transforming Healthcare for Older Adults as an Age-Friendly Health System." Published October 27, 2023. https://www.aha.org/news/blog/2023-10-27-transforming-health-care-older-adults-age-friendly-health-system.

[206] National Council on Aging. "Evidence-Based Falls Prevention Programs." Published December 1, 2023. https://www.ncoa.org/article/evidence-based-falls-prevention-programs;
World Health Organization. "Ageing." Accessed August 21, 2024. https://www.who.int/health-topics/ageing.

Population Experiencing Physical Disabilities

Background

The BOP defines disability as "an impairment that substantially limits an individual from performing major life activities."[207] This population requires specific care level designations that reflect an AIC's ability to perform important life activities, paired with appropriately trained employees who are equipped to deal with the necessary special accommodations. This population may need additional support from both custody and medical employees, as well as from an AIC companion (see the "Mental Healthcare Services" section for more information about companions).[208] Assistive technology, which is any adaptive or rehabilitative device that aids an individual with a disability in performing major life activities, must be readily available at every institution.[209]

Physical Disability Care Strengths

Efficiency

- **On-site Specialists:** Contract and employee on-site specialists, such as respiratory therapists, physical therapists, and orthopedic doctors, are a strength observed at visited MRCs. These specialists are valuable assets to an AIC with a physical disability by providing tailored medical care and rehabilitation.

Physical Disability Care Challenges

Equity:

- **Inconsistencies Across Institutions:** Inconsistencies in physical infrastructure, access to quality assistive technology, and employee support can disproportionately affect the special accommodations necessary for the physically disabled population. For example, it was reported that some institutions used plastic wheelchairs instead of metal ones due to security concerns. Interviewees expressed dissatisfaction, stating that plastic wheelchairs were less durable and raised concerns about fairness, particularly when comparing them to facilities that, according to them, allowed metal wheelchairs and operated at the same custody level. Additionally, it was observed that some institutions had differing accessibility features, such as limited access to wheelchair ramps, bed/shower rails, and other disability accommodations. These inconsistencies may result in inadequate access to necessary resources, potentially leading to inadequate care for AICs and posing a risk to their safety.

Timeliness

- **Assistive Technology:** Depending on both the staffing and equipment resources of a particular institution, an AIC in need of a specific assistive technology (e.g., wheelchairs, hearing aids, eyeglasses, canes) can experience extensive wait times to receive the necessary equipment. The process of receiving assistive technology can sometimes be

[207] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5200:005: Management of Inmates with Disabilities*. Washington, D.C., October 27, 2017. https://www.bop.gov/policy/progstat/5200_005.pdf.
[208] Ibid.
[209] Ibid.

inefficient due to approval processes from both the unit team, which is a team dedicated to fulfilling the program needs of each AIC and HSU.

Physical Disability Care Recommendations

Recommendation 4.42 (Process): Ensure that all institutions housing AICs with physical disabilities are adequately equipped to do so through sufficient physical infrastructure, staffing levels, and assistive technology. If an institution is not equipped to handle an AIC with a physical disability, the AIC should be promptly transferred to an institution that is.

- ***Rationale:*** AICs with physical disabilities require accommodations through assistive technology, employee support, and physical infrastructure conducive to proper mobility. If an institution cannot provide that due to inadequate resourcing, that institution should not be housing these AICs, as it is a safety risk.
- ***Priority (High):*** The resources to implement this recommendation already exist within the BOP. This recommendation would advocate for the safety and equitable care of AICs with physical disabilities.

Population with Mental Illness

[Please refer to the section above on Mental Healthcare Services.]

MRCs, Inpatient Hospitalization & Outpatient Specialty Care

Medical Referral Center

Medical Referral Centers (MRCs) are specialized institutions that provide advanced care for individuals with chronic or acute medical needs that cannot be managed at standard correctional institutions. MRCs are designated facilities that provide more comprehensive medical services, including inpatient and outpatient care, to individuals requiring specialized or complex treatments. It is critical to note that admission to nursing care services within an MRC is not considered inpatient hospitalization, as MRCs are not accredited as inpatient hospitals; they serve as designated facilities providing specialized and long-term care for AICs.

When an AIC is determined to require more intensive care that can be managed at a standard correctional institution, the referring institution submits a BP-A0770 form (often referred to as a "770") requesting transfer. The OMDT reviews these requests and prioritizes placement based on the severity of the AIC's condition. Once bed space opens at an MRC and the AIC's request is approved, the AIC is transported to the appropriate MRC for further treatment. Once treatment at the MRC is complete and the AIC is stable, they are redesignated by OMDT to an institution with an appropriate care level.

Inpatient Hospitalization

Inpatient hospitalization for AICs is a critical part of the healthcare continuum, becoming necessary when an AIC's medical condition escalates and requires sustained medical intervention. This level of care typically exceeds what can be managed on an outpatient basis or at an MRC, as it involves overnight and/or specialized supervision by medical personnel. Conditions warranting inpatient care may include severe chronic illnesses, acute medical crises, or post-surgical recovery that requires close monitoring and specialized treatment protocols. Sometimes, inpatient

hospitalization is needed while an AIC awaits placement at an MRC, particularly when their medical needs exceed the referring institution's capabilities. The reverse can also occur when a patient stabilizes and no longer requires inpatient hospitalization, but no MRC facility can receive them. This delay can lead to prolonged inpatient stays, even when the individual could be managed at a lower level of care, resulting in unnecessary healthcare costs and resource utilization. The cost of this care draws on the local institution's budget, including the cost of around-the-clock custody staffing. The institution monitors these cases through its utilization review committee (URC) to promote the efficient utilization of its resources.[210] Interviewees identified that this is an ongoing problem and frequently reported that AICs can wait months or longer for an MRC opening, resulting in extended stays in costly inpatient settings.

Outpatient Specialty Care

Outpatient specialty care refers to medical services provided by healthcare specialists that do not require an overnight stay in a hospital or medical facility. This type of care is typically needed when an AIC has a medical condition that requires expert evaluation, diagnosis, or treatment beyond what the HSU can provide. For example, an AIC might need to see a cardiologist for heart issues, an orthopedist for bone injuries, or an ophthalmologist for eye problems. When such specialized care is deemed necessary, it is often identified through a sick call or a chronic care visit, prompting a healthcare provider to submit a referral to be seen by a specialist.

Outpatient specialty services can take place on-site in the institution, off-site at a provider's office, or virtually using telehealth, depending on patient volume, institutional resources, and CMSC preference for seeing patients on- or off-site. Institutions may regularly bring certain providers on-site because they have a sufficient patient load and appropriate equipment for frequent clinics, like monthly optometrist visits for patients with vision challenges. If the service needs to be provided off-site due to the stipulations in the CMSC or the external provider being unwilling to come into the institution, a treatment date is confirmed, and the HSU, with the support of custody, works to find BOP employees who are basic prisoner transport (BPT)-certified to escort the trip.[211]

As mentioned earlier in this chapter, the BOP uses CMSCs to provide essential care for AICs needing both outpatient specialty care and off-site inpatient hospitalization. These CMSC companies establish relationships with local providers, arrange appointment logistics, and manage billing. They act as an intermediary between the institution and the provider. Each of the 121 institutions is responsible for securing and managing their own comprehensive contracts according to their institutional needs.[212]

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[210] More details on the utilization review committee process and concurrent review can be found in chapter 5.

[211] Custody level and security are considered with the decision to access off-site care. AICs with higher custody levels require more correctional officers to escort the AIC for outside care.

[212] Outside stakeholders interviewed have wondered why the BOP does not utilize national CMSCs, which may be more cost-effective than each institution negotiating their own rates. Based on BOP interviews, it is understood that individual institutions have unique needs due to patient population and location, so finding national contractors who can provide appropriate service to each of the 121 institutions seems unlikely. Furthermore, national contracts may restrict small businesses from being able to compete, which would

MRCs, Inpatient Hospitalization & Outpatient Specialty Care Strengths

Efficiency:

- **Productive Care Busses:** Certain institutions have coordinated with their CMSC to send "care buses" of several AICs in a group to an off-site provider's office to complete multiple visits or procedures at one time (e.g., routine colonoscopies). This approach facilitates an opportunity for more AICs to receive care in a timely manner, and correctional officers are utilized more economically compared to sending each AIC out on their own medical trip.

Effectiveness:

- **Established CMSCs**: Not all providers in the community are willing to treat AICs, so having CMSCs helps the Bureau connect AICs in need of care with providers willing to deliver the care. This helps to minimize the administrative burden of finding healthcare professionals willing to provide care to the AIC population.

MRCs, Inpatient Hospitalization & Outpatient Specialty Care Challenges

Timeliness: [213]

- **Long Waitlists:** Accessing specialty care can take a long time, potentially due to several factors. For instance, the contracted community specialist may be fully booked for months. Additionally, MRCs have limited bed space, and the prioritized list of AICs continuously evolves as patient acuity changes. For these reasons, patients may wait months to years to be seen by a specialist or sent to an MRC for care.
- **Lengthy Contract Set-Up**: Medical contracts can take a long time to review and establish at the institutional level, often due to collateral duties, position vacancies, and communication challenges between contracting employees and HSU. The utilization of interim 'bridge' contracts, necessitated while waiting for replacement contracts to be solicited, awarded, and implemented, can be particularly costly. Such delays pose financial burdens and leave the BOP ill-equipped to provide continuous care to AICs in need.

Effectiveness

- **Custody Challenges to Cooperation:** At certain sites, the team observed that custody did not always readily cooperate with medical employee directives to help deliver off-site

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run counter to the federal government's small business set-aside goals. More about the challenges with national CMSCs can be found in the "Finance" section later in this chapter or Chapter 5 on utilization review.

[213] Recent Department of Justice (DOJ) OIG audit support the team's observations and interviewee perceptions that timeliness for off-site and contractor-provided on-site medical care is a challenging issue. The March 2022 Audit of the FBOP Comprehensive Medical Services Contract Awarded to the University of Massachusetts Medical School found that the BOP lacked reliable processes or sufficient technology that monitored and analyzed wait times for outside medical care or the reasons for care delays. Additionally, the DOJ OIG determined that the CMSC did not adhere to contract requirements for on-site clinics, leading to delays in on-site care or additional outside medical trips. See: U.S. Department of Justice, Office of the Inspector General. *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School.* OIG 22-052. Washington, D.C., March 2022. https://oig.justice.gov/sites/default/files/reports/22-052.pdf.

medical care. For various reasons, custody may limit the number of medical trips that they are willing to escort or may be slow to report an emergency to the HSU. Reticence to collaborate is a safety issue for the entire institution and can cause an AIC's condition to worsen significantly.

- **CMSCs Not Meeting Needs**: While most institutions have CMSCs established for specialty care, many employees noted that the CMSCs were not adequately meeting the healthcare needs. For example, the CMSCs did not post open on-site specialist roles in a timely manner, did not provide a timely response for information, or on-site specialists were not held accountable for providing quality care. These lapses can hinder effective and efficient healthcare delivery.
    - The issue of unsatisfactory CMSCs may be connected to (1) inadequate multi-disciplinary communication between HSU, acquisition, and contracting; (2) a lack of quality assurance surveillance plans and trained contract administrators (contracting officer representatives or CORs) to administer and monitor contracts; and (3) challenges to enter timely and accurate information into the Contract Performance Assessment Rating System (CPARS).[214] The DOJ OIG has observed all these deficiencies through several audits, as summarized in its September 2022 Management Advisory Memorandum.[215]

Efficiency

- **Limited Resources:** Some institutions lack the equipment or personnel to deliver certain care on-site that other better-resourced institutions have. For example, one facility that the team visited did not have an optometrist contracted to come on-site for specialty clinics despite the institution having the appropriate optometry equipment. Missing critical equipment, employee vacancies, and insufficient CMSC providers lend themselves to unnecessarily escorted medical trips.
- **Insufficient Bill Review:** According to several DOJ OIG audits, the BOP struggled to review billing documentation in a thorough or timely manner, leading to the BOP being either fraudulently or accidentally overcharged for services rendered and sometimes required to pay penalty interest on late payments.[216] Greater diligence in this respect can serve to realize cost savings.
- **High Utilization of Hospital Care:** As mentioned in the "Care Levels" section, waitlists for MRCs are long, and patient acuity may be too great for an institution to address with its current resources. These elements may contribute to the fact that the number of outside hospital days per month per 1,000 AICs rose from 36 days in 2019 to

[214] According to BOP interviews, contract administration is often a collateral duty for employees.
[215] U.S. Department of Justice, Office of the Inspector General. *Management Advisory Memorandum: Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for Its Medical Services Contracts*. OIG-22-113. Washington, D.C.: September 26, 2022. https://oig.justice.gov/sites/default/files/reports/22-113.pdf.
[216] Ibid.

42.5 days in 2024.[217] The increase in hospital days corresponds to an increase in outside medical costs.

Patient-Centeredness

- **Inadequate Placement:** While institutions can send AICs in need of inpatient care to local hospitals instead of waiting for an MRC bed, this is a costly approach that can quickly negatively impact an institution's annual budget. Institutions that are unwilling or unable to expend those financial resources may keep the patient at the institution while they wait for an MRC transfer. As evidence of efforts to maintain budget compliance, the difference between the number of outside medical trips ordered and sent out tripled since 2019. However, keeping an AIC at a facility rather than sending them out can be unsuitable for a patient's needs and prevents them from receiving the appropriate level of care.

MRCs, Inpatient Hospitalization & Outpatient Specialty Care Recommendations

Recommendation 4.43 (Process): Facilitate partnerships between local contracting employees and the HSU to collectively manage and evaluate CMSCs through clearly defined Key Performance Indicators (KPIs). These KPIs should focus on metrics such as clinical outcomes, patient satisfaction, employee performance and engagement, and timeliness of service delivery. Establishing these partnerships will ensure that CMSCs are held accountable for their quality of service, directly enhancing patient outcomes.

- ***Rationale:*** DOJ OIG audits and team observations reveal inconsistent oversight of contract performance once established, where the HSU employees are disappointed by contractor performance yet rarely intervene to seek better conduct.[218] Enhancing inter-department communication by pairing the HSU, who are deeply aware of CMSC issues yet ill-equipped to hold them accountable, with contracting, who have the power to hold CMSCs accountable yet are not acutely aware of daily challenges, may improve CMSC performance.
- ***Priority (High):*** The resources are available and can easily partner to work towards better quality care delivery for AICs. This is something that the interviewees, the team, and DOJ OIG all support.

Recommendation 4.44 (Process): Require correctional and health services employees at institutions to shadow each other during onboarding to foster better rapport and understanding of each other's roles.

- ***Rationale:*** HSU employees at several institutions mentioned strained relationships at times with custody, inhibiting them from delivering patient care most efficiently and effectively. Exposing correctional employees to the purpose and benefits of facilitating care and building individual relationships early on may increase cooperation among

[217] U.S. Department of Justice, Federal Bureau of Prisons. "State of Health Services as a Health System." Email, 2024.
[218] U.S. Department of Justice, Office of the Inspector General, *Management Advisory Memorandum: Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for Its Medical Services Contracts.*

parties and improve care volume and quality. The opposite will be true for healthcare employees learning more about issues important to correctional officers.

- ***Priority (Low):*** The natural opportunity to implement this recommendation across the Bureau is already in place, as onboarding happens for both parties at the same time. Patient health outcomes will hopefully improve from an increased culture of care.

Recommendation 4.45 (Process): Require all BOP employees to obtain BPT certification to escort AICs as needed, prioritizing medical trips.

- ***Rationale:*** Mandating BPT certification for all BOP employees involved in transporting AICs ensures that employees are well-trained in the latest safety and security protocols, minimizing risks during transport while concurrently promoting access to healthcare services. Furthermore, standardizing this as a training requirement promotes consistency and fairness across BOP employees, supporting the BOP's commitment to maintaining high healthcare access standards for all AICs.
- ***Priority (Medium):*** Implementing this recommendation would support more timely outside care access, as more trained employees would be able to provide escorted trips. As BPT certification training is already offered as an optional course during new employee onboarding, the infrastructure and resources for mandating this course for all new employees across institutions should already be in place. However, it should be noted that mandating employees to be BPT-certified could be an issue for bargaining unit employees who do not wish to seek this certification.

Reentry Services and Supports

This section focuses on health-related reentry efforts provided by the HSD and the Reentry Services Division (RSD) up until release from BOP institutions. Reentry beyond this period (e.g., residential reentry management centers) and the quality of the reentry services and effort are outside the scope of this research study.

Reentry Background

In 2023, about 41,000 AICs were released from federal custody.[219] According to a GAO report from 2020, approximately 45 percent of people released from federal custody are re-arrested or return to a federal prison ("recidivate") within three years of release.[220] However, research indicates that lack of resources, such as access to education and job opportunities, as well as difficulties with SDOH, are factors that increase recidivism rates.[221] Hence, to ensure a successful

[219] U.S. Department of Justice, Federal Bureau of Prisons. "BOP Statistics: Inmate Release Numbers." Last updated July 2024. www.bop.gov/about/statistics/statistics_inmate_releases.jsp.
[220] United States Government Accountability Office. *Federal Prisons Bureau of Prisons Should Improve Efforts to Implement Its Risk and Needs Assessment System*. GAO-23-105139. Washington, D.C., March 20, 2023. https://www.gao.gov/assets/gao-23-105139.pdf.
[221] Butler, LaToshia, and Ebonyque Taylor. "A Second Chance: The Impact of Unsuccessful Reentry and the Need for Reintegration Resources in Communities." *Community Oriented Policing Services* 15, no. 4 (2022). cops.usdoj.gov/html/dispatch/04-2022/reintegration_resources.html; Link, Nathan W., Jeffrey

reintegration into society, it is critical that the correct programming is offered and access to care is arranged before release.

State governments are increasingly implementing supportive measures to aid the reentry of formerly incarcerated individuals, recognizing the importance of successful reintegration for reducing recidivism and fostering community safety. States are signing on to the Council of State Governments Justice Center's "Reentry 2030: 50 State Campaign," which commits states to publicly announcing and tracking progress around goals related to:

1. Enhancing access to essential services such as housing, education, job training, and mental health support;
2. Lowering barriers that limit growth and economic opportunities; and,
3. Advancing racial equity through data analytics to address disparities.[222]

Education, job training, and healthcare are key areas of reentry that states – whether or not they are participating in Reentry 2030 – are focusing on. In terms of education, states are committing to increasing the number of high school degrees and General Education Diplomas (GED), as well as college enrollments, through partnerships like the Georgia State University Prison Education Project.[223] Regarding job training, programs like Texas's Project Re-Integration of Offenders and Michigan's Vocational Village provide vocational training and job preparation services to AICs while incarcerated to equip them for the job market after release.[224] Specifically around healthcare, states are committing to securing Medicaid coverage for all eligible AICs prior to release, including SUD treatment, often through Section 1115 Medicaid demonstration waivers expanding eligibility, benefits, and SDOH provisions.[225] Collectively, these efforts reflect a growing understanding of the complex challenges faced by returning citizens and the benefits of a comprehensive approach to reentry support.

T. Ward, and Richard Stansfield. "Consequences of Mental and Physical Health for Reentry and Recidivism: Toward a Health-Based Model of Desistance." *Criminology*, 57, no. 3 (2019): 544–573. https://doi.org/10.1111/1745-9125.12213.

[222] Reentry 2030. "50 State Campaign." Accessed August 21, 2024. reentry2030.org/50-state-campaign/.

[223] Ibid.; Georgia State University. "Georgia State University Prison Education Program." Accessed August 21, 2024. perimeter.gsu.edu/gsupep/.

[224] National Conference of State Legislatures. *Successful Reentry: Exploring Funding Models to Support Rehabilitation, Reduce Recidivism.* Updated June 21, 2023. www.ncsl.org/civil-and-criminal-justice/the-importance-of-funding-reentry-programs.

[225] Kaiser Family Foundation. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." Published August 2, 2024. www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

Intake Process: Risk and Needs Assessment

Since the passage of the FSA in 2018, the BOP has conducted a risk and needs assessment for each newly admitted AIC through the two-part assessment system: the Prisoner Assessment Tool Targeting Estimated Risk and Needs (PATTERN), developed by the National Institute of Justice, and the Standardized Prisoner Assessment for Reduction in Criminality (SPARC-13), developed by the BOP. PATTERN measures an AIC's risk of recidivism using 11 factors that can change over time ("dynamic") and four factors that an AIC cannot change ("static"). Meanwhile, SPARC-13 engages four departments - Education, Health Services, Psychology Services, and Unit Management - to assess an AIC's needs in 13 different areas, as shown in Figure 6 below.[226]

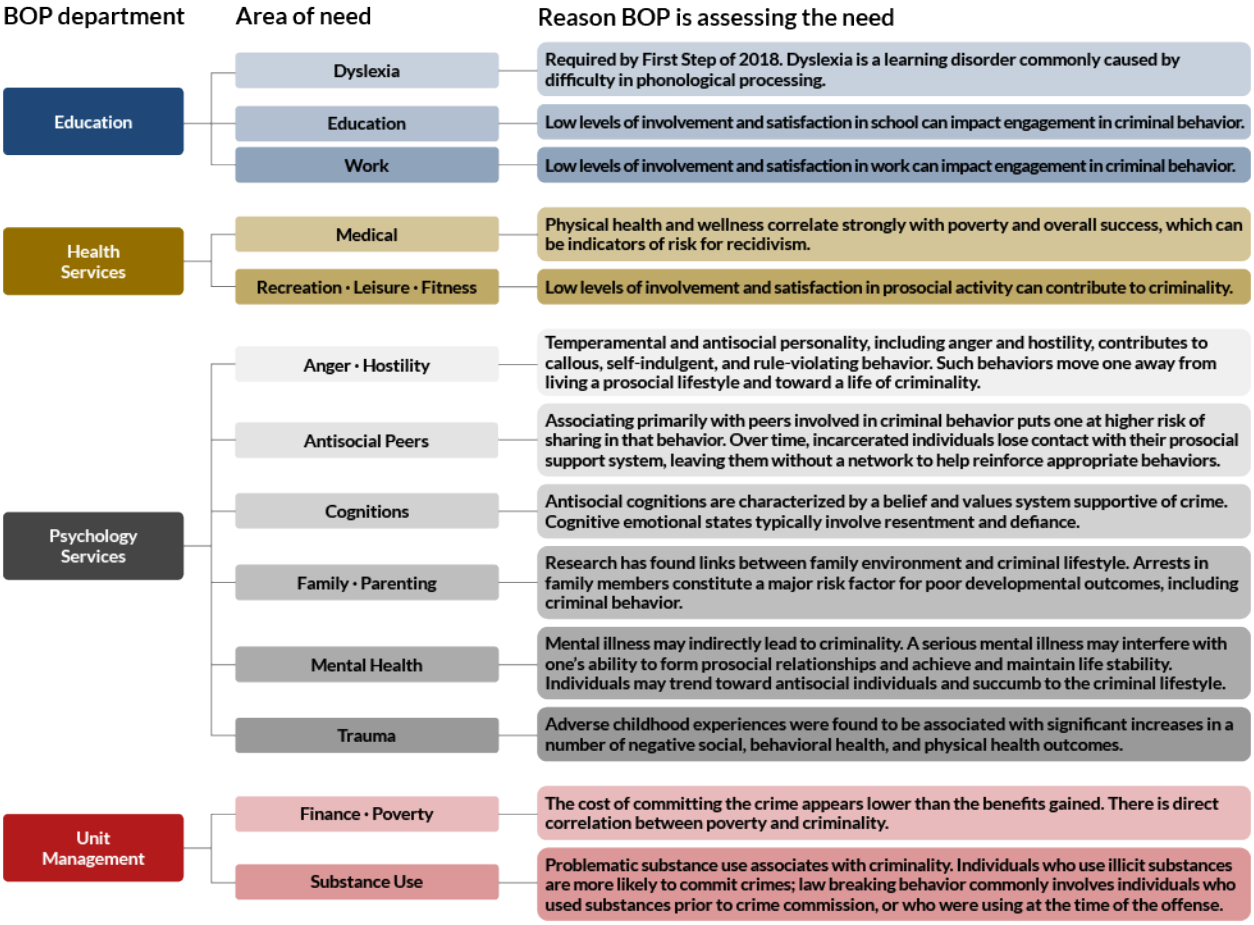

Figure 6: *Areas of Need Assessed by BOP by Responsible Department (Source: Government Accountability Office, 2023)* [227]

Based on the results of the SPARC-13, AICs are recommended to participate in EBRR programs or productive activities that align with their needs. Examples of programming include:[228]

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[226] United States Government Accountability Office, *Federal Prisons Bureau of Prisons Should Improve Efforts to Implement Its Risk and Needs Assessment System*.
[227] Ibid.
[228] U.S. Department of Justice, Federal Bureau of Prisons. *First Step Act Approved Programs Guide*. May 2024. https://www.bop.gov/inmates/fsa/docs/fsa-approved-program-guide.pdf?v=1.0.3.

- **Education:** This encompasses classroom literacy courses such as reading, phonics, and English as a Second Language. Such programming also covers job skills education such as Apprenticeship Training, Certification Course Training, Vocational Training, and Federal Prison Industries; these programs equip AICs with marketable skills to support their search for post-release employment opportunities.
- **Health:** Recreation delivers the goal-oriented "Wellness: Inside and Out" program to AICs with physical and behavioral health challenges to build skills and make behavioral changes. Medical offers the "Waysafe" planning and decision-making intervention for adults with SUD to improve decisions around health risk behaviors as they transition to the community.
- **Behavioral Health:** This encapsulates residential and non-residential group courses around trauma, parenting, anger and hostility, antisocial behavior, and cognition. For more information on behavioral health programming, particularly around substance use, see the "Substance Use Services" subsection earlier in this chapter.

Program placement and intensity of services are prioritized based on an AIC's recidivism risk, which is determined through PATTERN.[229] "Eligible" AICs – those serving a sentence for a conviction under certain provisions of the law, such as non-violent offenses – may earn time credits to apply towards reducing their sentence length for successfully participating in these programs.[230] As of August 2024, about 145,000 AICs are currently enrolled in curriculum-based EBRR programs and productive activities, and about 61 percent of the AIC population is eligible to earn time credits for their participation.[231]

Pre-release: Reentry Planning for Continuity of Care in the Community

As an AIC nears the end of their sentence, several team members and departments may collaborate to facilitate their reentry process, including the unit team, the reentry affairs coordinator, Psychology, and social workers. As aforementioned in the "Social Work" section earlier in this chapter, social workers are most concentrated at institutions with high-acuity behavioral and physical health patients; this distribution focuses social work-driven reentry efforts on complex patients who require the most support facilitating healthcare access post-release.

Supporting post-release healthcare access has several layers depending on the AIC's needs. For many AICs, access first starts with the need for health insurance coverage. Social workers assist eligible AICs with applications for Medicaid and Medicare to support community insurance coverage.[232] Besides managing the application process, social workers also schedule follow-up

[229] U.S. Department of Justice, Federal Bureau of Prisons. *First Step Act Initial Review of the SPARC-13 Needs Assessment System*. Washington, D.C.: March 2022. https://www.bop.gov/inmates/fsa/docs/bop_fsa_needs_validation_report_2021.pdf.
[230] Ibid.; The BOP website lists the crimes that render AICs ineligible for earning time credits off their sentence. See: U.S. Department of Justice, Federal Bureau of Prisons. "Disqualifying Offenses." Accessed September 23, 2024. https://www.bop.gov/resources/fsa/time_credits_disqualifying_offenses.jsp.
[231] U.S. Department of Justice, Federal Bureau of Prisons, *Federal Bureau of Prisons Fact Sheet*.
[232] U.S. Department of Health and Human Services. "HHS Authorizes Five States to Provide Historic Healthcare Coverage for People Transitioning out of Incarceration." Press release. July 2, 2024.

care with local community providers to aid in the transition of care. Finally, social workers coordinate with the HSU and RSD to support the AICs with their necessary post-release durable medical equipment and prescription medication needs.

Reentry Strengths

Safety

- **Enhanced Public Safety:** By providing rehabilitative programming based on evidence-based practices, AICs may be less likely to recidivate and more willing to reintegrate as productive members of society. Lower recidivism rates create a safer environment for the community.

Timeliness

- **Early Reentry Preparation:** The BOP identifies rehabilitation programming for AICs during the intake process and reports planning for reentry months before the projected release date.

Effectiveness

- **Comprehensive Programming:** Reentry programming under the FSA includes a variety of classes and modalities that all aim to teach positive, useful skillsets to AICs. For example, the Residential Drug Abuse Program (RDAP) consists of at least 500 hours of treatment programming delivered over 9-12 months.
- **Detailed Release Plans:** Social workers reported developing release plans for AICs with greater health needs to facilitate the reentry process. These plans include critical information such as resources in the AIC's place of release, steps to take for insurance enrollment and upcoming medical or behavioral health appointments in the community.

Reentry Challenges

Timeliness

- **Continuity of Care:** Despite allocating months for the pre-release planning process, facilitating healthcare access can take even longer. For instance, a lack of AIC identification documents can prolong the Medicare and Medicaid application process. Additionally, social workers may struggle to find community physicians within an AIC's geographical location licensed to prescribe medications for OUD, which may prevent the AIC from having continuous access to treatment.
- **Waitlists for Programming:** Due to employee and space limitations, AICs can wait months to participate in recommended FSA programming. While they may be earning time credits during this time simply for being enrolled, they are not actively participating in the recommended class. Thus, they are not learning or enhancing the knowledge and skills necessary to reduce the chances of recidivism.[233] However, they could be

www.hhs.gov/about/news/2024/07/02/hhs-authorizes-five-states-provide-historic-health-care-coverage-people-transitioning-incarceration.html.

[233] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5410.01 CN-2: First Step Act of 2018 -Time Credits: Procedures for Implementation of 18 U.S.C. § 3632(D)(4)*. Washington, D.C., March 10, 2023. https://www.bop.gov/policy/progstat/5410.01_cn2.pdf.

participating in another FSA program or Productive Activity that they are interested in, even if it is not part of their recommended programming.

Effectiveness

- **Complexities of Health Coverage:** Medicaid and Medicare eligibility and enrollment policies vary from state to state, which is challenging to navigate in a federal system where AICs could be released to a state different from the one in which the federal facility is located. One institutional social worker had to develop a resource guide on how to access these programs according to each state's policies.
- **Communication Between Agencies:** Many social workers were unaware if an AIC they submitted Medicaid or Medicare applications for received those benefits after release, implying that applications may have been submitted too close to release or a lack of effective communication and data sharing between institutions and social service agencies.
- **Reentry Employee Shortages:** Despite the need for social workers to facilitate healthcare access for AICs, most institutions do not have a social worker. While regional social workers can support institutions without social workers, their limited capacity means many AICs who may benefit from their reentry planning do not receive their services. Without social work's pre-release guidance, AICs may be challenged to access healthcare in the community.

Reentry Recommendations

Recommendation 4.46 (Process): Conduct monthly meetings between institutional social workers and regional counterparts to update and refine state enrollment policies for securing health coverage for AICs, ensuring streamlined access to healthcare. Additionally, a communication plan with state Medicaid agencies needs to be established to facilitate the application and enrollment process for AICs.

- ***Rationale:*** Health coverage policy regarding Medicaid varies by state, and regional social workers may have a broader awareness of state policies than institutional social workers located in one state.
- ***Priority (Low):*** This recommendation is feasible; resources like employees are available, and the high impact for AICs will occur, which will increase training for institutional social workers.

Recommendation 4.47 (People): Conduct a targeted evaluation of whether dedicated community outreach specialists could enhance AIC reintegration efforts within HSD, assessing their role in fostering connections with non-profit health agencies and neighborhood resource centers. Consider integrating insights into current or future BOP staffing tools to capture any identified staffing needs.[234] In the interim, support and hire peer support specialist(s) at each

[234] The specialist should stay informed about the U.S. Department of Justice's Office of Justice Programs (OJP) and the Centers for Medicare & Medicaid Services (CMS) Office of Minority Health's initiative, "Returning to the Community: Healthcare After Incarceration," which aids individuals in accessing health coverage and services upon reentry. See: Center for Medicare and Medicaid Services and the U.S.

institution to support patient-centered reentry coordination and to further bridge the gap in coordination.

- ***Rationale:*** A thorough needs assessment will provide critical insights into the staffing requirements needed to effectively support the complex needs of AIC reintegration, particularly regarding relationship-building with community partners to support healthcare access and SDOH resources. Understanding these needs will ensure that resources are allocated appropriately, enhancing the effectiveness of reentry programs. Interim peer support specialists can provide immediate support, leveraging their lived experience to assist AICs during the transition period, thus improving reintegration outcomes.[235] This approach aligns with best practices in correctional healthcare and reentry services, ensuring continuity of care and support.
- ***Priority (Top Priority):*** Determining the ideal staffing array for reentry may take time and resources to execute. In the meantime, peer support specialists are likely a more cost-effective alternative to social workers who can provide practical community coordination based on their own history on how to manage the post-release process. Stakeholders will view this recommendation as critical in reducing recidivism and will improve continuity of care efforts for formerly incarcerated individuals.

Department of Justice. *Returning to the Community: Healthcare after Incarceration*. April 2024. https://www.cms.gov/files/document/returning-community-health-care-after-incarceration-guide-health-care-reentry-english.pdf.

[235] "Enhancing Community Integration after Incarceration: Findings from a Prospective Study of an Intensive Peer Support Intervention for Veterans with an Historical Comparison Group." *ProQuest* 10, no. 33 (2022). https://doi.org/10.1186/s40352-022-00195-5.

Part C: Healthcare Operations

Staffing Operations

This section is not intended to be comprehensive but rather to connect the healthcare quality assessment with the staffing challenges observed. It highlights the most significant observations from interviews and site visits related to staffing operations, setting the stage for a deeper exploration of organizational structure and staffing patterns in Phase 3 of this study.

Staffing Operations Background

As described throughout this report, a well-functioning continuum of care is essential within the BOP to support AICs receiving consistent and timely healthcare services. However, the ability to maintain this continuum is heavily dependent on adequate and timely staffing of healthcare professionals. The hiring process within the BOP has been described by interviewees as excessively prolonged, often taking nearly a year from the initial application to the final onboarding of a healthcare professional.

These delays in hiring disrupt the continuum of care by creating gaps in staffing that hinder the consistent delivery of medical services. When healthcare providers are stretched thin or reassigned ("augmented") to non-medical duties due to staffing shortages, the ability to provide timely follow-up care, manage chronic conditions, and respond to acute health needs is compromised. Moreover, custody staffing shortages, which limit the availability of employees to escort AICs to off-site medical appointments, further disrupt the continuum of care; they delay necessary treatments and increase the risk of adverse health outcomes. Addressing these timeliness challenges in healthcare staffing is crucial to preserving the integrity of the continuum of care within BOP facilities.

Staffing Operations Strengths

Effectiveness

- **Clinical Leadership Delivers Quality Care**: The team observed that institutions with filled CD positions delivered care more effectively and efficiently than those without CDs. This is achieved through the CD's advanced clinical authority, advocacy for resources at the executive level, and authoritative communication with custody when issues arise.
- **Clinical/Administrative Co-Leadership Drives Action:** Effective healthcare management was evident when it relied on both clinical and administrative expertise. By assigning healthcare administration to the HSA and healthcare delivery to the CD, institutions ensure that leaders govern within their areas of expertise, thereby enhancing the overall productivity and effectiveness of healthcare services.

Staffing Operations Challenges

Timeliness

- **Staffing Shortages Delay Treatment:** Vacancies in healthcare and custody positions lead to delays in patient care. When healthcare providers are augmented for correctional

duties or when there are insufficient correctional employees to escort AICs to off-site medical trips, access to timely care is compromised.[236] These shortages, whether brief or prolonged, reduce the capacity for AICs of varying acuity to receive timely treatment.

- **Time-Consuming Hiring Process:** The hiring process for healthcare professionals can extend close to a year, from application submission to onboarding. Challenges with the USAJOBS platform, along with application assessments, contribute to delays in gathering and processing qualified candidates, leading to prolonged vacancies.

Effectiveness

- **HR Lack of Medical Expertise**: HR specialists without a healthcare specialty background may inaccurately assess the qualifications of prospective healthcare providers. This can result in the overlooking of suitable candidates or the hiring of underqualified personnel, affecting the overall quality of care.
- **Limited Ability for Programming:** Low staffing levels in the HSU limit the availability of non-critical medical services, such as preventative services, education, and programming, that promote physical and behavioral health wellness.

Efficiency

- **Lack of Critical Information Communication**: Interviewees lamented that communication gaps between institutions and the Central Office regarding staffing vacancies resulted in the Central Office being unaware of significant staffing shortages, hindering allocating necessary resources to address these gaps. For example, institutions reported sending staffing vacancies to their RDs, but RDs reported they do not routinely send institutional staffing vacancy information to the Central Office.
- **Lack of Paraprofessionals Hinders Efficiency:** The emphasis on hiring higher-level clinicians over support employees, such as medical assistants and transcriptionists, leads to inefficiencies. Clinicians spend time on tasks below their scope of practice (e.g., documenting the patient's encounter), reducing their capacity to provide direct patient care.

Healthcare Staffing Recommendations

Recommendation 4.48 (People): Deploy a specialized HR team dedicated to recruitment and retention strategies for healthcare professionals. The HR team members should be encouraged to achieve and maintain active American Society for Healthcare Human Resources Administration (ASHHRA) certification. This certification will signify their expertise in healthcare HR, enhancing their ability to effectively evaluate medical credentials, support compliance, and improve hiring outcomes.[237] In the interim, for immediate support to local HR, a medical professional should collaborate with HR employees in reviewing employment applications to prevent the exclusion of qualified candidates due to misunderstandings of medical credentials and avoid overlooking qualified candidates.

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[236] Additionally, augmentation overburdens employees with duties beyond their daily responsibilities, which negatively affects morale and retention.

[237] American Society for Healthcare Human Resources Administration. "Certified in Healthcare Human Resources (CHHR)." Accessed August 22, 2024. https://ashhra.org/education/certification/.

- ***Rationale:*** HR employees often do not have a medical background to fully understand the qualifications needed for a particular medical position.
- ***Priority (Top Priority):*** Deploying a specialized HR team with ASHHRA certification enhances the recruitment and retention of qualified healthcare professionals.

Recommendation 4.49 (People): Work with OMB to reassess the General Schedule (GS) grading scale to be more competitive with the community and similar federal counterparts such as Veterans Affairs.

- ***Rationale:*** A medical provider in settings outside the BOP makes far more than the same position within the BOP, with APPs making between $10,000-$30,000 more in the community than within the BOP.
- ***Priority (Top Priority):*** Reassessing the GS grading scale to align BOP HSD salaries with community standards and federal counterparts is a top priority to attract and retain healthcare professionals, directly improving AIC health outcomes and reducing wait times for quality care.

Recommendation 4.50 (People): Increase effectiveness by enabling medical professionals to operate within their appropriate scope of practice by developing a more robust healthcare cadre. This cadre would include clinical paraprofessional roles, such as medical scribes, certified nursing assistants, medical assistants, pharmacy technicians, and care coordinators/case managers.

- ***Rationale:*** Institutions are often inconsistently staffed, causing clinicians to spend time doing tasks below their scope, such as taking vitals, writing chart notes, and running pill lines. Swiftly hiring and onboarding paraprofessionals would align more with clinicians' community scope of practice, clearing their schedule so they can handle more complex tasks.
- ***Priority (Top Priority):*** This is an urgent recommendation as the relief of additional HSU employees will help clinicians work at the top of their scope with limited interruptions. There is a high impact on AIC health outcomes, and it is necessary to prevent harm to AICs.

Finances

Finance Background

Institutions have two budget categories that are subdivided by department (e.g., health services, correctional services, and reentry services). The two categories are "B1", which covers all activities inside the institutions, and "B2", which covers activities outside the institutions. Medical B1 refers to internal medical expenses, including on-site employee salaries, medical supplies, and medical equipment in the institution. Medical B2 refers to off-site medical expenses, including the bill for services, salaries for correctional employees who escort AICs, and vehicles. The United Financial Management System (UFMS) is a financial/procurement management system that tracks spending by all DOJ entities, replacing all other financial management systems across the DOJ to ensure consistency and improve financial management.

As mentioned above, every institution has a separate CMSC, and the contract rates differ between institutions. The BOP relies on these contractors to provide timely and accurate estimates of costs

via invoicing. Interviewees and outside agencies (e.g., GAO, DOJ OIG) reported that the accuracy, specificity, and timeliness of invoices provided by contractors vary and can be improved in some cases.

HSD's associated services cost $1.46 billion annually, accounting for approximately one-sixth of the BOP's overall budget. The cost of AIC medical care has increased by approximately 23 percent from 2017 ($615 million) to 2023 ($800 million), highlighting the growing financial demands of healthcare within the Bureau.[238] The annualized growth rate for the BOP's healthcare costs over the previous six-year period was approximately 3.52 percent.[239] Looking ahead, The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary has released projections that over 2023-2032, average annual growth in National Health Expenditures (NHE) (5.6 percent) will outpace average annual growth of gross domestic product (GDP) (4.3 percent).[240] If national trends are an indicator, the BOP could see faster growth in healthcare costs in the coming years, potentially approaching or even exceeding the projected NHE growth rate. This data underscores that while the Bureau's AIC's medical care cost rate is significant, it remains lower than the national average, which is projected to continue rising. The BOP may need to prepare for a future where healthcare costs rise more quickly, aligning with national trends. This preparation could involve budget adjustments, policy changes, or operational shifts to ensure that the BOP can continue to provide adequate healthcare services to its population without compromising other critical operations.

Various reports and audits from GAO and DOJ OIG surrounding financial management and healthcare spending tracking have been submitted. Unresolved recommendations from those reports still need to be addressed. In a 2017 report, GAO highlighted two challenges the BOP faces in tracking healthcare spending data. First, the "BOP lacks healthcare utilization data," and second, the "BOP does not analyze available healthcare spending data."[241]Additionally, a 2016 DOJ OIG audit found that the reimbursement rates they paid for medical services ranged from 115 percent to 385 percent of the Medicare rate. The BOP is the only federal agency utilizing off-site medical services without a reimbursement rate set by the government.[242]

Value-Based and Volume-Based Care

There are two main ways in which healthcare is delivered and reimbursed: volume-based and value-based care. Volume-based healthcare focuses on the number of services rendered and the

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[238] U.S. Department of Justice, *Federal Prison System: Salaries and Expenses – FY 2025 Performance Budget, Congressional Submission*.
[239] MeasuringWorth.com. "Measuring Worth - Measures of Worth, Inflation Rates, Saving Calculator, Relative Value, Worth of a Dollar, Worth of a Pound, Purchasing Power, Gold Prices, GDP, History of Wages, Average Wage." Accessed August 22, 2024. www.measuringworth.com/calculators/growth/noteongrowthrates2.php.
[240] Centers for Medicare & Medicaid Services. "CMS Releases 2023-2032 National Health Expenditure Projections." Press release. June 12, 2024. https://www.cms.gov/newsroom/press-releases/cms-releases-2023-2032-national-health-expenditure-projections.
[241] United States Government Accountability Office. *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Healthcare Costs*. GAO-17-379. Washington, D.C., June 29, 2017. www.gao.gov/products/gao-17-379.
[242] U.S. Department of Justice, Office of the Inspector General. *The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care*. OIG-e1604. Washington, D.C., June 2016. https://oig.justice.gov/reports/2016/e1604.pdf.

number of patients that are seen by the healthcare provider or institution. Value-based healthcare focuses on outcome, effectiveness, and patient satisfaction when looking at reimbursement and costs.[243] Both models are used in healthcare, but volume-based is criticized for its focus on quantity over quality, which can lead to overdiagnosis and over-screening for patients, increased administrative work and burnout for providers, and decreased patient satisfaction. Conversely, value-based healthcare focuses on preventative care and chronic care management, which decreases the need for patients to seek out medical care. Additionally, value-based healthcare is a holistic approach that considers SDOH and increases overall patient satisfaction. Value-based healthcare can also reduce burnout for providers due to the decrease in administrative tasks and repeat patient visits.[244]

CMSCs focus on volume-based care and not value-based care. CMSCs are intended to cover all medical costs that a single institution may need within one contract with limited consideration for the quality of the care that these contracts provide. Additionally, some members within the BOP have looked to expand its contract to regional and even national-level contracts that would generalize the services provided. Making this shift may lead to rural institutions struggling to find accessible medical care for AICs in their care. Additionally, AICs often face SDOH that volume-based healthcare does not always account for, such as socioeconomic status, education, previous housing, and food security.

Finances Strengths

Effectiveness:

- **Financial Data at the Institution Level:** Since the CMSCs are controlled at the institution level, the HSA and business administrators within institutions can track healthcare spending. The institutions' HSAs and auxiliary employees, if available, track their spending and identify when additional money is needed annually. The way this information is tracked and presented to the Warden varies between institutions. The most common method observed was the HSA reporting the overall B1 and B2 budget in the Governing Body Meeting Minutes.[245]

Efficiency:

- **New Financial System:** UFMS is a more structured system that allows better tracking of financial data if input is accurate.

- **Med-Surge-Prime Vendor (MSPV):** The BOP has entered into an agreement with the Department of Veterans Affairs to utilize the MSPV Medline, a national contract that reviews spending on medical and surgical equipment. Using an already existing system

[243] Deep Scribe. "Volume-Based Care and Value-Based Care: Pros and Cons." Accessed August 22, 2024. www.deepscribe.ai/resources/volume-based-care-and-value-based-care-pros-and-cons.
[244] Ibid.
[245] Governing Body Meeting Minutes should be developed quarterly by the Warden, AW, CD, HSA, QIIPC Consultant, chief pharmacist, and chief dental officer at every institution. Although institutions use different formats, information in the document includes staffing numbers, bio-medical ethics, quality improvement plans, NPMs, risk management, infection prevention, budget, patient perception survey, and programmatic review.

within the government is more efficient and enhances the quality of data monitoring for spending.

- **National Prime Vendor:** There is a national prime vendor for pharmaceuticals, which facilitates conducting a spend analysis for per capita comparisons and tracking high-cost pharmaceutical areas due to the national contract.

Finance Challenges

Timeliness

- **Delayed Invoices:** CMSCs are utilized for their medical services and billing services at the institutional level; therefore, institutions depend on the contractor to compile the data from outside providers and provide an invoice. However, the BOP can wait months or even years to get the invoice. While waiting for an invoice, the contractors' cost estimate for the services rendered is used to estimate expected costs. Some contractors do not provide accurate estimates, and the institution's business administrator is required to be consistent in checking estimates and requesting updates. All these issues with the contractors make it difficult to accurately track the costs of off-site medical care and know when there is a need for additional funding.

Efficiency

- **Institution-Specific CMSCs:** CMSCs are used for each institution to obtain off-site medical services rather than having set reimbursement rates. The 2016 OIG report on reimbursement rates for off-site medical care estimated the BOP spent at least $100 million more in FY14 than it would have if it could pay Medicare rates for off-site medical care.[246] Additionally, it does not have accurate data surrounding its utilization of healthcare services; therefore, it is unable to competitively seek out regional or national contracts if desired. Contractors require years of data detailing healthcare utilization to get an accurate idea of the services needed.
- **Communicating Financial Information to HSD Leadership:** While the HSAs and business administrators at institutions report having a good understanding of medical spending for their institution, this information is not being passed up to the Wardens, regions, or Central Office in any standardized way. If information is passed up, which the team was only able to observe at five institutions, then the only number provided is the overall B1 and B2 budget without details surrounding high-cost services. The regional comptrollers shared that they are unable to narrow spending down by specialty to identify potential areas of cost saving.

Effectiveness

- **Healthcare Utilization Data:** Utilization data is not tracked because HSD cannot gather or analyze cost data in depth, as their systems do not track the necessary information. BEMR is not tied to UFMS, which makes it difficult to verify services with payments. Additionally, BEMR requires providers to scan in documents from outside providers; therefore, to track down the number of a specific service type, someone would

[246] U.S. Department of Justice Office of the Inspector General, *The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care*.

need to open each individual patient record.[247] This lack of data inhibits the ability to identify cost drivers and potential areas for cost savings.

Finance Recommendations

Recommendation 4.51 (Technology): Conduct an independent evaluation of the agency's comprehensive medical services contracts to explore the current status and to consider transitioning from a volume-based model to a value-based model. This evaluation should compare contract performance measures and provide recommendations on whether continued institution-based medical contracting or regional/national contracts would better meet the healthcare needs of AICs. Ultimately, the evaluation should prioritize shifting contractual performance expectations to improve patient outcomes and enhance the overall quality of care provided and cost efficiency for the agency.

- ***Rationale:*** In the context of correctional healthcare, the distinction between volume-based and value-based payment models is crucial for improving care delivery and cost management. Volume-based models (also known as fee-for-service), which reimburse providers based on the quantity of services rendered, have been criticized for incentivizing overutilization without necessarily improving patient outcomes. Burwell (2015) outlines how the Department of Health and Human Services has advocated for value-based payment models that link reimbursement to the quality of care provided. [248] This approach not only aims to enhance patient outcomes but also to reduce unnecessary healthcare costs. Furthermore, the Healthcare Payment Learning & Action Network (2017) highlights the benefits of alternative payment models, including improved care coordination and patient satisfaction. [249] The Centers for Medicare & Medicaid Services (CMS) Value-Based Programs illustrate the positive impact of prioritizing patient outcomes and cost efficiency, showcasing the potential benefits of transitioning to a value-based model. A dedicated comprehensive evaluation would be necessary to ensure that contractual performance expectations are aligned with industry best practices, ultimately enhancing the quality of care provided and achieving greater cost efficiency for the agency. [250]
- ***Priority (High):*** Renegotiating contracts is a high priority because it will improve access to healthcare and improve timeliness, but it is a major lift for employees.

Recommendation 4.52 (Process): Increase communication surrounding medical finances by requiring the institution's business administrator, in collaboration with the HSA, to report medical spending based on specialty and service type within their institution to the regional comptroller and to HSD at the Central Office level on a quarterly basis.

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[247] U.S. Department of Justice Office of the Inspector General, *Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for Its Medical Services Contracts*.
[248] Burwell, Sylvia M. "Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Healthcare." *New England Journal of Medicine* 372, no. 10 (2015): 897-899. https://doi.org/10.1056/NEJMp1500445.
[249] Healthcare Payment Learning & Action Network. *Alternative Payment Model (APM) Framework*. 2017. Accessed August 22, 2024. https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.
[250] Centers for Medicare & Medicaid Services. "Value-Based Programs." Accessed August 22, 2024. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.

- ***Rationale:*** Enhancing the scope of information beyond reporting B1 and B2 numbers will support the BOP in better tracking healthcare utilization data, identifying high-cost procedures, and optimizing contracts. By pinpointing the most frequently used services at each institution, HSD can develop need-based contracts, thereby increasing access to care and improving patient satisfaction. To ensure this is feasible, the BOP should integrate its systems (as discussed later in this chapter) to allow HSAs and Business Administrators to have an automated means to look at financial data in depth.
- ***Priority (High):*** This is a feasible solution to increasing the tracking of healthcare utilization data and finance data.

Data Collection and Evaluation

Background

To understand the strengths and challenges in providing healthcare to AICs, the BOP needs to have and analyze the appropriate data to identify root causes. Many public and government sectors use frameworks such as the Results-Based Accountability (RBA) method to make data-driven decisions. RBA begins with the end goal in mind, working backward to determine the means necessary to achieve that goal. Performance measures in RBA assess whether customers or clients are better off because of the services provided, focusing on the quality, efficiency, and effectiveness of these services. To determine the most crucial performance measures, RBA asks three key questions: How much [care] was provided? How well was that [care] delivered? And is anyone better off [because of the care provided]?[251] Such an approach enables organizations to identify strengths and weaknesses in their services array and drive change.

There are two main measurement sets that are used in the community to determine how well healthcare is being provided to patients and to evaluate whether a patient is better off due to the care provided. The Healthcare Effectiveness Data Information Set (HEDIS) measures are the most widely used performance measures in the healthcare industry. HEDIS, through the National Committee for Quality Assurance (NCQA), consists of over 70 measures ranging from preventative care to chronic care, which are updated annually. HEDIS measures are spread across the Six Domains of Healthcare and can be adapted for various settings depending on the level of care. HEDIS measures focus on how well care is being provided and includes standards for determining if anyone is better off.[252] Consumer Assessment of Healthcare Providers and Systems (CAHPS), through the Agency for Healthcare Research and Quality (AHRQ), has developed evidence-based surveys that can capture patient's experiences and feedback on the care provided. CAHPS also utilizes the Six Domains of Healthcare to determine the impact of care provided.[253] Additionally, the Centers for Medicare and Medicaid Services (CMS) has implemented quality assurance measures that can be utilized to improve data tracking and analysis.[254]

Taking these community standards as a framework, aspects of the BOP's data collection and analysis were reviewed to identify strengths and areas for improvement.

Bureau Electronic Medical Record (BEMR)

Electronic health records (EHRs) are systems that allow providers to record electronic versions of the patient's medical history and can include information such as demographics, medications,

[251] Clear Impact. "Results-Based Accountability." Accessed August 22, 2024. clearimpact.com/results-based-accountability/.
[252] National Committee for Quality Assurance (NCQA). "HEDIS and Performance Measurement." Accessed August 22, 2024. www.ncqa.org/hedis/.
[253] Agency for Healthcare Research and Quality. "Consumer Assessment of Healthcare Providers and Systems (CAHPS)." Accessed August 22, 2024. www.ahrq.gov/cahps/inde.g.html.
[254] Centers for Medicare & Medicaid Services. "Quality Measures." Last modified May 1, 2024. www.cms.gov/medicare/quality/measures.

vital signs, medical history, immunizations, and testing results.[255] The Institute of Medicine (IOM) Committee identifies the core functions EHRs should serve:

- **Health Information Data:** Include the patient's diagnoses, medication, allergies, demographics, and test results.
- **Results Management:** Automatically display test results, consults, and patient consent.
- **Order Entry/Order Management:** Allow for computerized order entry, which can limit medication errors by using "forcing functions" and crosschecking with the facility's formulary.
- **Decision Support:** Include computerized decision support, which can provide reminders or suggestions on treatment plans.
- **Electronic Communication and Connectivity:** Allow providers (physicians, pharmacists, radiologists) to exchange data as well as allow communication between providers and patients (e.g., lab result alerts).
- **Patient Support:** Include computer-based patient education, specifically surrounding preventative and chronic care.
- **Administrative Processes:** Include scheduling systems and billing and management systems.
- **Reporting and Population Health Management:** This includes the capability to collect data to satisfy reporting requirements and internal quality improvement efforts.[256]

The BOP contracted the development and customization of the Bureau Electronic Medical Record (BEMR) in 2006 for correctional use by adding functionality that enhances security and control over sensitive information. BEMR houses electronic medical records for all AICs in its care. It viewed other commercial EHRs as more susceptible to data breaches.

BEMR includes information about AICs, such as their medical, social, and psychological history. Additionally, the BEMRx module within BEMR stores all pharmaceutical records. BEMR is connected to SENTRY, the BOP's system for managing custody matters for AICs, which also stores information about their demographics. BEMR is implemented at all 121 facilities and allows employees to electronically access AIC medical records immediately following transfers, as opposed to paper medical records, which were used prior to BEMR.

Dashboards

Around 2012, HSD employees developed internal dashboards to highlight trends across the Bureau. These dashboards emphasize data visibility with respect to delays in care, which can be visualized at both the regional and institutional levels. HSD works with the Office of Research and Evaluation (ORE) to develop and post their data using SAS Analytics 7.5. The dashboards are divided into administrative and clinical displays. The clinical display includes datasets on multiple different topics, such as the number of late consults, late histories and physicals, late chronic care appointments, and national performance measures. The dashboard trend displays help HSD

[255] Centers for Medicare & Medicaid Services. "Electronic Health Records." Last modified September 6, 2023. www.cms.gov/priorities/key-initiatives/e-health/records.
[256] Institute of Medicine (U.S.) Committee on Data Standards for Patient Safety. *Key Capabilities of an Electronic Health Record System: Letter Report*. National Academies Press, 2023. www.ncbi.nlm.nih.gov/books/NBK221800/.

quickly identify areas of concern and the respective region and institution with concerns, then consider an action plan to address such issues. The dashboards are useful to institutional employees because they enable them to review metrics quickly without the need to run separate reports in BEMR.

Data Sources

Institutions use the following documents and mechanisms to track and report data on staffing levels and healthcare delivery:

- **Quality Improvement Meeting Minutes:** These minutes include analyses of all approved studies, risk management issues, National Performance Measure (NPM) statistics, and environment of care/biomedical safety equipment checks.[257] This document is created in consultation with the AW, CD, Chief of Psychiatry, Chief of Psychology, HSA, Assistant HSA (AHSA), QIIPC Nurse, Director of Nursing, Nursing Supervisors, Chief Social Worker, Chief Pharmacist, and Laboratory Supervisor.[258]
- **BP MED 18:** The BP MED 18 is an institution-specific staffing report for medical personnel that institutions supply to their regional offices on a monthly basis. It displays all available positions within the HSU, including vacancies and any known departure days for employees.
- **Governing Body Meeting Minutes:** Institutional employees update and present Governing Body Meeting Minutes to their local leadership on a quarterly basis. They address topics including human resources management, quality improvement plans, infection control, budget, facilities, and Patient Perception of Care survey results. The topics and level of granularity vary by institution.
- **BEMR Reconciliation Report:** BEMR Reconciliation reports display the number of requests and consults that are delayed in each institution. This report is supplied to regional offices on a monthly basis.

Data Collection and Analysis Challenges[259]

Safety

- **No Notifications for Employees of Actions Needed:** BEMR does not provide alerts or notices to employees about pressing action items like medication changes, laboratory testing, and preparation for upcoming procedures. This puts the patients at risk of not receiving correct and appropriate care. It also contributes to the risk profile of institutions because it puts the BOP at risk due to medication errors and accidental mistreatment of patients. Additionally, not having notifications for preventative screenings, such as

[257] FMC Carswell develops Quality Improvement Meeting Minutes that clearly display important data that identify areas of risk and areas of success.
[258] Quality Improvement Meeting Minutes were only seen at FMC Carswell.
[259] Spelling out the challenges the BOP is facing in data collection and analysis is important; however, the BOP is aware of the challenges facing their EHR and has a well-developed wish list of improvements. However, the current funding for BEMR upgrades has not been consistent or large enough to allow the BOP to make the necessary changes. To make these wishes feasible, there needs to be more money allocated to the updating of systems.

colonoscopies and mammograms, increases the chances that AICs will not receive the testing and diagnostics they need in a timely manner.

- **No Clinical Support Tools:** BEMR does not offer any clinical support tools. Clinical support tools (e.g., chronic kidney disease risk calculators and depression measuring tools) are a community standard, and they provide guidance on treatment methods, medication dosages, and diagnosis. They decrease the time providers spend entering notes and increase patient care and safety by limiting medication errors and showing providers clinical guidelines in real time to ensure treatment is appropriate. While the BOP has access to the clinical support tool InterQual, it cannot communicate with BEMR, and employees do not use it frequently or consistently, as chapter 5 of this report explains.

Effectiveness

- **Incorrect Drop-Down Options in BEMR:** BEMR does not have sufficient drop-down options to accurately categorize symptoms and diagnoses. Therefore, employees need to choose options that most closely approximate certain cases. For example, there are limited drop-down options for basic symptoms such as those observed in a cold. This impacts the ability of HSU employees to keep an accurate record of completed care and leads to imprecise information in the EHR.
- **No Inpatient System for MRCs:** BEMR lacks an inpatient function to aid the care provided. Inpatient functions are composed of tools that improve efficiency in patient care. Currently, providers are required to write out orders and notify their employees since BEMR does not flag patient charts when they are updated. Additionally, inpatient functions in the community include medical finances, bed management, and scheduling, which allow providers to have an overarching view quickly. This lack of an inpatient feature in BEMR leads to challenges in workflows and conducting administrative processes.
- **No Diagnostic Imaging in EHR:** There is no diagnostic imaging embedded in BEMR. As such, employees need to view the images in a separate system or request to use their radiology and X-ray technicians' equipment to view them. This is a time-consuming task that can impact the effectiveness of provider care during appointments.
- **Cannot Efficiently or Effectively Pull Data:** HSU employees must scan medical records from outside healthcare facilities into BEMR because it lacks the ability to process information from other EHRs. BEMR stores the scanned pages in a separate location from the data and notes; therefore, it is difficult to get a full picture of a patient's history without opening all the scanned documents. This inefficient process of reviewing all scanned documents is not consistently followed, meaning the BOP does not have specific data to review the most common services, high-cost services, and cost-saving measures.
- **No Identification of Root Causes:** Although dashboards track the trends in regional and institutional healthcare, employees do not consistently analyze the data they collect to identify root causes and find solutions to optimize healthcare.
- **Dashboards are Not Live:** Due to cybersecurity concerns, the dashboards in SAS are connected to the nightly BEMR extract server rather than the live BEMR database. Thus, the dashboards are updated each evening rather than in real time. However, employees at

visited institutions noted that on numerous occasions, data in the dashboards were not updated for days or weeks. These delays are caused by system downtime, which is outside the control of HSD.

- **Inconsistent Dashboard Use:** Dashboard usage rates are low and inconsistent across all levels of the organization. At the institutional level, employees often prefer BEMR reconciliation reports to dashboards because they believe reports to be more accurate and timelier. At the regional level, the use of dashboards depends on the employees; some RHSAs are using them weekly, while others never use them. Central Office employees do not use dashboards frequently because of limited employee capacity, and the data provided in dashboards is not rolled up into a report that clearly displays successes, root causes, or overall numbers. Those that we spoke with at the Central Office level did not promote or require the use of dashboards, so any interaction is voluntary.
- **No Efforts to Track Refusal of Care:** AICs can refuse care while incarcerated. However, there is no way to track this refusal, either in the dashboards or by retrieving a summary report through BEMR. Therefore, the dashboards may inadvertently reflect refusals as delays in care, which can make it appear as though institutions are struggling with maintaining the timeliness of care.
- **Dashboards Only Show Trends:** HSD's dashboards do not utilize business intelligence (BI)[260] best practices and only focus on showing data trends in healthcare. While the dashboards focus on data mining and reporting, they do not include other important features such as benchmarking, number analysis, and visual analysis. HSD is unable to pull data on how much care has been provided within a given timeframe, and the dashboards do not include data sets on whether AICs are better off due to the care provided. Hence, leadership may not have a clear understanding of the BOP's operations and the root causes of challenges.

Patient-Centeredness

- **Informal Bed Management System:** There is not a formal bed management program for patient care; instead, the BOP relies on self-created Excel spreadsheets to track the movement of AICs to and from MRCs.[261] These spreadsheets are maintained by the two National UR Nurses, who manually pull this data from numerous resources since the spreadsheet is not connected to any BOP systems. The potential for error due to lack of automation and difficulties with oversight may impact patient care, as it is easy for AICs to be forgotten.
- **Limited Patient Education Tools:** As mentioned earlier in this chapter, education is critical to understanding and managing patient health concerns. BEMR offers education tools; however, they cannot be accessed until after the provider has completed the note,

[260] Tableau. "What Is Business Intelligence? Your Guide to BI and Why It Matters." Accessed August 22, 2024. www.tableau.com/learn/articles/business-intelligence.

[261] BOP uses SENTRY to collect and maintain information on all AICs. This system is used by OMDT to facilitate the non-medical placement and transfer of AICs. However, SENTRY is a system focused on compliance with the Violent Crime Control and Law Enforcement Act and the Prisoner Litigation Reform Act which aim to ensure safety and security of AICs. SENTRY is not a medical system and is used only to inform the National UR Nurses as they make decisions surrounding placement and transfers of AICs based on medical needs.

and many of the providers do not complete their notes until after the visit because entering them takes too long. Most federal AICs have a high school education or less, which impacts their health literacy (see "Preventative Health Education and Literacy" section earlier in this chapter for more information).[262] The lack of accessible patient education materials further hinders their ability to properly address their medical concerns.

Timeliness

- **Time-consuming Notes Input:** When referencing BEMR, institution employees most commonly complain that it takes too much time to enter notes, especially pertaining to the number of "clicks" to get to the necessary screens for inputting notes. Therefore, employees often handwrite notes during appointments and then type their notes into BEMR after the clinical encounter. This is not only a tedious duplication of efforts that ultimately limits the number of patients they can see in a day, but it also increases the risk of doctors creating transcription errors.

Efficiency

- **BEMR is Not Fully Automated:** BEMR does not take advantage of the automated features that community EHRs have, such as the ability to input lab results into the notes without having to copy and paste from a different section of the EHR and the ability to upload documents and receive documents from other systems without needing to scan them in manually. The lack of automated features impacts the efficiency of the providers, requiring them to spend time doing administrative work that could be spent on clinical care. In the community, EHRs have incorporated communication automation, reporting and analytics automation, and automated reminders, as well as artificial intelligence (AI).[263]
- **BEMR is Not Connected to Necessary Systems:** Since BEMR was built by an outside vendor and due to cybersecurity concerns, BEMR does not have the ability to speak with the necessary BOP systems, except for SENTRY. In the community, EHRs are connected to the billing and invoicing system, staffing numbers, scheduling system, labs, and other EHRs. BEMR does not have the capability to connect with these systems, which decreases efficiency and requires cross-checking among different systems.
- **Systems are Out of Date:** BEMR and the dashboards are out of date, and this impacts their efficiency due to bugs, delays, and untimely system crashes. BEMR was first created in 2008, and updates are often slow due to age and the small team that is responsible for running the system. Dashboards utilize SAS 7.5, and the most recent version is 9.4, which means that updates and bug fixes have not happened in over a year and a half.

Data Recommendations

Recommendation 4.53 (Technology): Upgrade the EHR to allow it to complete all the functions outlined by the IOM. Specifically, BEMR should:

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[262] "Education Levels of Federally Sentenced Individuals." 2023. United States Sentencing Commission. December 18, 2023. https://www.ussc.gov/research/research-reports/education-levels-federally-sentenced-individuals#:~:text=Most%20federally%20sentenced%20U.S.%20citizens.

[263] Valant. "EHR Automation Features That Improve Practice Efficiency." Accessed August 22, 2024. www.valant.io/resources/blog/ehr-automation-features-that-improve-practice-efficiency/.

- Include clinical support tools that offer suggestions on treatment plans that align with HSD's clinical guidelines and provide guidance on medication dosages to decrease medication errors;
- Increase access to patient education materials that allow the provider to access them prior to the end of entering notes so that the patient leaves the appointment with printed materials;
- Include alerts that inform medical personnel of medication change orders and any upcoming or overdue testing that needs to be conducted (e.g., colonoscopies, mammograms, and vaccinations);
- Include more automated features such as having labs embedded in the notes and the ability to upload notes without having to scan in numerous documents to decrease the amount of time providers are spending inputting notes;
- Include diagnostic imaging such as ultrasounds and X-rays to increase efficiency and improve patient care;
- Allow providers to use a speech-to-text options to increase efficiency; and
- Be able to communicate with other BOP systems, specifically financial and administrative systems, so that the BOP can tie utilization to cost.

- ***Rationale:*** Updating BEMR with automated and clinical tools that are standard practice in the community will allow providers to save time on charting, allow patients to be seen in a more efficient manner, increase patient education, and decrease medical errors. If BEMR is unable to support these functions, the team recommends considering adopting a new commercial-off-the-shelf (COTS) EHR that is certified by the Office of the National Coordinator for Health Information Technology (ONC). Suggested improvements to BEMR are not being introduced for the first time in this report. Various physicians and HSD employees have highlighted the challenges of BEMR to Central Office. There is currently one memo that this team is aware of that highlights the challenges physicians face in BEMR and offers potential solutions. To update BEMR, HSD must prioritize based on available funds and seek the help of the owners of BEMR, which presents a challenge. However, BEMR should be a high priority for HSD since it is impacting the quality of healthcare, patient safety, provider efficiency, and employee satisfaction.
- ***Priority (High):*** Updating the EHR is necessary to ensure safe and effective patient care and increase the efficiency of healthcare employees. This will require funds and personnel.

Recommendation 4.54 (Technology): Adopt a COTS medical bed management system to ensure that AICs are tracked and moved to institutions with appropriate care levels. Adopting a bed management system can also allow the BOP to track beds throughout their facility based on care level and programming, such as RDAP. This would allow for a more seamless transfer of AICs into new facilities that meet their medical needs. Using a COTS bed management system will not allow the system to communicate with BEMR or SENTRY, but it is a good first step to identifying and tracking all AICs that are in the wrong care level facilities and in need of a transfer.

Following the purchasing of a bed management system, if the BOP would prefer a system that can communicate with their other internal systems, then the BOP should convene a working group including the National UR Nurses, HSD's Quality Improvement Section Chief, OMDT employees,

Information Technology and Data Division (ITDD) employees, institution medical employees (specifically focusing on MRCs), and members of the BEMR group to develop a working plan for the creation of an internal bed management system that has the ability to communicate with BEMR and SENTRY.

- ***Rationale:*** Using self-created Excel spreadsheets is the current way in which medical beds and medical transfers are managed. There is little to no tracking of space within programs across the BOP. This practice is ineffective and can lead to significant delays in appropriate care for AICs. A new medical bed management system is needed to improve the timeliness and efficiency of transfers across the BOP and ensure that AICs who need more significant care are able to receive it before their problems compound.
- ***Priority (Top Priority):*** Not having a bed management system is a high risk for the AICs and for the BOP. This can be remedied quickly and with minimal funding.

Recommendation 4.55 (Technology): HSD's dashboards should be updated and developed in alignment with business intelligence and RBA best practices in mind.[264] Specifically, HSD should upgrade its system to an automated platform that utilizes business intelligence.

- ***Rationale:*** Utilizing a system that relies on business intelligence best practices allows HSD to aggregate, analyze, visualize, and share data. HSD needs these features to understand where there are gaps in healthcare delivery, analyze the root causes of challenges, and present the data to HSD and BOP leadership and Congress. This system would also allow tracking of how much care regions and institutions are providing, utilization of services, and highlighting successes in the care they are providing.[265]
- ***Priority (Low):*** This recommendation is a short-term fix for the BOP, but it will be less of a priority with the adoption of an updated EHR.

Recommendation 4.56 (Technology): Enhance the timeliness of off-site care by adding a feature to BEMR that requires users to indicate when and why they change due dates for a consultation, diagnostics, or procedures.

- ***Rationale:*** Once the scheduled target date for off-site medical care is adjusted in BEMR, there is no history of what the original scheduled target date was or who made the change. Enabling BEMR to reflect who assigns scheduled target dates and the change history will make it easier to track if a patient's care has been excessively delayed, motivating institutions to deliver more timely care. In turn, more timely care lowers the organization's risk profile because routine medical concerns are less likely to become catastrophic.
- ***Priority (Low)*:** Implementing this recommendation would support more timely patient care across institutions with a one-time BEMR update but would require additional resources that may presently be unavailable.

[264] Tableau. "What Is Business Intelligence? Your Guide to BI and Why It Matters." Accessed August 22, 2024. www.tableau.com/learn/articles/business-intelligence.
[265] Discussions with benchmarking agencies such as the California Department of Corrections and Rehabilitation (CDCR) highlight systems utilizing business intelligence that are better able to track and display data for line-level employees and leadership.

Recommendation 4.57 (Technology): Develop a monthly centralized point-in-time report that aggregates all institutional BP MED 18 Staffing Reports and submit it to the Central Office. This consolidated report will offer a comprehensive overview of staffing across facilities, enabling enhanced resource management and informed decision-making at the Central Office level.

- ***Rationale:*** Central Office does not receive institution staffing reports, as this reporting stops at the regional level. Additionally, since not all systems are connected within the BOP, there is limited knowledge of which positions are funded to accurately understand staffing position vacancies. Sending staffing reports to Central Office HR and HSD and increasing accurate knowledge of funded positions may raise higher authorities' awareness of the staffing shortages at institutions and may inspire more immediate intervention (human and financial resources) to be deployed.
- ***Priority (High):*** Employee resources are available for implementation of this recommendation. Communication will be streamlined, and problem-solving will become more efficient. Stakeholders will better understand staffing vacancies through Central Office communications.

Chapter 5: Utilization Review Process

Task 2 of the statement of work calls for an analysis of the utilization review (UR) process, which is currently undergoing changes to enhance efficiency and effectiveness through the lenses of cost-efficiency, timeliness, and appropriateness. This analysis involves comparing the Federal Bureau of Prison's (BOP or Bureau) UR process with those employed by other organizations in the public sector, aiming to identify effective practices that could be considered for adoption across the organization. This chapter provides background information on UR, a summary of effective practices that outside organizations use, as well as an analysis of the gaps between the current state of the UR process and its desired future. It concludes with recommendations to enhance the efficiency and effectiveness of that process.

Background on UR

Defining UR and Utilization Management (UM)

This chapter discusses two related concepts to address the statement of work: UR and UM. It is important to distinguish the two to understand the direction of the analysis and recommendations herein. UR focuses on reviewing outside medical services for specific individuals, whereas UM assesses the effectiveness and efficiency of outside medical services for a collection of individuals. The following text defines UR and then explains how UM is applied to UR.

BOP defines UR as "a comprehensive approach to healthcare management that involves a continuous assessment of [Adult in Custody (AIC)] health needs, the resources required to meet those needs in the most effective and efficient manner, and the specified timeliness of service delivery."[266] The primary goal of the UR process is to make evidence-based decisions on whether AICs need to access medical care off-site and what type of care is needed.[267] For example, an institution could use UR to determine whether it should transport an AIC with a heart condition to a community healthcare provider for a cardiology procedure or consult or continue monitoring their condition without additional intervention for the time being.

The three components that make up the UR process at the BOP are prospective, concurrent, and retrospective reviews:[268]

- **"Prospective** (prior to service delivery and use of resources) review of requests for specialized medical, mental health, and dental services that cannot be provided in the [health services unit].
- **Concurrent** (during service delivery and use of resources) review of the use of inpatient medical and mental health beds and specialty services; monitoring the span of treatment and length of inpatient stay; tracking orders for services to ensure services are completed

[266] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6031.05: Patient Care*. Washington, D.C., May 14, 2024. https://www.bop.gov/policy/progstat/6031.05.pdf.
[267] UR is also required for in-house contracted specialists and diagnostic testing by contracted technicians. See: Ibid.
[268] Ibid.; for pictorial representation of this process, refer to the "Description of the UR Process" section later in this chapter.

in a timely manner; and managing catastrophic care cases by providing care in a cost-effective setting.
- **Retrospective** (after service delivery and use of resources) review the efficacy of care and resource utilization."

Utilization Review Committees (URCs) at each institution decide whether to approve or disapprove requests for outside medical services during prospective review. If a provider's request for an AIC to receive treatment is approved, employees at the institution conduct concurrent review while the AIC is off-site receiving that treatment. Employees conduct a retrospective review once the AIC returns to the institution after receiving medical services.

Connection between UR and UM

UR focuses on clinical and resource issues related to AIC outside care on a case-by-case basis, while the purpose of UM is to optimize the value of contract medical services by aggregating and analyzing data from individual cases to identify trends in clinical outcomes and expenditures.[269] Practitioners engage in UM by identifying trends to measure how effective and efficient those services are over time and applying corrective measures and cost-mitigation strategies to their UR processes as needed. The following example illustrates how practitioners can use UM to identify a cost-driver and take action to address it:

Institution employees review their outside medical expenditures for the month and notice a significant increase in dollars spent on urology appointments compared to previous months. They use data on the number of urology appointments completed and the provider billing rate to surmise whether the increase in expenditures can be attributed to a larger volume of appointments, a billing rate increase, both, or neither.[270] Employees determine that the increase is due to volume and decide to convert off-site urology consultations to telehealth consultations to mitigate expenses for escorting AICs into the community.

Importance of UM and UR in Correctional Healthcare

The U.S. Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment requires corrections departments to provide adequate healthcare to AICs in Estelle V. Gamble (1976).[271] UM and UR help protect the rights of AICs and enable accountability by creating a record of treatment decisions and decreasing the risk profile of corrections departments and their employees by aligning practice with legal requirements. Comprehensive UM programs should help identify systemic problems in the provision of medical care by compiling and analyzing many individual UR prospective, concurrent, and retrospective reviews, then enhance overall care by applying strategies to address such problems. These practices help avoid

[269] California Department of Corrections and Rehabilitation, Correctional Healthcare Services. *Healthcare Department Operations Manual: Utilization Management Program.* Sacramento, C.A., 2022. https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch01-art2.15.pdf.
[270] The increase might also result from additional, and/or more complex treatment.
[271] *Estelle v. Gamble*. 429 U.S. 97 (1976). https://www.law.cornell.edu/supremecourt/text/429/97.

healthcare scenarios that may prompt a Civil Rights of Institutionalized Persons Act investigation.[272]

UR in the BOP

UR Categories of Care

During prospective utilization reviews, determinations are made about whether a consult or procedure is approved for an AIC. These consult and procedure requests fall into four different categories for approval:[273]

1. **Medically Necessary**
    a. Emergency: immediate, acute, or emergent conditions that, without care, would cause rapid deterioration of the AIC's health, significant irreversible loss of function, or life-threatening consequences.
    b. Non-Emergency: medical conditions that are not immediately life-threatening but without care could result in:
        i. Serious deterioration of an otherwise manageable condition leading to premature death
        ii. Significant reduction in the possibility of repair later without present treatment
        iii. Significant pain or discomfort impairs the AIC's participation in daily activities.
2. **Medically Acceptable – Not Always Necessary**: The intervention may improve the AIC's quality of life while incarcerated.
3. **Limited Medical Value**: Interventions that provide little or no medical value, are unlikely to result in substantial long-term gain, or are expressly for an AIC's convenience.
4. **Extraordinary**: Interventions that affect the life of another individual, are considered investigational in nature, or are otherwise deemed an exceptional medical intervention.

Generally speaking, "medically necessary" requests are approved. The other categories of requests are more complex and often merit additional discussion prior to an approval decision.

Outside Medical Expenditures and UM

History and Relevance

UM is relevant to containing expenditures for outside medical services because the UR process approves requests for those services, monitors their delivery, and tracks the types and frequency of those services. For example, institutions can use the information they gather during the UR process to determine the most frequent and most expensive procedures they use outside medical services to deliver.

However, outside care costs and utilization data have historically been challenging to track. The September 2022 Department of Justice Office of Inspector General (DOJ OIG) Management

[272] *Civil Rights of Institutionalized Persons Act*. Public Law 96-247. *U.S. Statutes at Large* 94 (1980): 349-354. https://www.congress.gov/bill/96th-congress/house-bill/10/text.
[273] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6031.05: Patient Care*.

Advisory Memorandum synthesized the work of 11 OIG audits and reviews conducted since 2016 and reiterated issues from previous audits around paying excessive costs for outside healthcare due to insufficient healthcare utilization data and inefficient billing review. Issues identified included the lack of consistent reimbursement rate negotiations, deficiencies in bill review, and the inability to collect and leverage institutional spending data to consider regional medical services contracts. As a result, the OIG emphasized the need to develop healthcare utilization data collection strategies and a uniform billing review and approval process.[274] A 2019 report by a Panel of the National Academy of Public Administration has echoed this finding, stating that "A key data limitation constraining HSD's ability to manage healthcare operations as a system is the lack of consistent utilization data on outside medical services…".[275]

Notably, off-site medical services are the single largest cost driver for medical services in the BOP healthcare system, according to a 2017 report by the Government Accountability Office (GAO).[276] Off-site medical services accounted for 39 percent of its total medical expenditures in FY 2016, as shown in Figure 7 below.[277]

[274] U.S. Department of Justice, Office of the Inspector General. *Management Advisory Memorandum: Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for Its Medical Services Contracts*. OIG-22-113. Washington, D.C.: September 26, 2022. https://oig.justice.gov/sites/default/files/reports/22-113.pdf.
[275] National Academy of Public Administration. *Assessment of the Bureau of Prison's Organizational Alignment with Healthcare Mission*. Washington, D.C., 2019. https://s3.us-west-2.amazonaws.com/napa-2021/studies/federal-bureau-of-prisons-medical-data-managment/BOP_NAPA_Deliverable_1_Final.pdf.
[276] U.S. Government Accountability Office. *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Healthcare Costs*. GAO-17-379. Washington, D.C., June 2017. https://www.gao.gov/assets/d17379.pdf.
[277] The long waitlist for Medical Referral Center (MRC) transfers contributes to such expenditures as it causes a greater demand for outside medical services (see chapter 4 for additional discussion).

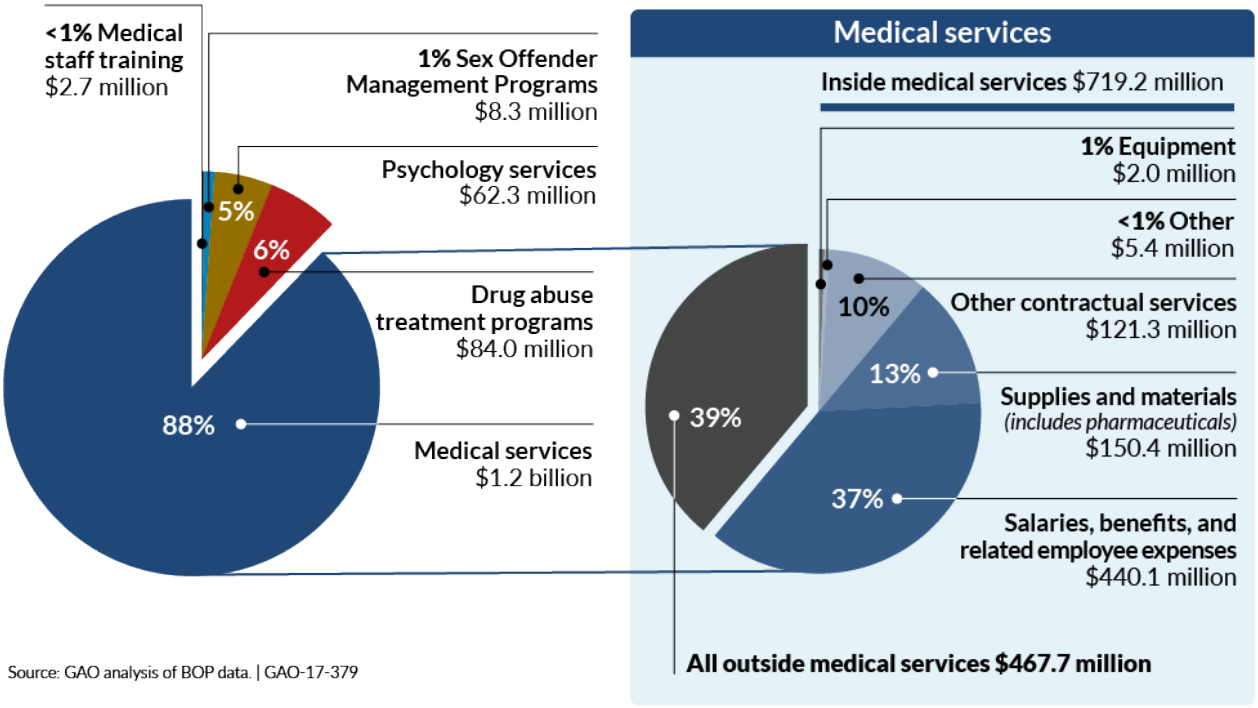

Figure 7: *Total Healthcare Obligations and Total Medical Services Obligations for FY2016 (Source: Government Accountability Office, 2017)*[278]

Financial Tracking

Budget and Process

Institutions have two budget categories called "B1" and "B2". The B1 budget encompasses funding for activities inside the institutions (e.g., employees working on-site), and the B2 budget encompasses all funding for activities outside the institutions (e.g., off-site medical services). The B1 and B2 budgets are subdivided by institution departments (e.g., health services, correctional services, correctional programs, reentry services). The following expenses are included in the costs for off-site medical services that are billed against the B2 budgets for health services departments (also known as health services units; HSUs) at institutions:

- Hospital/community provider bills for treatment and overhead
- Vehicles
- Pay for custody transportation escorts, including overtime[279]

Institutions form their annual budgets based on projections from historical data and other known factors. Central Office reviews these requests and then allocates annual budgets to each institution through regional offices. Throughout the year, regional offices adjust institutional budgets, often

[278] U.S. Government Accountability Office, *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Healthcare Costs.*

[279] Institutions sometimes need up to five correctional officers and a lieutenant to escort AICs to off-site medical appointments. The number of officers it requires varies based on considerations include the AIC's custody level. For example, fewer officers are required to escort a low-security AIC than a maximum-security AIC.

based on monthly projections institutions send to their respective regional offices. Many interviewees noted that these frequent adjustments are unavoidable, as B2 expenditures are especially hard to predict based on variables such as new patient needs, unexpected equipment failure, and catastrophic cases. This approach requires the BOP to be reactive to changes in expenditures rather than anticipatory of significant expenses.

Financial Tracking Personnel & Roles

Internal

Inconsistent levels of specialization and training in matters of financial management in the HSUs contribute to the difficulty of identifying cost drivers, especially within off-site medical services. Employees in institutional financial management departments and Health Services Administrators (HSAs) are responsible for monitoring and reporting data on medical expenditures. However, financial management employees often lack expertise in medical cost estimates and billing, while HSAs may not have formal training in salient matters of financial management. This hinders the efforts of institutions to maintain timely and accurate invoices and hampers their ability to analyze data on medical expenses related to quantity, quality, and expenses.

Some institutions have Financial Program Specialists (FPSs) working in their HSUs in addition to FPSs embedded in their financial management departments. Interviewees report that the FPSs benefit the institutions by applying expertise to medical coding and billing, adding capacity for HSAs, and serving as a liaison between departments. The institutions are often more able to gather more granular information about cost-drivers and health outcomes as a result.

External

On an external basis, comprehensive medical services contracts (CMSCs) connect institutions with outside medical services providers to deliver care by contractors. By contract, CMSCs manage the claims process and billing for services that outside providers render. The institutions rely on CMSCs for accurate and timely estimates and actuals for the costs of outside medical services. In addition, they rely on CMSCs to provide information about additional services outside medical providers and facilities order for AICs. For example, the outside medical provider may need to apply additional treatment to address complications arising during a procedure. It is important for institutions to receive such information in a timely manner to provide for accurate concurrent and retrospective review and cost monitoring, as well as report data on costs and quality of healthcare to the regional offices consistently. This chapter provides more information on the role of CMSCs in the subsection describing the UR process below.

Current Organization and Roles for the UR Process

The following subsection offers more information on how employees in the Central Office, regional offices (including Central Office employees assigned to the regional offices), and institutions are involved in the UR process.

Central Office: Prospective and Concurrent Review

In the Central Office, the Population and Correctional Health Branch Chief oversees the Quality Improvement (QI) section chief and team. The QI section chief is responsible for risk management and performance improvement (as shown below in Figure 8), which includes UR. The QI section chief's UR duties are to oversee UR-related employees at all levels, develop UR policy and guidance for the field, and provide continuing education for all employees involved in the UR process.

National UR Nurses act as the medical bed managers for the seven Medical Referral Centers, which provide the highest level of care to AICs. These nurses work with the Office of Medical Designation and Transport (OMDT) to review and approve requests to transfer AICs into MRC care. Once admitted to the MRC, the National UR Nurses perform concurrent review by monitoring AIC length of stay in that setting, determining whether they need the continued level of care, and reviewing and approving "413 Requests" (transfers out of MRCs after care level has been downgraded). Additionally, they provide training and guidance on UR-related tools, processes, and procedures, such as the clinical decision-making tool InterQual (see the "Technology Used in the UR Process" section later in this chapter for more information). They also analyze UR data collected from MRCs and conduct consultation queue reviews for line institutions with consults pending for greater than 30 days. Around 2018, there were three National UR Nurse positions; however, one of these positions was taken back since the position was not filled during a hiring freeze. There are currently two National UR nursing positions, and both are filled.

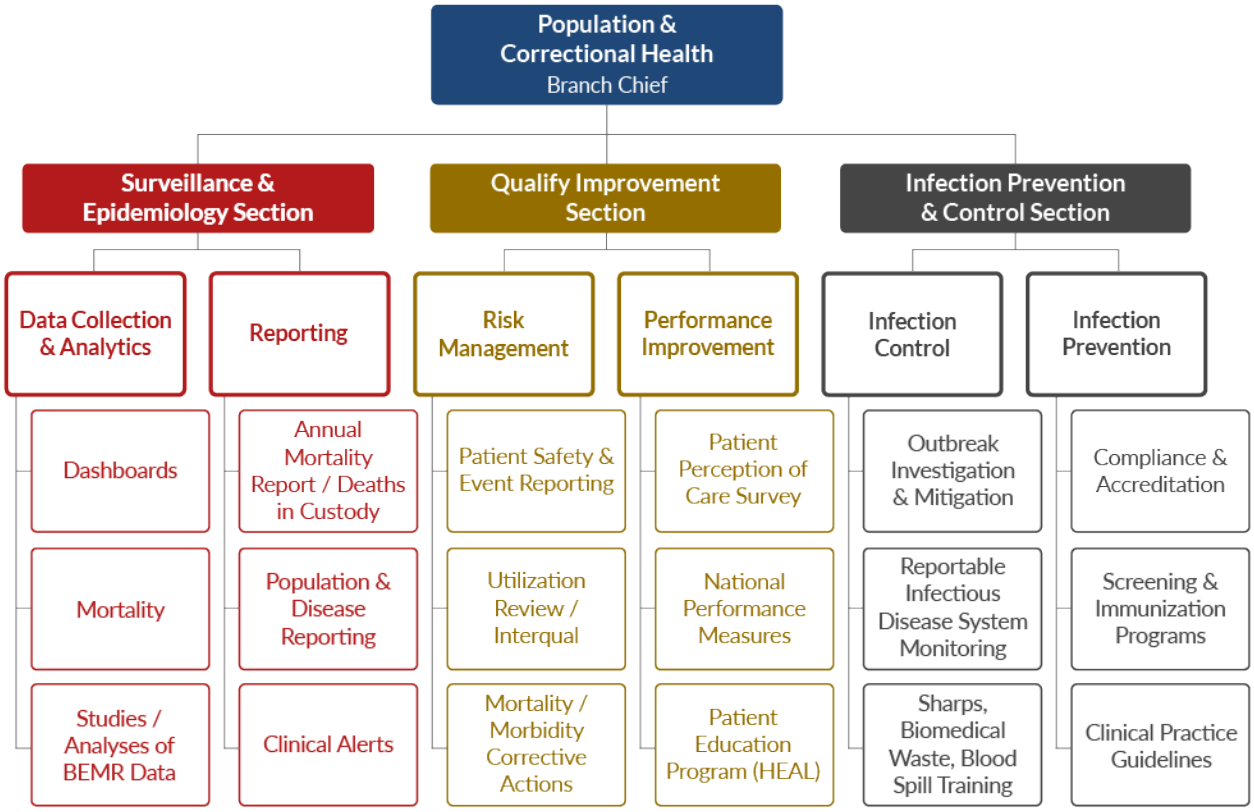

Figure 8: *Current Organizational Structure of UR at Central Office (Source: BOP HSD, 2023)*[280]

Regional Offices: Prospective Review

Employees in the regional offices, including Central Office employees assigned to the regional offices, who participate in the UR process are the Regional Quality Improvement and Infection Prevention and Control (QIIPC) Consultants, Regional Nurse Consultants, and Regional Medical Directors. These employees are responsible for prospective review of certain high-cost, high-risk requests that are outlined in a BOP internal policy document and in the Patient Care Program Statement 6031.05.[281] The Regional QIIPC Consultant or Regional Nurse Consultant reviews the regional consultations and makes a formal recommendation for approval or denial, which is submitted to the Regional Medical Director (RMD) to make the final decision. These team members notify the institution when a decision has been made so that the institution can document and initiate the next steps.

Institutions: Prospective, Concurrent, and Retrospective Review

Medical employees at the institutions are responsible for identifying potential needs among AICs for off-site medical treatment and applying prospective UR, as well as concurrent and retrospective reviews if needed. Each institution's clinical director (CD) has the final decision-

[280] This figure comes from a document internal to the BOP that is not public.
[281] Internal document "Elective Consults Requiring Regional Review" provided to the team on January 23, 2024; U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care.*

making authority over most requests for off-site medical services, though CDs at Care Level 1-3 institutions must seek RMD approval for some off-site treatments and procedures.

The employees involved in the UR process at institutions vary based on the mission, care level, and staffing levels at each institution. At the MRCs, UR nurses are responsible for tracking available bed space, processing high-cost and high-risk consults through the evidence-based clinical decision support tool InterQual ahead of URC meetings, preparing relevant documentation for URC meetings, keeping URC meeting minutes, tracking consults through the process once approved, and notifying AICs about approval decisions. If MRCs are unable to fill those positions, the responsibilities fall to the QIIPC nurse, CD, or HSA.[282] At "line" institutions (non-MRCs), the employees involved in the UR process vary more. Ideally, QIIPC nurses are responsible for facilitating URC meetings and managing consultations once approved. However, UR work is a collateral duty for QIIPC nurses, who are primarily responsible for preventing and controlling infectious diseases in patients, as well as quality improvement activities like program quality improvement, institution audits, and mortality reviews. Nurses, Health Service Administrator Assistants (HSAAs), HSAs, and CDs need to take on more responsibility for the UR process when QIIPC nurse positions are vacant or the provider lacks capacity.

Each institution has a URC chaired by its CD that meets regularly to determine whether it should provide AICs treatment by outside providers.[283] HSU employees make the requests that URCs review. Members of the URC can vary depending on institutional staffing levels and practice but often include at least the referring providers and the HSA (along with the CD). The frequency of URC meetings depends on case volume, with policy recommending weekly meetings at MRCs, Care Level 3 institutions, and complexes, and biweekly for line institutions. The HSA and CD develop operating procedures for their institution's URC, determine the frequency of URC meetings, and document UR decisions in the AIC's electronic health record (EHR) housed through the Bureau Electronic Medical Record (BEMR). The CD is responsible for notifying the AIC of the URC's decision.

[282] One MRC visited did not have its UR nurse positions filled, so the clinical nurse manager was covering some of those duties.
[283] Several of the institutions the team visited had vacant Clinical Director positions. In those cases, the acting Clinical Director (often the Regional Medical Director or a Clinical Director from a nearby institution) would review and approve or deny requests on their own time, without synchronous input from referring providers.

Description of the UR Process

Figure 9 provides an example of the steps an institution would take in the UR process to prospectively approve, concurrently monitor, and retrospectively review an AIC's treatment.

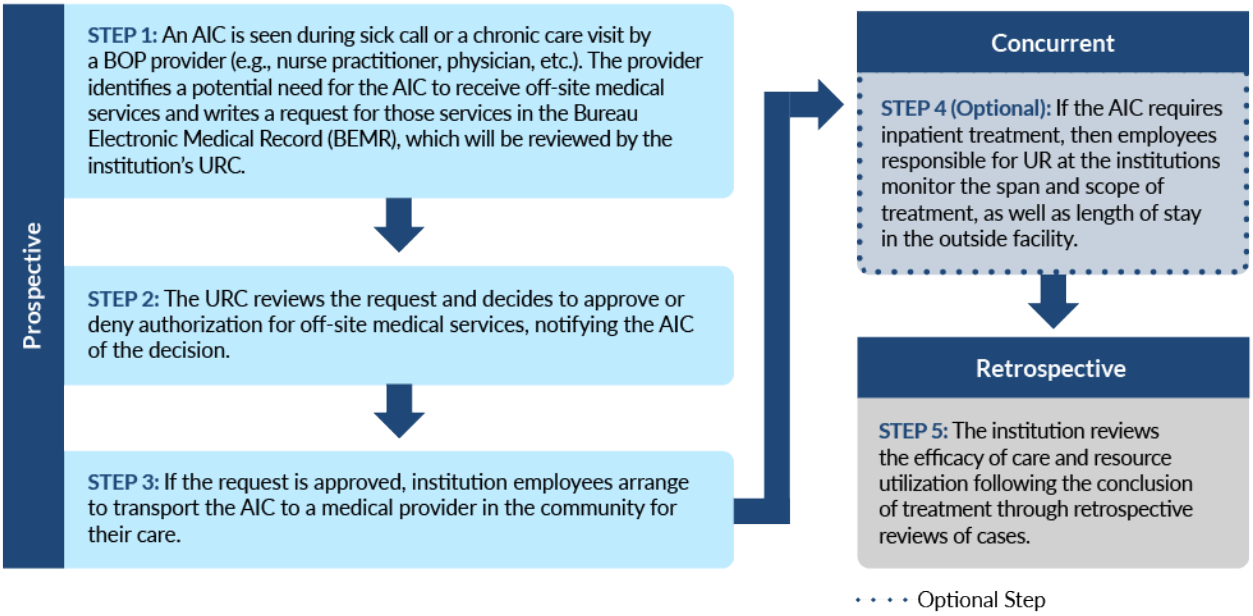

Figure 9: *Prospective, Concurrent, and Retrospective Utilization Review Process (Source: BOP Interviews and Program Statement 6031.05. Figure Created by Team)*

Elaboration on Step 2: AIC Response to Denial

Grievance processes are vital tools to identify instances where healthcare could be deficient and provide AICs a venue to raise concerns about their healthcare. Healthcare providers can also analyze data from multiple grievance process cases to identify broader risks to the healthcare system, such as a general lack of timeliness of care. The BOP has an Administrative Remedy Program for AICs to seek formal review of any issue relating to an aspect of their confinement, including healthcare.[284] If AICs would like to refute the denial of care, they must complete and file a "Request for Administrative Remedy", or "BP-9" form, with employees at their respective institution. Institution Wardens must respond to AICs to inform them whether and how the grievance will be addressed. If an AIC is not satisfied with the Warden's response, they are entitled to complete and file a "Regional Administrative Remedy Appeal", or BP-10 form. If the AIC is not satisfied with the Regional Director's (RD) response, they are entitled to complete and file a "Central Office Administrative Remedy Appeal", or BP-11 form for a final decision.

[284] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 1330.18: Administrative Remedy Program*. Washington, D.C., January 6, 2014. https://www.bop.gov/policy/progstat/1330_018.pdf.

Elaboration on Step 3: Role of Comprehensive Medical Services Contracts (CMSCs)

Institutions' CMSCs connect the institution with off-site medical services providers and play an important role in step 3 of the UR process. Once off-site care is reviewed and approved by the appropriate URC authority, the HSU administrative employees coordinate the scheduling of such care through CMSCs. These contractors build relationships with certain community medical providers in the local area and contact the providers directly to set up these appointments. These appointments are added to a shared schedule that both the CMSC and BOP employees can access. Based on the schedule, the BOP identifies which of their Basic Prisoner Transportation (BPT)-certified employees are able to take each trip out, often sending at least two BPT-certified employees per trip depending on AIC custody level.[285] If many patients need similar services (e.g., eye exams), the HSU may work with the CMSC to periodically bring outside providers on-site and work through the waitlist in a more timely and efficient manner. Alternatively, some institutions work with outside providers to send an entire bus of AICs to a community provider's office to receive a service, such as mammograms or CT scans (see chapter 4: "Inpatient Hospitalization & Outpatient Specialty Care" for more details around "care busses").

Technology Used in the UR Process

InterQual

BOP uses a software called InterQual to assist and inform health services employees in making evidence-based decisions on whether AICs need treatment in the community and what type of treatment is applicable. According to Change Healthcare, InterQual is "An evidence-based clinical decision support solution for payers, providers, and government agencies who want to help ensure clinically appropriate medical-utilization decisions."[286] It includes criteria that assist in determining if the proposed services are clinically indicated and provided at the appropriate level or if further evaluation is needed,[287] benchmarks for length of stay, guidelines for expected progress, care facilitation, and admission considerations. InterQual is a resource that all institutions can access, but HSD interviewees estimate that only about five percent of line institutions utilize it due to a lack of policy requirements, dedicated UR employees, lack of integration with BEMR, and staffing shortages.

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[285] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 5538.06: Escorted Trips.* Washington, D.C., August 29, 2014. https://www.bop.gov/policy/progstat/5538_006.pdf. Note that given the BOP's "custody-first" mindset, anyone can be BPT-certified. BPT-certified Health Services employees may escort trips if custody resources are strained.

[286] Change Healthcare (Optum). "InterQual Solution." Accessed July 22, 2024. https://www.changehealthcare.com/clinical-decision-support/interqual.

[287] Priority Health. "InterQual LOC Criteria for Medical Decision-Making." Accessed July 22, 2024. https://www.priorityhealth.com/provider/manual/standards/utilization-management-program/interqual-loc-criteria#:~:text=InterQual%C2%AE%20criteria%20are%20a,by%20the%20utilization%20review%20nurse.

BEMR

During an on-site medical appointment, a clinician inputs any off-site care needs in BEMR. These consult requests are then held in a queue in BEMR to mark that they need to go through the local URC process. Here is how BEMR and its queue factors into the process:

- The institutional UR authority can pull the patient's medical records and determine whether the consultation is warranted or not.
    - If warranted, the CD can mark the consultation as approved and either approve or modify – if clinically indicated – the clinician's target consultation date in BEMR.
    - Denied requests and the rationale for the denial must also be noted in BEMR. Once decided, the CD or designee will notify the AICs in writing or electronically about the approval or denial decision.
- In MRCs, some consultations are run through InterQual before the URC meeting, specifically those that are high-cost or high-risk. If an InterQual review prior to the URC meeting is needed, the CD can mark it in BEMR, and it is added to the queue for review by the UR nurse.
- Consultations requiring prospective regional review are marked in BEMR by the institutional UR authority, which automatically sends it into a regional queue for the Regional QIIPC Consultant or Regional Nurse Consultant to process.

During the URC meetings, information accessed in BEMR is used by the attending medical employees to review the patient's medical records and make determinations on what treatment is needed.

Desired Future State of UR

2024 Patient Care Policy

BOP issued an updated Program Statement 6031.05 on Patient Care on April 8, 2024,[288] rescinding the Patient Care policy that governed its healthcare programming since June 3, 2014.[289] This updated document more comprehensively details the UR components, process, and responsible parties, increasing institutional and regional responsibility and accountability. The major changes include:

- **Detailed Utilization Review Components:** The 2014 policy had prospective, concurrent, and retrospective review requirements in one bulleted list without clear organization or terminology descriptions. The 2024 policy separates, defines, and explains the utility of each type of review. Additionally, it lists several more requirements and examples under each category.
- **Focus on Cost-Efficiency and Timeliness:** The 2024 policy's language and requirements reflect intentions to track cost and resource efficiency, as well as increased efforts to monitor any delays in care.

[288] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care.*
[289] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.04: Patient Care.* Washington, D.C., June 3, 2014. https://www.bop.gov/policy/progstat/6031_004.pdf.

- There is an explicit reference to performing concurrent reviews on cases that are "straining resources" and the need to track services to "assure completion in a timely manner."
- URCs now assign due dates to approved specialty care requests.
- CDs must now provide weekly reports to the RMD on high-cost cases, and HSAs are now required to provide monthly updates to the Regional HSA (RHSA) on past-due specialty care requests.

- **Recommendations for Local URC Review:** The previous statement did not prescribe how often institutional URCs should meet and had a limited list of primarily healthcare personnel who should be included. The 2024 statement adds many more recommended URC members, including custody, and suggests a specific cadence based on institution type.
- **Mandates for Regional and Central Office Review:** "Prior approval" for treatments and procedures of high cost, high risk, or questionable necessity were not required in the rescinded policy. The 2024 policy requires regional review and approval for certain elective interventions already approved locally. Central Office approval is now required for services deemed "extraordinary."

Organizational Realignment

The current UR structure is undergoing changes, as shown in Figure 10. In the realignment, the Quality Improvement section is splitting into two sections and has a chief over the UR section. This allows for complete dedication to utilization management within HSD. In addition, six new positions have been authorized for regional UR nurses. With each region gaining a UR nurse, the UR team can provide more direct support to the institutions. Furthermore, they are developing a UR work group including volunteers from the field who will give guidance and suggest improvements in the UR process.

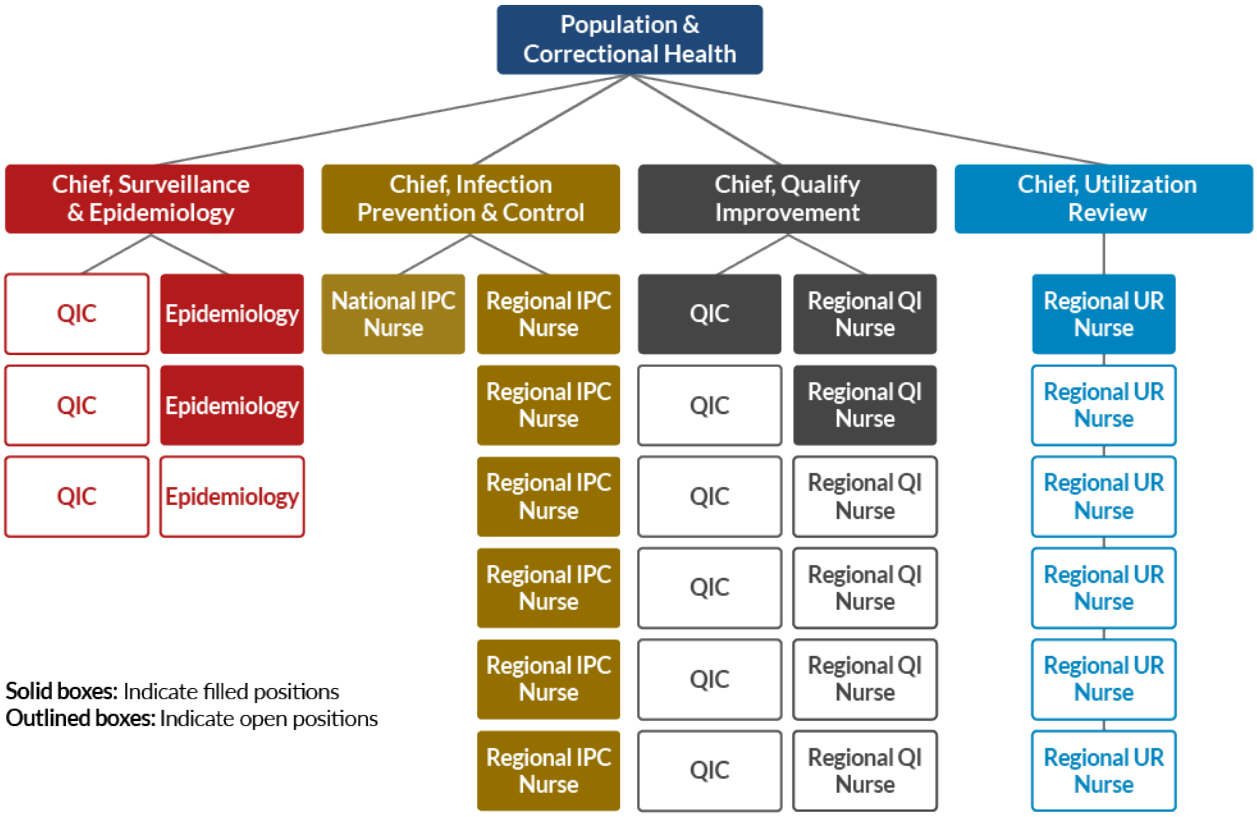

Figure 10: *Proposed Future Structure of UR at Central Office (Source: BOP HSD, 2024)*[290]

Effective UR Practices and Benchmarks

This section describes the history, policies, and effective practices of two governmental organizations that employ UR: the California Department of Corrections and Rehabilitation (CDCR) and the Immigration and Customs Enforcement Health Services Corps (IHSC). Additionally, this section highlights the challenges of comparing the BOP UR process to the private sector, given its unique financial role and UR factors.

[290] This figure comes from a document internal to the BOP that is not public.

Government Benchmarks

California Department of Corrections and Rehabilitation

CDCR is a good benchmark organization because of its corrections-focused mission, robust UR policy, and strong implementation and oversight of that policy. It is well-regarded by its peers in the practice of correctional healthcare and other subject matter experts interviewed for this report. CDCR is also responsible for the stewardship of a relatively comparable number of AICs (approximately 102,000) to the BOP (approximately 158,000).[291] However, CDCR's budget for medical services was $2.7 billion in 2022-2023, while HSD's budget is $1.46 billion annually.[292]

Some state departments of corrections the team examined to inform this report embed standards and procedures for their UR processes, if any, in their policies focused on topics such as quality improvement and risk management.[293] However, California law requires CDCR to maintain a separate UR program and policy to secure their permanence, improve quality, contain costs, and manage risks.[294] Overall, the most effective element of CDCR's policy on UR is its strong language. CDCR's policy on UR begins with the program's scope of duties and an explanation of its purpose: "… to optimize the value of contract medical services… by ensuring appropriate, timely, safe, and cost-effective care for patients who require [it]."[295] It sets forth roles and responsibilities for the UR program at the statewide, regional, and institutional levels of the organization. In addition, the policy includes standards for the responsibilities, membership, reporting structure, and meeting procedures of CDCR's headquarters and institutional utilization management committees.

The policy contains many other components that make it a model for UR policies in other departments of corrections like the BOP. Some additional facets of the policy are it:

- Provides the purpose of the UR program and ties it to the strategic objectives that further CDCR's goals. For example, one objective that relates to the goal of ensuring timely care

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[291] California Department of Corrections and Rehabilitation. *Weekly Report of Population*. October 2, 2024. https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2024/10/Tpop1d241002.pdf; U.S. Department of Justice, Federal Bureau of Prisons. "Population Statistics." Last modified September 12, 2024. https://www.bop.gov/mobile/about/population_statistics.jsp.

[292] California Department of Corrections and Rehabilitation. *2022-23 State Budget*. Accessed October 11, 2024. https://ebudget.ca.gov/2022-23/pdf/Enacted/GovernorsBudget/5210.pdf; While a comparison of healthcare staffing between the CDCR and BOP could provide context, it was not included as part of this study phase. Comparing staffing ratios between the two is complex due to differences in budgets, organizational structures, and position descriptions. Position authority for CDCR is available online: California Correctional Health Care Services. "What is CCHCS?" Accessed October 24, 2024. https://cchcs.ca.gov/factsheet/. BOP staffing details can be found online: U.S. Department of Justice, Federal Bureau of Prisons. *FY 2025 Congressional Budget Submission BOP Salaries and Expenses – Exhibits*. Accessed October 24, 2024. https://www.justice.gov/d9/2024-03/bop_se_fy_2025_pb_exhibits_3.7.24_omb_cleared_final_1.pdf).

[293] One example is the Virginia Department of Corrections. Virginia Department of Corrections. *Health Services Operating Procedure 701.2: Health Services Continuous Quality Improvement Program*. Accessed September 13, 2024. https://vadoc.virginia.gov/files/operating-procedures/700/vadoc-op-701-2.pdf.

[294] *Provisions of Care and Treatment* Exclusions. California Code of Regulations (2019), Title 15, §3999.200. https://www.law.cornell.edu/regulations/california/15-CCR-3999.200.

[295] California Department of Corrections and Rehabilitation, Correctional Healthcare Services. *Healthcare Department Operations Manual: Utilization Management Program.*

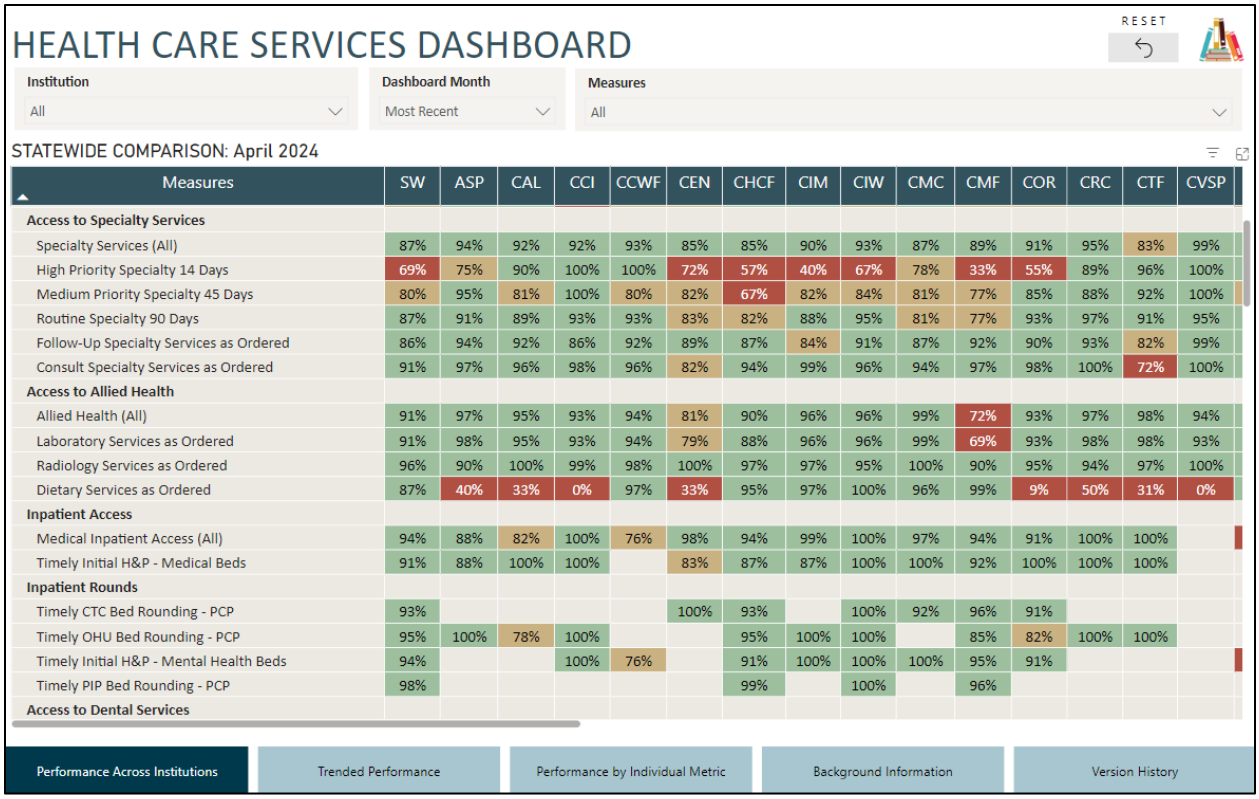
for patients who require it is to "Manage requests for specialty services to reduce backlogs."

- Establishes a Utilization Management Committee at Headquarters and stipulates its membership, responsibilities, and the body that it reports to (the Quality Management Committee).
- Sets requirements for Institutional Utilization Management Committees, including their membership and minimum meeting frequency (monthly).

CDCR leverages the following effective processes and practices that support its UR policy.

- **Robust Telehealth Program:** CDCR placed a greater emphasis on expanding its telehealth program following the 2008 "Federal Receiver's Turnaround Plan of Action."[296] This improved AICs' access to timely healthcare and reduced expenditures on off-site medical trips.[297]
- **Third-Party Contracts for Billing Adjudication Services:** This helps to ensure that medical bills are accurate and appropriate, potentially reducing expenditures on outside medical trips. Billing adjudication services can also provide information to institutions that would alert financial management employees and healthcare administrators of cost drivers within off-site medical care. The third-party vendor also saves time for healthcare administrators and other institution employees that would otherwise be spent investigating discrepancies between estimates and invoices or collecting and reporting data on projected and actual expenditures.
- **Strong Data Collection & Visualization Practices and Performance Metrics:** CDCR used these metrics to create a public Healthcare Services Dashboard, as shown in Figure 11 below, which provides numerous and detailed metrics on specialty services and other key topic areas relevant to healthcare timeliness, quantity, quality, and cost-efficiency.[298] A few germane examples are the timeliness of primary and specialty services, costs per AIC for hospital stays and specialty care, and potentially preventable hospital stays.

[296] California Department of Corrections and Rehabilitation. *Achieving a Constitutional Level of Medical Care in California's Prisons: The Federal Receiver's Turnaround Plan of Action*. Sacramento, C.A., June 6, 2008. https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/2008-06-08_Receivers_Turnaround_Plan_of_Action.pdf.
[297] Chapter 6 of this report provides more information on CDCR's telehealth program.
[298] California Department of Corrections and Rehabilitation, Correctional Healthcare Services. *Healthcare Services Dashboard*. Accessed July 22, 2024, https://cchcs.ca.gov/dashboard/.



Measures	SW	ASP	CAL	CCI	CCWF	CEN	CHCF	CIM	CIW	CMC	CMF	COR	CRC	CTF	CVSP
Access to Specialty Services															
Specialty Services (All)	87%	94%	92%	92%	93%	85%	85%	90%	93%	87%	89%	91%	95%	83%	99%
High Priority Specialty 14 Days	69%	75%	90%	100%	100%	72%	57%	40%	67%	78%	33%	55%	89%	96%	100%
Medium Priority Specialty 45 Days	80%	95%	81%	100%	80%	82%	67%	82%	84%	81%	77%	85%	88%	92%	100%
Routine Specialty 90 Days	87%	91%	89%	93%	93%	83%	82%	88%	95%	81%	77%	93%	97%	91%	95%
Follow-Up Specialty Services as Ordered	86%	94%	92%	86%	92%	89%	87%	84%	91%	87%	92%	90%	93%	82%	99%
Consult Specialty Services as Ordered	91%	97%	96%	98%	96%	82%	94%	99%	96%	94%	97%	98%	100%	72%	100%
Access to Allied Health															
Allied Health (All)	91%	97%	95%	93%	94%	81%	90%	96%	96%	99%	72%	93%	97%	98%	94%
Laboratory Services as Ordered	91%	98%	95%	93%	94%	79%	88%	96%	96%	99%	69%	93%	98%	98%	93%
Radiology Services as Ordered	96%	90%	100%	99%	98%	100%	97%	97%	95%	100%	90%	95%	94%	97%	100%
Dietary Services as Ordered	87%	40%	33%	0%	97%	33%	95%	97%	100%	96%	99%	9%	50%	31%	0%
Inpatient Access															
Medical Inpatient Access (All)	94%	88%	82%	100%	76%	98%	94%	99%	100%	97%	94%	91%	100%	100%	
Timely Initial H&P - Medical Beds	91%	88%	100%	100%		83%	87%	87%	100%	100%	92%	100%	100%	100%	
Inpatient Rounds															
Timely CTC Bed Rounding - PCP	93%					100%	93%		100%	92%	96%	91%			
Timely OHU Bed Rounding - PCP	95%	100%	78%	100%			95%	100%	100%		85%	82%	100%	100%	
Timely Initial H&P - Mental Health Beds	94%			100%	76%		91%	100%	100%	100%	95%	91%			
Timely PIP Bed Rounding - PCP	98%						99%		100%		96%				
Access to Dental Services															

Figure 11: *CDCR Healthcare Services Dashboard*
(Source: CDCR Healthcare Services, 2024)[299]

The dashboard, built on Power BI (see the "Data Collection and Evaluation" section in the previous chapter), can filter and sort data by institution, month, and metric. CDCR can manipulate and query the data to address questions such as "what are the top volume specialties for off-site trips"? It can do this due to the capabilities of the software it built the dashboard in and its practice of hiring "Physician Programmers" in its IT department. The Physician Programmers implement ideas for additions and improvements from CDCR's health services employees on a technical level. They translate ideas from clinical employees very well owing to their combined experience in healthcare and programming.

Additionally, CDCR creatively oversees the utility of clinical decision-making tools like InterQual. The BOP is challenged to monitor how consistently UR nurses at MRCs and other providers in line institutions write consult requests for the URC using the InterQual criteria. However, CDCR uses a proxy measure to monitor how consistently its employees use the tool: percent of requests approved or denied through URCs that meet the InterQual Criteria. It also tests for inter-rater reliability between UR nurses on an annual basis.

Immigration and Customs Enforcement Health Services Corps

IHSC is an appropriate benchmark due to its similarity in mission and population, as it is responsible for delivering healthcare to noncitizens who are detained within the custody context.

[299] Ibid.

Additionally, interviewees cite IHSC as a model for improved processes, organizational structure, and communication between facilities and headquarters.

Despite the similarities, it is important to note some key differences between the umbrella organization of Immigration and Customs Enforcement (ICE) and the BOP. According to FY2023 data, the average length of stay for AICs within ICE facilities was 38.6 days.[300] Meanwhile, the average length of imprisonment imposed on AICs in BOP custody as of January 2024 was 149 months.[301] Additionally, 84.9 percent of BOP AICs are US citizens,[302] while ICE detainees are all non-citizens;[303] thus, US citizens have legal rights to adequate medical care while incarcerated under the Eighth Amendment, while ICE detainees gain access to healthcare through ICE's national detention standards and other internal policies.[304] The contrast between the AIC duration of facility stay and legal standing is essential for contextualizing this benchmark.

IHSC's Healthcare Compliance Division began building its UM capabilities around 2020, starting with consultations involving the U.S. Marshalls and the BOP about how their UR processes worked and what technologies they used. After completing acquisition requirements and further market research, MCG Health was the selected vendor for IHSC's evidenced-based care guidelines. The IHSC team began building its UR infrastructure, processes, and workflows by focusing on retrospective reviews and refining its approach through lessons learned. Prospective reviews were introduced in late 2023, and at the time of writing this report, concurrent reviews have also been introduced to select facilities.

While no UM policies have been officially implemented, IHSC has several policies at various stages of development. Currently, a draft UM guide and a draft UM directive are both under review. Additionally, standard operating procedures for UR consultant workload management, UM database management, MCG Care Guideline training, and prospective, concurrent, and retrospective URs are all being developed.

In terms of data, utilization data is currently being tracked for all three types of review, including the number of referrals that would trigger a review, the number of concurrent reviews completed for inpatient admissions, and the types of MCG Care Guidelines used. Claims cost data tracked include claim type, off-site provider, procedure codes, diagnosis codes, paid claim amounts, and estimated cost savings related to potentially avoidable hospital days.

IHSC exhibits the following effective practices for implementing UR processes in its facilities:

- **Pilot Programs**: Given resource constraints and an interest in a methodical roll-out, IHSC introduced concurrent reviews at just three of their 18 sites to develop metrics and workflow.

[300] U.S. Immigration and Customs Enforcement. *FY23 Detention Statistics*. Accessed August 22, 2024, https://www.ice.gov/doclib/detention/FY23_detentionStats.xlsx.
[301] U.S. Sentencing Commission. *Quick Facts: Bureau of Prisons (January 2024)*. Accessed August 22, 2024. https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/BOP_January2024.pdf.
[302] U.S. Department of Justice, Federal Bureau of Prisons. "Inmate Citizenship." Accessed July 22, 2024. https://www.bop.gov/about/statistics/statistics_inmate_citizenship.jsp.
[303] U.S. Immigration and Customs Enforcement. "ICE Enforcement and Removal Operations Statistics," Accessed July 22, 2024, https://www.ice.gov/spotlight/statistics.
[304] U.S. Immigration and Customs Enforcement Health Services Corps. "Comprehensive Healthcare." Accessed July 29, 2024. https://www.ice.gov/detain/ice-health-service-corps.

The small-scale approach enabled them to intentionally refine processes and procedures before implementing agency wide.

- **Limited Prospective Reviews**: At the time of writing this report, not all off-site referrals go through the UR process. Currently, computed tomography (CT) and magnetic resonance imaging (MRI) scans, cardiology referrals, and surgical procedures are criteria selected that require prospective review. This supports appropriate plans of care for noncitizens, enables utilization management practices (UMP) staff to evaluate clinician use of care guidelines in accordance with established workflows, and identifies additional training needs.
- **UR Benefits Education:** The UM team explained the benefits of UR and MCG guidelines to clinicians, highlighting smart resource utilization, liability protection, and support for their clinical discretion. Such education inspired clinicians to want to use this new tool and promoted an agency-wide UM culture.
- **Mandatory Guidelines Training**: IHSC required virtual MCG clinical care guideline training for referring healthcare providers. They started with physicians, advanced practice providers (APPs), and then clinical pharmacists. This approach ensured these providers were all equally equipped to access and apply guideline tools. MCG Healthcare Guideline training and subsequent certification are required for UMP employees to support the accurate application of the guidelines.
- **Field Engagement:** IHSC mandates headquarters clinical staff to periodically support field operations by way of temporary duty (TDY) assignments. The UM team cites this requirement as an asset for socializing UR's benefits with field staff, generating buy-in, and being 'in touch' with the realities of fieldwork.

Private Sector Benchmarks

A Note on Challenges with Comparisons

It is very challenging to identify effective practices that the BOP could implement in its UR program amongst the non-governmental healthcare organizations it examined to inform this report. Non-governmental healthcare systems are on the opposite end of financial transactions from the BOP by their very nature. In other words, non-governmental healthcare systems can bill insurance companies, individual patients, and organizations like the BOP for their services. As a result, the ways they incur costs for transporting patients to other medical facilities and performing consultations and procedures are fundamentally different from the ways that BOP incurs costs for its corresponding activities. The practices that non-governmental healthcare systems apply in processes that are analogous to UR are not applicable in correctional healthcare. The purpose and practice of UR differs so greatly between the BOP and private organizations that effective practices for private healthcare organizations have little or no relevance in the context of correctional healthcare.

In addition, non-governmental healthcare systems do not use the term "utilization review." The most similar processes they employ are called "prior authorization" and "peer review." However, the purpose and practice of such activities still differ from UR in corrections in important ways. This is evident when considering the process of prior authorization, which only involves providers requesting that health insurance companies provide coverage for the treatment of their patients.

Utilization review in corrections differs from prior authorization in that it is based on clinical determinations of need. Non-clinical considerations like the cost of treatment cannot be weighed in decisions to approve or deny medically necessary care for AICs. Additionally, the process of peer review in this context refers to the practice of monitoring medical orders: for example, comparing the number of CT scans an individual provider orders against the average number of CT scans the providers order in a given timeframe.

Analysis of UR in the BOP

This section highlights the strengths of the UR process and challenges in fulfilling all elements of the 2024 Patient Care policy, given resource constraints. Strengths and challenges are organized using the "people, process, technology" framework, which emphasizes the importance and interconnectedness of these three critical components to synergistically improve outcomes.

UR Strengths

Strengths with People

- **Multi-disciplinary URC Teams Enhance Patient Well-Being:** Institutional URCs include medical personnel in their formal membership but often invite employees from other departments, such as correctional services, chaplaincy, and psychology services, to join when reviewing the case of a complex patient. For example, FMC Carswell includes contractors from the University of North Texas, its CMSC, in its URC meetings to better coordinate schedules and off-site medical trips. Involving multiple disciplines when the patient's case is complex and high-risk increases patient safety by ensuring all facts and opinions are presented and considered while continuing to reserve final decisions on care for the appropriate clinical authorities.
- **Committed Providers Deliver Patient-Centered Care:** While visiting institutions and conducting interviews, the team identified many providers committed to providing quality healthcare on- and off-site to AICs despite limitations. These providers work to well document on-site consultations to best justify their recommendations for off-site care, and that necessary care and tests have been completed prior to the URC. UR nurses at MRCs continuously review the UR queue and run cases through InterQual to provide the best care for the patient.

Strengths with Process

- **Multi-level Review Supports Safety:** High-cost, high-risk consultations require regional and/or Central Office review. Mandating that such consultations are reviewed at higher levels allows for better risk management and helps provide the most appropriate care to AICs.
- **Thorough UR Aids Effectiveness and Efficiency:** The 2024 Patient Care Program Statement provides detailed guidance on the three components of the UR process: prospective, concurrent, and retrospective. The additional guidance clarifies HSD's expectations for institutions in continuously monitoring care and assessing the

effectiveness of approved consultations.[305] Tracking the care of AICs from start to finish is necessary to better monitor the utilization of resources, the effectiveness of treatment plans, and the effectiveness of providing quality care.

- **URC Timeline Fosters Punctual Care:** The 2024 Patient Care Program Statement provides clear guidelines on timeliness for URCs, encouraging institutions to meet more frequently to support AICs being approved for care in a timely manner. MRCs, complexes, and Care Level 3 institutions are expected to meet weekly. Penitentiaries (USPs), Federal Correctional Institutions (FCIs), camps, and detention centers are expected to meet bimonthly. The team observed during site visits that if there was a CD on-site to lead the URC, institutions met bimonthly or monthly.
- **Services Guidelines Facilitate URC Efficiency:** The BOP has outlined services that do not need to be approved through the UR process because they are in line with community health guidelines. This allows providers to focus on clinical care instead of devoting time to reviewing clinically necessary cases, enabling URCs to be dedicated to more complex cases.
- **Informing AICs Cultivates Equity:** The CD or lead of the URC is required to notify AICs of the decisions made and document the rationale for denying requests. Informing AICs of the URC's decision-making promotes equity and allows the AICs to receive guidance on the next steps in the treatment plan.

Strengths with Technology

- **InterQual Use Fosters Efficiency and Effectiveness:** The BOP offers InterQual access to all its institutions, which is regularly utilized in the UR process at MRCs. InterQual assists the HSU employees with matching community standards for treatment and determining clinically appropriate care. It also offers additional steps that can be taken to avoid unnecessary care.
- **Institution-wide EHR Increases Productivity:** The BOP uses BEMR as its EHR across all institutions. Utilizing the same EHR allows for the UR process to be more efficient because all providers can view AIC medical records without transferring physical records between facilities. Central Office and the regions are also able to remotely view the URC queue at the institution and regional levels to identify backlogs or trends.

UR Gaps between the Current State and Desired Future State

The BOP has a vested interest in minimizing its risks of delayed and costly care, as evidenced by several audits and the April 8, 2024 Patient Care policy. However, improving UM practices and implementing the 2024 policy may be challenging given the current circumstances at line institutions.

[305] For example, the new program statement provides five steps that need to be taken when conducting concurrent review for hospitalizations and emergency referrals, catastrophic care cases, continuity of care cases, and monitoring pending orders. These five steps focus on the quality of care the AIC is receiving, potential to move the AIC to a facility better suited for their needs, and the cost of the current treatment.

Challenges with People

- **Missing URC Team Members:** Under the 2024 Patient Care policy, the BOP encourages a broad range of personnel to attend weekly or bimonthly meetings. The BOP also expects that a lower-level administrative or clinical position will be assigned to facilitate these meetings. However, the team observed that URC meetings did not always occur in any regularly scheduled manner or with the expected attendees. Institutions without a CD may send requests directly to the RMD for review and approval without having a URC meeting, and institutions with a CD may limit URC invitees to select clinicians.
- **Lack of Timeliness Trackers:** The 2024 policy emphasizes the importance of delivering timely care, but there is no position expressly assigned to monitor these delays. The nurse case manager is not a role that the BOP currently employs; social workers are more oriented towards OUD treatment services and release programming, and UR nurses who monitor consults through the process only exist at MRCs. Thus, current employees may be unable to closely monitor the timing of care given collateral duties.
- **Overburdening the HSU Leadership:** All responsibilities for implementing the UR portion of the Patient Care policy fall on the CD and HSA. These individuals are often already busy with other duties and perhaps unable by policy to delegate some of their responsibilities to team members. Furthermore, several institutions the team visited did not have a CD, causing the HSA to be solely responsible for the HSU management. Hence, updating local UR practices to meet the 2024 policy may need to be given lower priority for implementation based on a competing confluence of important tasks assigned to upper levels of leadership.

Challenges with Process

- **Lack of Report Guidance:** The CD and HSA are required to deliver regular reports to the regions under the 2024 policy, but there is no reporting template currently provided to institutions to be in compliance. Such an approach requires institutional leadership to develop their own report format, which may cause institutions to report data in different formats that are challenging to synthesize for a fuller picture. However, the team applauds the efforts currently underway to create detailed templates that automatically populate relevant data on a weekly, monthly, and quarterly basis and supports sharing these templates with all institutions once finalized.
- **Unclear Role Assignment:** The 2024 policy states that specialty care consultation data will be used to prioritize requests and risk management and that UR data will be tracked and reported at regular intervals. However, it is unclear who is responsible for monitoring this data and making subsequent decisions. Analysis may be deprioritized without a dedicated resource for these initiatives, continuing to hamper the BOP's risk management strategy.
- **Inconsistent Data Tracking:** The aforementioned UR data is required to be tracked and reported at the quarterly Governing Body Meetings moving forward, but some institutions the team visited struggled to hold governing body meetings given staffing challenges and other more pressing needs. If institutions are not adequately supported to

carry out basic functions, additional duties like quarterly governing body meetings could be neglected.

- **Variable Medical Costs**: Utilization data related to outside medical expenditures, including off-site medical trips and telehealth services, is challenging to track because the rates for consults, procedures, and other treatments vary across geography and CMSC.[306] Variable rates also make it difficult to draw conclusions about cost drivers connected with outside medical services.

Challenges with Technology

- **Limited InterQual Usage:** All institutions have access to InterQual, which may inform the most appropriate and, subsequently, most cost-effective course of action. However, in practice, an institutional provider must request training from the National UR nurses if interested in utilizing this tool. Given these factors, most institutions opt not to use InterQual on their own accord, and inappropriate or more expensive care that is not community standard may be selected earlier in a patient's treatment journey.[307]
- **Difficulty Collecting Utilization and Cost Data**: Many audits have recommended efforts to collect more healthcare utilization and spending data to make more informed decisions about service procurement and budgeting. However, the BOP has difficulty gathering data related to outside medical expenditures under its current technological infrastructure, both at an institutional and Bureau-wide level. The inability to easily view the percentage of utilization requests by category (e.g., outside care, specialist evaluations, procedures of limited medical value), percentage of requests by specialty, and general approval rate for requests make it challenging to identify and recommend cost-saving measures.
- **Siloed Financial Systems**: Data collection is further hampered by the fact that the BOP's financial management system does not interface with BEMR. Therefore, departments from the Central Office to the institutional level have inconsistent access to the data on medical expenditures and types of treatment completed.

Recommendations on UR and UM

The following five recommendations are aimed at narrowing the gap between the current and desired future state of UR and UM. Like the analysis section above, recommendations are also marked according to the "people, process, technology" framework and priority is scored based on the six criteria described in chapter 2.

Recommendation 5.1 (People): Expand healthcare financial services to include one healthcare FPS position at each institution and one healthcare actuary in Central Office to add

[306] National Academy of Public Administration. *Assessment of the Bureau of Prisons' Organizational Alignment with Healthcare Mission*. Washington, D.C., 2019. https://s3.us-west-2.amazonaws.com/napa-2021/studies/federal-bureau-of-prisons-medical-data-managment/BOP_NAPA_Deliverable_1_Final.pdf.

[307] Further evaluation of the integration of the Interqual system into BEMR and its impact on improving healthcare decision-making across BOP facilities may be needed to fully assess this issue. However, given the completion of the current project, a more detailed assessment falls outside the scope of this report.

healthcare financial management expertise at a local level and enable more accurate healthcare cost projections at a global level.

- ***Rationale:*** The healthcare FPS would help institutions to more consistently monitor and compare estimates and actual expenditures on medical services. They would enable institutions to break down costs by more granular elements like the volume or costs of different types of treatment. Institutional FPSs can then report key financial information like the volume of and specialty associated with appointments, procedures, and hospital stays, as well as catastrophic cases, up the organization to promote greater visibility into cost drivers at the national level. Then, the Central Office healthcare actuary can be a dedicated resource to analyze this institutional data, as well as the standardized UM data set (see Recommendation 5.3), to predict Bureau healthcare costs moving forward.

  These two positions fill multiple voids. At the institutional level, institutional financial management employees often lack experience in medical estimates and billing, while health services employees often lack experience in financial matters like billing and accounting. A healthcare FPS would bridge the gap between finance and medical and aggregate useful data for use at higher levels. At the Central Office level, a healthcare actuary would take the next step of utilizing this aggregated data to identify cost drivers and forecast future costs.
- ***Priority (Medium):*** Implementing this recommendation would support data aggregation for critical financial decisions intended to save money over time. However, hiring these personnel will require additional financial resources, which may be hard to access given competing priorities.

Recommendation 5.2 (Process): Improve efficiency by encouraging UR authorities (CDs and UR nurses) to independently approve or deny requests outside of URC meetings, starting with Care Level 3 facilities.

- ***Rationale:*** Some institutions visited struggled to conduct URC as recommended in policy due to resourcing constraints. For institutions that are able to conduct URC with a large team, the team observed and interviewees reported that clinicians besides the CD do not often contribute to the conversation. Encouraging capable local authorities to approve/deny straightforward consults outside of URC meetings and reserving URC meetings for active interdisciplinary conversation around challenging cases would be a better allocation of provider time and, subsequently, financial resources. This practice would also provide education to providers on how to properly justify their written requests.
- ***Priority (Medium):*** This recommendation is relatively easy to implement since it does not require additional personnel resources and would save providers' valuable time, which would likely be well-received. Patients may also directly benefit if their cases are reviewed on a rolling basis rather than in a batch, as they can be scheduled for off-site care once the clinical authority signs off.

Recommendation 5.3 (Process): Enhance effectiveness of the bill adjudication process by implementing the existing national contract to support the accurate gathering of a standardized UM data set to inform cost drivers. Then, utilize the identified cost driver data through healthcare

actuarial resources or contractors to accurately project future healthcare needs and corresponding spending.

- ***Rationale:*** Bill adjudication support is critical for enhancing the accuracy and appropriateness of medical bills and can help identify cost-drivers for off-site medical care. While the BOP has utilized third-party adjudicators in the past, the vendors have not always upheld the terms of the contract. The BOP has had a national billing adjudication contract for more than four years but has not been able to implement it for lack of Authority to Operate because the DOJ considers data security to be an unresolved cybersecurity issue. Utilizing existing bill adjudication contracts to gather Bureau-wide data would enable the BOP to identify cost drivers and project future healthcare needs and expenses accordingly.
- ***Priority (High):*** DOJ OIG has called for utilizing this contract to process and confirm accurate, complete healthcare claims.[308] However, the national bill adjudication contract is currently inaccessible due to the DOJ data security constraints.

Recommendation 5.4 (Process): Support timeliness and improve clinical efficiency by partnering with third-party consult reviewers to conduct initial utilization review, starting with Care Level 3 facilities. In the long-term, look to transition initial UR reviews in-house by hiring UR nurses at non-MRCs to facilitate URC meetings, monitor UR data, and approve requests that pass evidence-based screening outside of URCs, starting with Care Level 3 facilities and complexes.

- ***Rationale:*** Determining the appropriateness of off-site medical care is a collateral duty for providers at non-MRCs that may be challenging to accomplish given competing priorities. The team supports the BOP's efforts to contract with third-party reviewers to conduct the initial review through evidence-based criteria screening tools (such as InterQual) before passing along to the CD for final approval. Such an approach would increase timeliness of reviews, free up employee resources, and support clinically appropriate care. Starting the roll-out with Care Level 3 facilities is an efficient use of resources given that these facilities naturally must conduct more UR due to the acuity of their patient population. Eventually, the BOP should transition to completing these initial reviews in-house across institutions, similar to the process at MRCs. Besides the initial reviews, these UR nurses could also facilitate URC meetings. Such additional human resources would contribute to more timely consult reviews and identify the most suitable course of action based on community guidelines.
- ***Priority (Medium):*** Utilizing clinical evidence-based decision tools is a best practice employed by benchmark organizations to support more appropriate care for AICs. Additionally, this proposal is supported by quality management leadership. This recommendation requires resources to implement, but could result in savings in the long-term.

[308] U.S. Department of Justice Office of the Inspector General, *Management Advisory Memorandum: Notification of Concerns Resulting from Multiple Office of the Inspector General Reviews Related to the Federal Bureau of Prisons Strategy for its Medical Services Contracts.*

Recommendation 5.5 (Technology): Estimate how consistently institutions use InterQual by determining the percentage of approved URC requests that meet InterQual criteria and periodically testing for inter-rater reliability amongst nurses that use InterQual.

- ***Rationale:*** HSD is challenged to determine how consistently healthcare employees at the institutions use InterQual to inform their requests for off-site and telehealth medical services. CDCR uses the percentage of approved requests that meet InterQual criteria to estimate how well and how often its institutions use the tool. It is important for providers to justify requests properly to assure records of AIC treatment reflect their due diligence in making decisions to approve or deny outside medical services. Accurate recordkeeping also helps to promote accountability in the process because employees can revisit past events and be better informed to make corrective actions in the event of errors.
- ***Priority (Low):*** This recommendation is relatively easy to implement and would improve accountability and reduce risk on the margins.

Chapter 6: Telehealth

This chapter provides background information on the Health Service Division's (HSD) telehealth program (the Telehealth Program) and effective practices from outside organizations that operate healthcare systems with a telehealth component, as well as organizations that offer effective practice models for telehealth providers. It also provides an analysis of the benefits and limitations of telehealth and identifies gaps between the current state and the desired future state of the Telehealth Program. It concludes by offering recommendations on how to move from the current state to the desired future state.

Background on Telehealth

The Federal Bureau of Prisons (BOP or the Bureau) defines telehealth as including "all healthcare provided wherein the patient and provider are separated, and delivery of care is facilitated by use of telecommunication technology… includ[ing] both primary and specialty care."[309] The Telehealth Program began in 2001.[310] It has expanded incrementally since that time but faced implementation challenges resulting from the Coronavirus Disease 2019 (COVID-19) Pandemic, the lack of equipment and connections between equipment and existing network lines for internet access, a lack of employee capacity and training to set up and use the necessary equipment, and questions about data security. Further hindering its advancement, the Health Services Division (HSD) issued a memorandum dated June 14, 2023, instructing the institutions not to establish new telehealth programming with contract providers utilizing networks outside the BOP. Mission-support offices had urged HSD to issue this memorandum so that such operations comply with data security requirements under the Department of Justice's (DOJ) procurement policies.[311] Subsequently, Assistant Directors for HSD and Information Technology and Data Division (ITDD) issued a joint memorandum on April 17, 2024, that reauthorized institutions to continue pursuing new telehealth operations to obtain specialty services in the community.[312]

Current Organization, Roles, and Administration

HSD's National Health Technology Administrator (NHTA) in the Central Office is responsible for developing and overseeing the Telehealth Program. The NHTA is supported by the Telehealth

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[309] U.S. Department of Justice, Federal Bureau of Prisons. *Program Statement 6031.05: Patient Care*. Washington, D.C., May 14, 2024. https://www.bop.gov/policy/progstat/6031.05.pdf.; Regional offices and institutions use telehealth to provide primary and specialty care to AICs. BOP healthcare employees can provide those services from within a BOP location. For example, regional employees can provide telehealth services to an institution. Institutional employees can also provide telehealth services to institutions other than their own. In addition, institutions can secure telehealth services for primary and specialty care they are unable to provide internally by contracting with providers in the community.

[310] FMC Lexington was among the first three institutions in the BOP to establish telehealth operations beginning in 2001. The other two institutions were FMCs Rochester and Springfield.

[311] The 11 staff offices that compose Central Office include three program-focused offices, six mission-support offices, and two special program offices. HRMD and ITDD are two of the mission-support offices. For more information, see: National Academy of Public Administration. *Assessment of the Bureau of Prison's Organizational Alignment with Healthcare Mission*. Washington, DC, 2019. https://s3.us-west-2.amazonaws.com/napa-2021/studies/federal-bureau-of-prisons-medical-data-managment/BOP_NAPA_Deliverable_1_Final.pdf.

[312] BOP's technical requirements include the use of a specific videoconferencing platform and equipment.

Advisory Committee (TAC), which is comprised of individuals from Central Office, the regional offices, and Institutional Telehealth Coordinators (ITCs).[313] The TAC is responsible for advising the NHTA on decisions and guidance related to the Telehealth Program, promoting and monitoring the use of telehealth services, and providing technical assistance to employees in the institutions as they implement telehealth.

Figure 12 below shows the current organizational structure of the Telehealth Program. The dotted line between regional employees and the TAC and NHTA indicates that, in general, the regional employees report directly to their Regional Directors (RDs) while taking guidance on the Telehealth Program from the TAC and NHTA. The dotted line between ITCs and regional employees indicates they report to their Wardens through the institutional chain of command while taking guidance on the Telehealth Program from regional and Central Office employees.

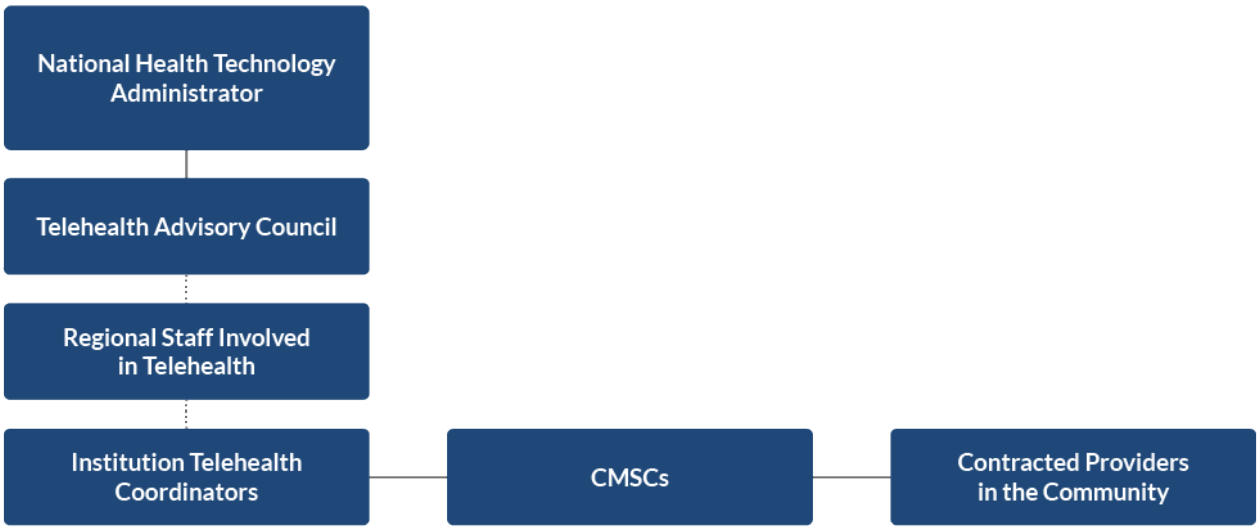

Figure 12: *Current Organizational Structure of the Telehealth Program*
(Source: Figure created by the team based on interviews with the BOP*)*

Employees at the regional offices, including Central Office employees assigned to the regional offices, are also responsible for promoting telehealth and supporting their respective institutions in implementing those services. Some of the BOP employees in the regional offices use their clinical qualifications to provide telehealth services to adults in custody (AICs) at institutions in their regions to add capacity at times.[314] For example, Regional Medical Directors, who are Central Office employees assigned to the regions, can serve in this capacity.

[313] The current official title for Institutional Telehealth Coordinators is "Specialty Clinical Coordinator". However, their duties can encompass more than specialty clinics. For example, they may need to schedule telehealth appointments with a BOP provider for primary care. The BOP is developing two additional position descriptions for similar roles that may be given a different title. This report uses the term "Institutional Telehealth Coordinators" to refer to all such positions.
[314] For example, a physician at the regional level may conduct chronic care visits for AICs to add capacity for institutions with one or more vacant Staff Physician positions.

At the local level, Medical Referral Centers (MRC) and line institutions are responsible for administering telehealth. Institutions with relatively mature telehealth capabilities often help other institutions to stand up their telehealth operations. Some institutions have ITCs that are responsible for coordinating the stand up of telehealth services in their respective institutions, ensuring the equipment is in working order, overseeing employees to ensure they observe HSD's patient care protocols,[315] and providing support for AICs and comprehensive medical services contract (CMSC) providers during telehealth appointments. They serve an important role in ensuring that telehealth appointments are timely, efficient, and effective. ITCs are required to have clinical qualifications because clinical professionals can better support the process by coordinating with, and anticipating the needs of, outside providers.[316] For example, clinical professionals have the requisite training and access to review information in Bureau Electronic Medical Record (BEMR) about AIC history and previous treatment to provide upon the telehealth providers' request. Their training enables them to gather more detailed medical information for providers during appointments and make accurate notes of the providers' orders for services like bloodwork.

Process

The process for administering telehealth at institutions is similar to the process for arranging outside medical trips for AICs. A provider at the institution identifies a potential need for an AIC to receive outside medical services and writes a request in BEMR, which the local utilization review committee (URC) approves or disapproves. If approved, the URC determines whether the need can be addressed by an off-site medical trip or a telehealth appointment. Some institutions schedule all approved care that can be administered virtually as telehealth appointments by default. The ITC coordinates with the CMSC to schedule a telehealth appointment after the Utilization Review Committee (URC) notifies them of the action item to create that appointment.

Technology and Equipment

Technology and equipment play an important role in telehealth operations. The technology available to organizations determines the scope of primary and specialty care activities that can be met using telehealth. For instance, the type of equipment needed to provide mental health services through telehealth is vastly different than what is needed for medical specialties like dermatology and cardiology. For example, telehealth consults for dermatology may require sophisticated camera equipment. As such, the quality of technology available to an organization also impacts its capacity to implement telehealth. An organization with more sophisticated equipment will likely complete more appointments than another organization with little, or less sophisticated, equipment. Different types of equipment also require appropriate technical training for employees to use them.

Mobile workstations, known as "telehealth carts," are used to administer remote healthcare delivery. A telehealth cart is an adjustable cart with a high-definition camera with tilt and zooming

[315] U.S. Department of Justice, Federal Bureau of Prisons, *Program Statement 6031.05: Patient Care*.
[316] Currently, the BOP requires candidates for the position to have a nursing license or higher. It is considering opening the role to candidates that are paramedics in the future.

capabilities for clear visuals of a patient.[317] Telehealth carts that institutions use vary by model, and each model has different capabilities. For example, institutions may use free-standing telehealth carts that include medical instruments, wall-mounted models with instruments attached, and desktop models without instruments. In 2021, Central Office purchased 62 carts. Leveraging economies of scale for bulk purchasing enabled it to purchase the carts at a lower cost per unit. HSD also found that the bulk purchase saved employee time on requests and approvals for smaller purchases by individual institutions.

There is no standard, formal training on technical matters related to the use of telehealth equipment. Typically, staff assigned to the regional offices such as Regional Health Systems Administrators (RHSAs) and Regional Nurse Consultants, and the TAC are responsible for assisting institutions with their telehealth operations as an informal, secondary duty.

Current Implementation of Telehealth

There is no comprehensive policy on telehealth. Rather, the practice of telehealth is governed and guided by memoranda on specific topics like COVID-19 and security and information technology (IT) standards and requirements.[318] HSD recognizes this gap and is in the process of developing a telehealth policy.[319]

Overall, HSD's implementation of the Telehealth Program across the institutions is uneven but progressing. This is attributable to the large number of resources required to roll out operations in all institutions at once and a lack of employee capacity to use those resources. It prioritizes certain institutions for implementation over others based on factors like their care level designation and population size. As of 2022, approximately 55 percent of the institutions had telehealth carts, but a smaller percentage were operational (26 percent), and an even smaller percentage had been used (14 percent). No employees are solely dedicated to the Telehealth Program. Even ITCs, of which there are five currently, perform the role as an additional duty to their clinical roles, and custody roles when they are augmented.

The physical spaces institutions use for telehealth appointments also vary. Some dedicate space in AIC housing units, while others use office space in their HSU. Some institutions lack the dedicated space they need to administer telehealth. In some instances, they set up equipment in clinical spaces in their HSU like triage rooms. Depending on the size of this room, it can be difficult for providers to have adequate mobility to perform their clinical duties and ensure privacy for AICs during telehealth appointments. The Analysis section of this chapter provides more

[317] MedicalExpo. "GlobalMed Batter-powered telemedicine cart." Accessed June 19, 2024. Battery-powered telemedicine cart - ClinicalAccess® - GlobalMed - height-adjustable / with drawer / secure (medicalexpo.com).
[318] Smith, M.D. *Memorandum: Waiver to Health Services Policy*. Washington, D.C.: U.S. Department of Justice, Federal Bureau of Prisons, June 30, 2021. https://www.bop.gov/foia/docs/covid19__national_policy_waiver_6027_02_health_services_accreditations_2021.pdf.
[319] HSD is also interested in incorporating information provided by this section in its draft policy. The sub-sections, "Effective Practices" and "Analysis and Recommendations" below provide findings regarding the key aspects that a telehealth policy should address and effective practices it observed in the telehealth practice of external organizations.

information about challenges and limitations related to the Telehealth Program and the practice of telehealth in general.

As this chapter's subsection on "Barriers and Limitations to Telehealth" explains, it is not possible to conduct a high-quality empirical analysis of the quality and outcomes of care for AICs through the Telehealth Program during the timeframe allocated to researching and writing this report. This is attributable to a lack of routine, standardized data captured and collected across the organization specific to telehealth apart from an equipment roster and few dedicated employee resources. Anecdotally, most institutions visited were: waiting to establish or resume telehealth services with outside providers due to the pause that was in effect until April 17, 2024; unable to arrange observations of telehealth appointments or interviews with employee involved with telehealth; or not using their telehealth cart. Most AICs interviewed did not have experiences with telehealth to share. Those AICs that did have experience receiving care through telehealth reported they enjoyed the relative ease and timeliness of appointments but did not have more detailed feedback or critiques to share.

HSD's internal analyses indicate that the top four current and historical barriers to telehealth are: (1) lack of local awareness/support; (2) challenges connected with IT/facilities; (3) lack of equipment; and (4) lack of patient-side employees. The "Analysis of the Telehealth Program" section of this chapter provides more information on each of the four current barriers. Despite such challenges, the BOP recognizes the potential of telehealth to reduce expenditures on off-site medical services (the "B2" budget described in Chapter 5), which make up about 39 percent of total spending on healthcare (B1 and B2). In 2022, HSD estimated that it could avoid as much as $23 million to $28 million each year on outside consults alone.[320] This estimate is not an all-inclusive amalgamation of cost avoidance potential because it does not account for such possibilities as reducing repeat off-site medical trips due to missing labs or reports, or reduced employee time devoted to preparing and approving off-site trips.

HSD's Future Vision for the Telehealth Program

HSD plans to expand the Telehealth Program substantially over the next three to five years by implementing a new policy and organizational structure and adding staff and equipment.[321] It will address matters of organizational structure by hiring dedicated telehealth positions. As of June 28, 2024, HSD hopes to hire all 21 of these positions by the end of FY 2024. Funding for the 21 positions is provided through the First Step Act (FSA) between FYs 2023-2024.[322] The planned distribution of hires by organizational level is as follows:

HSD at Central Office

- 1 National Telehealth Administrator (NTA)

[320] The basis of this estimate is provided in a non-public document but these figures are approved to share in this text.
[321] HSD plans to make another central purchase of telehealth carts to distribute to institutions similar to its purchase in 2021.
[322] The FSA provides positions and financial resources to the BOP for carrying out its requirements. Telehealth is directly related to the FSA requirement for provision of medications for opioid use disorders. See: *First Step Act of 2018.* Public Law 115-391. *U.S. Statutes at Large* 132 (2018): 5194-5249. https://www.congress.gov/115/plaws/publ391/PLAW-115publ391.pdf.

- 6 Regional Telehealth Administrators (RTAs)

Institutions

- 14 Institutional Telehealth Coordinators (ITCs)

The future organizational structure, prospective staffing levels and reporting relationships are shown in Figure 13 below.

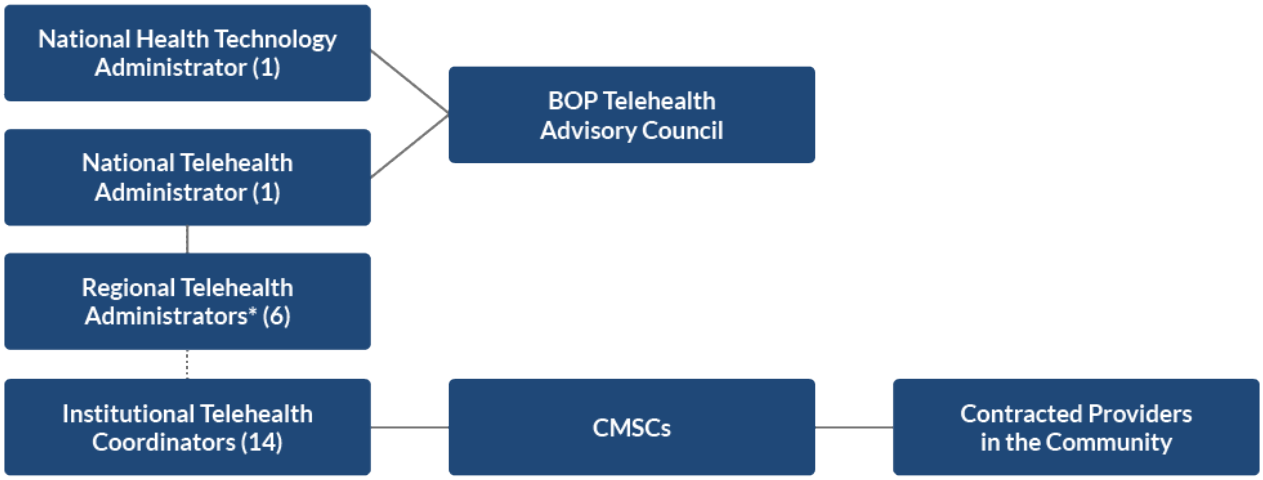

Figure 13: *Future Structure of the BOP Telehealth Program and Number of Dedicated Positions (Source: Figure created by the team based on interviews with HSD)*

The NTA will assume many of the NHTA's current responsibilities for the Telehealth Program. The position will be supported by six RTAs in the Central Office. These additions will produce a division of labor for the program that is more commensurate with the size and scope that HSD envisions for the Telehealth Program. In addition, the new positions will provide an organizational structure dedicated to telehealth and responsible for many of the current ad-hoc duties of the TAC and its members. For example, health services employees in the regional offices train employees at institutions on telehealth procedures and equipment, but this duty is not reflected in any of the regional office position descriptions. There is also no formal, standardized training for Central Office and the regional offices to provide to the institutions.

The remaining fourteen FSA positions are planned to be assigned to individual institutions in the form of ITCs.[323] While these positions will report to their respective Warden through the institutional chain of command, institutions cannot convert ITC positions to other position types like correctional officers or medical records assistants. The positions are also classified as "no-bid, no pull". This means that the ITCs will not be able to bid on work shifts, assignments, or posts, and cannot be augmented to serve correctional posts or assigned to perform clinical duties outside the context of telehealth.

[323] HSD convened members of the TAC, the RHSAs, and others to decide on which institutions should receive the authority to hire the nine Institutional Telehealth Coordinators. They considered aspects of the institutions such as their current availability of operational hardware, current telehealth operations, consults queue, and care level designation.

HSD is also developing two new position descriptions that set out different clinical qualifications and Office of Personnel Management General Schedule (GS) grades for ITCs. This will expand opportunities for applicants because the only active position description for telehealth coordinators is a GS-10 Specialty Clinic Coordinator for registered nurses.

Effective Telehealth Practices and Benchmarks

This section notes key differences between telehealth operations in corrections and other governmental and non-governmental organizations, summarizes guidance from organizations with relevant subject matter expertise, and distills effective practices from healthcare organizations in the public and private sectors.

Guidance from Telehealth Organizations

As HSD refines its telehealth policy, it will look towards benchmarks and other agencies to exchange best practices in both the implementation and execution of telehealth in a correctional setting. In fact, HSD and the NHTA have already been in touch with agencies like IHSC and the Veterans Health Administration (VHA) to inform their thinking on policy. Organizations such as the National Institute of Justice (NIJ), the Department of Health and Human Services (HHS), as well as the American Telemedicine Association (ATA) have published and referenced best practice guides that will be used to inform HSD development and implementation of a new telehealth policy.

American Telemedicine Association

The ATA is an organization that focuses on the advancement of telehealth in the United States. It publishes many materials that provide guidance and effective practices for practitioners following a large uptake of telehealth services resulting from the COVID-19 pandemic. According to the ATA, 97 percent of healthcare providers in the private sector had the operational capability to use telehealth as of April 2020.[324]

Ensuring data security in the administration of telehealth is a major point of emphasis. The ATA highlights effective practices to limit data security risks when conducting telehealth, including implementing: [325]

1. **Ongoing Manual Tests**: Including regular pressure testing to make sure that the system is reliable and "leak resistant." Pressure testing evaluates the safety of internal controls and highlights security vulnerabilities within a system.
2. **Continuous Employee Training on Risk Identification**: Employees must be adequately trained to identify and report security threats that may be present within a telehealth system. Running these training courses on a continual basis ensures that employees are prepared to handle the dynamic nature of threats as technology advances.

[324] American Telemedicine Association. *The Adoption of Telehealth*. May 10, 2021. https://www.americantelemed.org/wp-content/uploads/2021/05/Adoption-of-Telehealth.pdf.
[325] Health Sector Coordinating Council: Cybersecurity Working Group. *Health Industry Cybersecurity – Securing Telehealth and Telemedicine*. October 2023, Reprint of 2021 Edition. HIC-STAT_2023.pdf (healthsectorcouncil.org).

The ATA cites these practices as cost-effective solutions to lessen the risk of cyber security threats and tools to evaluate security needs on an ongoing basis.

National Institute of Justice

The NIJ is the research, development, and evaluation arm of the DOJ and works to provide tools that improve programming in corrections. Its work is tailored to correctional settings, so its tools for planning and implementing telehealth are uniquely relevant to the BOP.[326] One such tool is the telehealth process shown in Figure 14 below. The process begins with a comprehensive analysis of medical requirements and healthcare satisfaction that incorporates AIC feedback and data. Next, the model calls for organizations to develop an implementation plan aimed at improving healthcare quality and delivery and prioritizing security protocols.

NIJ also outlines steps to determine cost-effective solutions, anticipate future technology upgrades, and conduct thorough surveys of available products and services. NIJ's cost estimation model assists organizations in understanding the financial implications of implementing telehealth within their facilities. It includes inputs, some of which are specific to corrections departments, such as: installation and equipment costs, training expenses, operational maintenance, and potential savings from reduced medical and transportation costs.

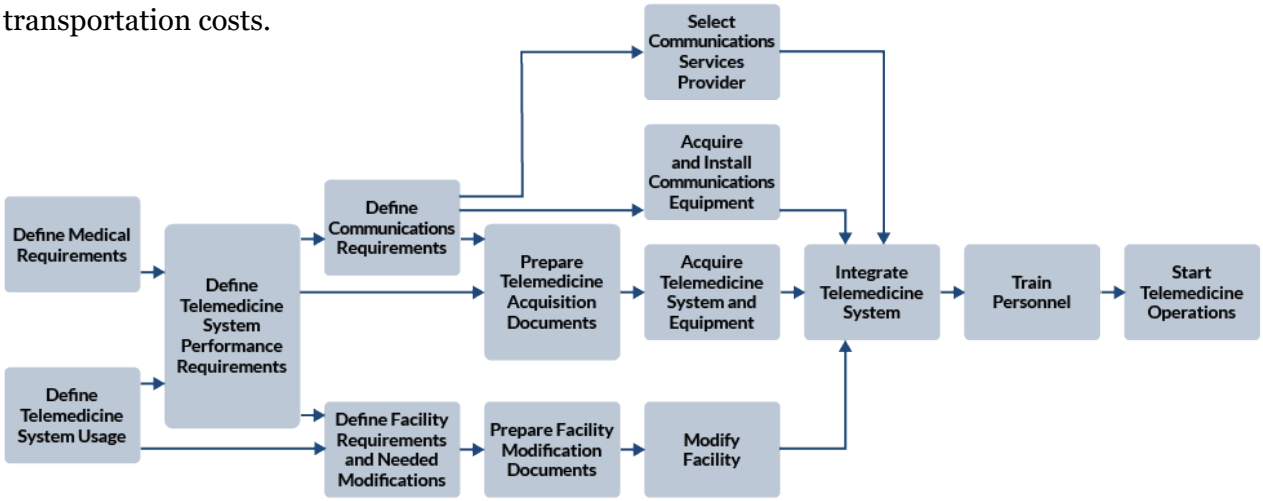

Figure 14: *Telehealth Implementation Process (Source: NIJ, 2002)*[327]

The Department of Health and Human Services

A key part of HHS' mission is to provide effective health and human services and foster sound, sustained advances in the sciences underlying medicine and public health. As such, it maintains a comprehensive set of effective practice guides for organizations with telehealth programs to

[326] U.S. Department of Justice, National Institute of Justice. *Implementing Telemedicine in Correctional Facilities*. May 2002. https://www.ojp.gov/pdffiles1/nij/190310.pdf.
[327] Ibid.

consider.[328] They discuss topics like legal constraints, cybersecurity concerns, billing, and patient care. The guides also make recommendations about the different types of specialties that telehealth is appropriate for, as well as proper procedures by specialty type. For example, it outlines the preparation and treatment processes for patients receiving cancer care through telehealth.[329]

The Centers for Medicare and Medicaid Services (CMS) makes a telehealth toolkit available to benefit agencies' telehealth programs.[330] The toolkit includes considerations for improving access to telehealth for specialty populations. For example, it explains that non-English speaking patients are less likely to utilize telehealth than English-speaking patients. Such considerations can be even more important in the context of corrections given unique constraints on communication between AICs and their providers.

Benchmark Organizations Using Telehealth

This subsection details effective practices from governmental and non-governmental organizations that administer telehealth programming. Some differences between telehealth operations in corrections departments and other organizations are important to bear in mind when considering how transferable effective practices are between the two. For example, corrections departments must adhere to stringent security requirements when they transmit information and use technology to protect AIC's personal identifiable information and reduce the security risks associated with unauthorized access to their appointment times and locations.[331] In addition, institutions have CMSCs that can preclude them from seeking telehealth services from providers outside of those contracts. Thus, they do not have direct access to the full supply of providers in their local and regional markets.[332] Another difference is that some organizations use health aids or patient family members instead of telehealth coordinators to attend to the needs of providers during telehealth appointments.[333]

California Department of Corrections and Rehabilitation

CDCR is a good benchmark organization because of its corrections-focused mission, reputation amongst the subject matter experts interviewed for this report, robust telehealth policy, and

[328] U.S. Department of Health and Human Services, Health Resources & Services Administration. "Best Practice Guides." Accessed August 22, 2024. Best practice guides | Telehealth.HHS.gov.
[329] U.S. Department of Health and Human Services, Health Resources & Services Administration. *Introduction to Telehealth and Cancer Care*. Accessed August 22, 2024. Introduction to telehealth and cancer care | Telehealth.HHS.gov.
[330] Centers for Medicare and Medicaid Services. *Telehealth for Providers: What you Need to Know*. Revised May 2023. https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf.
[331] For example, the BOP can only use approved equipment that conforms with agency and department-level standards. This differs from practice in the private sector, where providers and patients can often connect with whatever equipment is readily available to them such as a laptop or mobile device. Additionally, outside telehealth providers must adhere to BOP's requirements when conducting telehealth appointments with AICs, such as using approved videoconferencing platforms like WebE.g.
[332] Comprehensive medical services contracts can contain provisions that prevent institutions from contracting with other providers for certain healthcare services.
[333] For example, the individual in the room will take notes and attend to the provider's requests to manipulate the patient's limbs or take their blood pressure. The BOP could use employees with lower levels of clinical training to make such positions easier. However, the practice would require a tradeoff between more expedient hiring and a reduction of quality and efficiency of telehealth appointments.

developed telehealth program. It is also responsible for the stewardship of a comparable number of AICs (~120,000) to the BOP (~158,000).[334] However, CDCR's budget for medical services was $2.7 billion in 2022-2023, while HSD's budget is $1.46 billion annually.[335]

CDCR placed a greater emphasis on expanding its telehealth program following the 2008 "Federal Receiver's Turnaround Plan of Action" in order to increase AIC access to healthcare, public safety, and reduce expenditures on off-site medical services.[336] Its telehealth program directly supports four of the six goals in the Federal Receiver's plan:[337]

1. Ensure timely access to healthcare services
2. Establish a prison medical program addressing the full continuum of healthcare services
3. Recruit, train, and retain a professional quality medical care workforce
5. Establish medical support infrastructure

CDCR's policy around telehealth addresses many topics that corrections organizations should consider.[338] It provides information on the purpose of the policy, how the headquarters office and regions provide operational oversight and guidance to the field, and responsibilities for the program at the statewide, institutional, regional, and headquarters levels. The policy details operational requirements for state employees in primary care, and for contractors in specialty care. It also includes procedures for contracting for telehealth services and clinical and technical procedures for conducting appointments. Finally, CDCR's policy enumerates responsibilities for Institutional Telemedicine Coordinators, their chain of command, and IT employees. CDCR's Policy requires that institutional employees designated as "Clinical Presenters" accompany AICs during telehealth appointments to provide clinical support as needed. Employees need to be qualified as registered nurses for specialty care and medical assistants for primary care before they can become Clinical Presenters.

CDCR exhibits four effective practices for operating telehealth programs in correctional environments:

1. **Purchasing Equipment Centrally:** Standardizes the tools (e.g., telehealth carts) that institutions use and does not require individual institutions to use their limited

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334 U.S. Department of Justice, Federal Bureau of Prisons. "Statistics." Accessed August 22, 2024. https://www.bop.gov/about/statistics/population_statistics.jsp;#:~:text=158%2C501%20Total%20Federal%20Inmates,Last%20Updated%20June%2020%2C%202024.

335 California Department of Corrections and Rehabilitation. *2022-23 State Budget*. Accessed October 11, 2024. https://ebudget.ca.gov/2022-23/pdf/Enacted/GovernorsBudget/5210.pdf.

336 California Department of Corrections and Rehabilitation. *Achieving a Constitutional Level of Medical Care in California's Prisons: The Federal Receiver's Turnaround Plan of Action*. Sacramento, C.A., June 6, 2008. https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/2008-06-08_Receivers_Turnaround_Plan_of_Action.pdf

337 The numbering of the goals in this report correspond to the numbers in the Federal Receiver's plan. Thus, #1-3 and #5 are relevant to telehealth, whereas #4 and #6 are not.

338 California Department of Corrections and Rehabilitation, Correctional Healthcare Services. *Healthcare Department Operations Manual, Telemedicine Specialty Services and Primary Care*. Sacramento, C.A., Revised March 25, 2024. https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch03-art4.1.pdf.

resources on those tools. This enabled CDCR to ensure all 33 of its institutions have telehealth carts.[339]

2. **Providing Primary Care at Headquarters:** Uses Telehealth Coordinators at the central level to facilitate primary care visits for institutions with staffing shortfalls.
3. **Designating Employees and Resources for Telehealth:** Promotes the productivity of the telehealth program without a need to draw on resources or employee time outside the program. Each CDCR institution has a designated Telehealth Coordinator and specialty room for telehealth appointments attended to by a registered nurse.
4. **Listing the Types of Specialty Care Services Authorized for Telehealth:** Promotes uniformity in practice and reduces the need for employees to use discretion in considering whether treatment should be performed on-site or off-site.

Immigration and Customs Enforcement Health Service Corps (IHSC)

IHSC is a good benchmark organization due to its responsibilities for providing healthcare in the context of a custody-oriented mission. In addition, the BOP and IHSC have communicated to share knowledge about the elements that comprise robust telehealth policies.

IHSC is responsible for providing medical care to individuals in its custody. Based on detainee population, IHSC's healthcare system is roughly the size of one of the BOP's six regions. Initially, IHSC's telehealth program solely offered telepsychiatry services. IHSC expanded the scope of its telehealth services to include behavioral health to address mental health in the intervening years. At the headquarters level, the Telehealth Program Manager and Analyst support the coordination of telehealth within IHSC facilities. At the local level, the facility Triad consists of an HSA, CD, and Nurse Manager to assist with the coordination of telehealth services.

IHSC Telehealth policy outlines the steps that medical professionals should take in providing effective care. It leverages health promotion, disease management, and telehealth technologies to provide remote clinical, specialty care services, detainee and professional health-related education, and consultation services. IHSC policy also outlines requirements for its providers like credentials. It lays out responsibilities for the Clinical Services Support Units to develop, review and update policies and official guidance for implementing administrative and clinical procedures related to telehealth services while also provides administrative oversight, guidance, and training on the utilization of telehealth technologies.

IHSC clinicians must promptly document care provided in the patients' electronic health records (EHR) based on existing IHSC policies and the IHSC Health Records Management Operations Memorandum. Non-IHSC personnel and contractors are required to document the care they provide promptly and transmit all information about encounters to IHSC electronically. IHSC facilities are responsible for entering that information into patients' EHRs.

[339] CDCR uses at least one dedicated telehealth cart for appointments with contracted specialists and one additional cart for primary care appointments at each institution.

IHSC utilizes the five effective practices below to help ensure that patients receive care that is timely, efficient, and of high quality. They also help it to make best use of telehealth services, which drives down the resources it would otherwise use on off-site medical trips.

1. **Advanced Equipment:** Provide flexible viewing angles by using wide-angle, high-definition video cameras to enhance the clinical aspects of communication such as body language or other physical symptoms.
2. **Medical Documentation Accessibility:** Access the patient's health record in real-time during telehealth encounters.
3. **Training:** Ensure that employees are well-trained by effective communication means and understand how to troubleshoot minor issues to provide quality care for patients.
4. **Maintain Proper Virtual Bedside Manner**: Make care more patient-centered.
5. **Strategy:** Set clear goals for the utilization of Telehealth Services while utilizing group sessions to address behavioral health concerns.

Massachusetts General Hospital (MGH) Center for Telehealth

The MGH Center for Telehealth is a long-standing and comprehensive telehealth program. MGH has been a pioneer in telehealth since 1967 when Dr. Kenneth Bird established one of the first telemedicine programs in the United States connecting the hospital to Boston's Logan Airport to assess the health of ill travelers virtually. Dr. Bird proposed using television cameras to examine patients remotely. One camera would be at Logan Airport, while the other remained in an MGH emergency room. The system enabled real-time video consultations, the transmission of electrocardiogram (ECG) images, and microscopic examination of urine and blood samples.[217] In 1970, MGH expanded services to include psychiatric care for veterans by partnering with Veterans Affairs Hospital. After years of refining processes and protocols that enable remote clinical care models, MGH created telehealth services for specialties such as neurology and stroke clinics. Due to the initial success of the program, it decided to invest in telehealth by creating the MGH Center for Telehealth to centralize its telehealth resources, strategy, and coordination. It has become a model for healthcare organizations owing to its research-driven approach.

The Center for Telehealth maintains a robust and comprehensive telehealth policy. It lays out the purpose and approved service array for its telehealth operations including consultations, follow-up appointments, urgent care, and primary and specialty care for chronic conditions. The policy also authorizes providers to use a wide array of devices such as tablets, computers, and smartphones to conduct telehealth appointments.

The Center for Telehealth utilizes the following five effective practices to support the success of its program:

1. **Secure Technology:** Uses a secure version of its videoconferencing platform of choice that is designed for healthcare visits, helping to ensure patient privacy and data security.
2. **Pre-appointment Preparation:** Medical assistants contact patients in advance of telehealth appointments to ensure a stable internet connection and that MGH's security requirements are met. It tests all equipment and medical instruments in advance of appointments to ensure they are in good working order.

3. **Contingency Planning:** Providers or their assistants provide patients with alternative means to contact them if they are unable to connect using their preferred method.
4. **Education and Support:** Provides training materials such as videos, written instructions, and a list of frequently asked questions to its employees and patients.
5. **Ongoing Research:** Conducts research on telehealth's impact on patients' access to, and perception of, care as well as their clinical outcomes on an ongoing basis.

Internal Model of Effective Practice – FMC Lexington

FMC Lexington, visited by the research team, provides a good example through which to understand the potential of telehealth operations at the institutional level. HSD considers it to be its flagship institution for the Telehealth Program. It was among the first three institutions to establish telehealth operations beginning in 2001 and has made improvements to those operations since.[340] FMC Lexington's CMSC is the University of Kentucky (UK), and the institution's telehealth program benefits from a longstanding and fruitful partnership with the UK Telecare Department. It currently provides medical services to an average of 100 AICs through telehealth and operates 25 specialty clinics. FMC Lexington also employs the effective practices that the Effective Practice section of this chapter highlights. According to HSD, FMC Lexington's telehealth operations are saving about $1.2 million each year.[341] The following four effective practices, drawn from employee and AIC interviews and the team's site visit, make FMC Lexington's telehealth program a model for other institutions:

1. **Robust Data Collection**

   FMC Lexington maintains a dataset that quantifies the results of its telehealth program. The dataset lists the 25 specialty types it uses off-site providers for, as well as the four specialties that use telehealth on-site. Each of those items is tied to a combined five performance metrics and cost factors. These are:

   1. Number of AICs seen
   2. Cost of off-site medical trip
   3. Cost of telemedicine appointment
   4. Number of clinics
   5. CMSC provider billing rate

   Robust data collection allows FMC Lexington to identify resource needs based on the volume of AICs it is treating, measure cost avoidance attributable to telehealth, as well as report quality data to decision-makers in regional offices and Central Office.

2. **Partnership with the University of Kentucky**

   FMC Lexington's comprehensive medical services contract with UK provides access to a wide range of specialty providers. UK's academic orientation means that many of its

[340] FMCs Rochester and Springfield were also among the first institutions to establish telehealth operations.
[341] This is a conservative estimate because it only accounts for savings on employee time for the minimum two correctional officers required to escort AICs to outside medical appointments. It does not yet account for other factors, like differences between billing rates between virtual and in-person appointments, or the additional correctional officers needed to escort higher security level AICs to outside appointments.

healthcare providers are interested in research, the unique profile of the AIC patient population, and promoting their work by serving as champions for greater telehealth adoption and presenting at conferences with FMC Lexington employees. The observable collegial nature of the partnership produces a healthy and effective working relationship between the two parties. In addition, UK's work with FMC Lexington exposes its students to potential job opportunities at the institution through word of mouth and internship programs.

3. **Strong Resource Allocation Strategies**

   FMC Lexington employs resource allocation strategies that promote efficiency in its use of physical space and employee time. FMC Lexington set aside "telehealth suites" in its floor plan to dedicate space for telehealth appointments. This enables it to conduct a greater volume of telehealth appointments simultaneously and prevents telehealth carts or other equipment from taking up space in other health services spaces. FMC Lexington also dedicates days of each week to different specialties, such as dedicating the telehealth space, equipment, and employees to cardiology appointments on Mondays. This practice increases the timeliness of care for AICs while reducing costs to the institution because it reduces the need for employees to escort AICs to their telehealth appointments in small numbers and off-site providers are often willing to charge less per patient for clinics than individual patients.

   In addition, FMC Lexington employees work with UK to set aside dates and times on providers' schedules for telehealth clinics as many as 12 months in advance. They confirm the appointments at least two weeks in advance. This allows them to schedule appointments for AICs in short order once their care is approved. The employees' approach to scheduling ensures that there is a supply of providers available to meet the demand for telehealth appointments. It also allows time for the institution employees and CMSC providers alike to coordinate and review the patient's information and be better prepared for appointments.

4. **Technical Assistance and Operational Support to Other Institutions**

   FMC Lexington has helped other institutions set up network infrastructure and equipment for their telehealth operations. It also provided training on the equipment and clinical procedures for appointments, as well as guidance for coordinating with outside providers of telehealth services. It maintains "quick reference guides" on topics like licensure, troubleshooting, and clinical procedures by specialty type that it provides to other institutions upon request.

Analysis of the BOP's Telehealth Program

This section assesses benefits derived from telehealth, as well as the barriers and limitations to greater implementation in the context of the Telehealth Program. The subsection on barriers and limitations identifies gaps between the current state of the Telehealth Program and HSD's desired future state for the program. It also explains why this report is unable to make an empirical assessment of the quality, timeliness, and efficiency of the Telehealth Program related to patient

outcomes. The chapter concludes by providing recommendations for addressing gaps between the current and future state.

Benefits of Telehealth

The following list divides the benefits derived from the telehealth program into the categories "People", "Process", and "Technology" to make them more easily identifiable.[342]

Benefits Related to People

- **Employee Time:** Telehealth enables institution employees across departments to use their time more efficiently. For example, correctional employees can spend time ordinarily used to escort AICs to off-site medical appointments and clinics to focus on safety issues within the institution, while health services employees may prioritize work on consults. The Telehealth Program also has the potential to redistribute institutional providers' duties for conducting chronic care visits. Such practices help to alleviate the strain that institutions short on providers experience.

Benefits Related to Process

- **Data, Cost Avoidance, and Employee Scope of Duties:** Certain data points would be logical for institutional telehealth employees to collect as they go about operating their programs. For instance, they could collect specialty provider treatment rates for individual appointments and clinics for both in-person and telehealth consults. This data could inform both the institutions' telehealth operations and utilization management because specialty provider rates for telehealth are often cheaper than they are for in-person consults. Institutions could use the data to help them determine if they could have avoided costs during their utilization retrospective reviews, which assess the efficacy of care and resource utilization for completed treatment. Utilization prospective reviews could even beneficially use the data to choose a most cost-efficient option between sending AICs on off-site medical trips or to telehealth consults.

Benefits Related to Technology

- **Access to Care:** Telehealth broadens an AIC's access to healthcare by providing clinical care not available on-site. It can also increase the number of medical providers in the community willing to work with institutions on a contractual basis simply because it does not require AICs to be present in their offices, where they can draw undue attention from their patients who are not incarcerated. Telehealth also provides inherent incentives to contract providers by eliminating travel time and associated costs. Telehealth is a strategy for geographically remote institutions to address backlogs in care left by staffing shortages. They can also use it to increase the number of specialty practices available to them by searching outside of their local communities where there are often few specialty practices. Furthermore, institutions can better accommodate the medical needs of specialty

[342] The benefits and topics in each category are closely connected to one another within the content of telehealth. This is especially true for "Process" and "Technology". Telehealth, by its very nature, employs technology that produces dramatic differences in the logistics or "Process" by which patients attend their appointments.

populations by adding instruments to their telehealth carts (e.g., ultrasound probes for female AICs).

- **Timeliness and Quality of Care Reduce Risks:** Institutions provide care to AICs more quickly by using telehealth because off-site medical trips require more scheduling and logistics like ensuring there are enough correctional officers available to escort AICs to their appointments. Relatedly, institutions save time on logistical matters in those cases when AICs' medical issues require follow-up telehealth appointments. In addition, telehealth for both primary care and specialty care helps institutions to identify and address AICs' medical needs in a timelier fashion than off-site medical trips. This helps to them to reduce or mitigate instances where AICs' medical conditions become chronic and/or worsen over time. In turn, institutions reduce their risk profile for failing to provide AICs with appropriate, adequate, and timely care.

Barriers and Limitations to Telehealth

The BOP has not realized the full benefits of telehealth described above due to some barriers and limitations described in this subsection. HSD's internal analyses found that three of the top barriers to greater implementation of the Telehealth Program are:

1. **Lack of Local Awareness/Support:** There is a need for a lead telehealth professional at each institution.
2. **Problems with Equipment:** Some institutions encountered issues with broken or missing pieces of equipment.[343] Some had allowed the software licenses for their equipment to lapse following long periods of storage prior to installation.
3. **Lack of Trained Patient-Side Employees:** There is a need for telehealth coordinators at institutions to ensure AICs get to appointments on time and mitigate the number of cancellations to maintain good working relationships with telehealth providers in the community.

Research for this report confirms that these barriers persist to the present and indicates additional limitations related to people, process and technology.

Limitations Related to People and Process

- **Quantity and Quality of Telehealth Services:** It is not possible to conduct a high-quality empirical analysis of the quality and outcomes of the BOP's telehealth program during the timeframe allocated to researching and writing this report. There is no routine data captured and collected across the organization specific to telehealth apart from an equipment roster. Standardized metrics on telehealth are not tracked on a regular basis because of a shortage of leaders and employees responsible for telehealth at each level of the organization. There are plans to develop a standardized list of metrics and track them once the aforementioned NTA and RTA positions are filled. Therefore, this report's analysis of the quantity and quality of the telehealth services provided is limited by a lack of the following inputs:

[343] GlobalMed committed to addressing all software and hardware issues with telehealth carts until all BOP equipment is fully functional.

- A large enough sample of sites with the requisite data to represent the enterprise;
- Number of telehealth appointments/clinics completed across the sample;
- Medical follow-up data on AICs that received telehealth services and/or AIC surveys on their perception of care;
- Common software and data input rules that would allow the BOP to combine data from its institutions; and
- Comparable datasets from outside organizations that provide telehealth services.

- **Dedicated Staffing:** To successfully implement a robust telehealth program, it is essential that at least one ITC that is a medical professional is physically stationed within an institution and available to help other employees troubleshoot equipment; connect with outside providers; and train individuals on properly administering a telehealth appointment. Without this stationary individual, institutions can be confused on who to contact when having trouble with administering telehealth appointments. It is also important to note that this provider must have approved clinical privileges before conducting telehealth services.

Limitations Related to Technology

- **Scope of Care:** Although some primary care and specialty care can be administered, certain physical examinations and procedures cannot be performed remotely, restricting the scope of care that can be provided through telehealth. For example, a neurosurgical consultation requires an AIC to physically see a physician so the physician can physically touch the area of concern and possibly administer further testing.
- **Community Infrastructure:** Some institutions are challenged to build robust telehealth operations because providers and hospitals in their local communities lack the necessary infrastructure, equipment, and technical knowledge to support it.

Recommendations on Telehealth

Recommendation 6.1 (People): Hire or designate an ITC at each institution. Consider classifying ITCs at Care Level 3-4 institutions as no-bid, no-pull positions, and ITCs at Care Level 1-2 institutions as an addition to clinical duties.

- ***Rationale:*** CDCR employs a mix of no-bid, no-pull ITCs, and ITCs with multiple duties. Correctional institutions with high care level designations and/or large AIC populations are challenged to administer the needed volume of telehealth appointments because of the preparation and time required. Having the same individual ITC in the same location every day provides a central point of contract employees and CMSC providers to reach out to with operational matters. On the other hand, institutions with lower care level designations and/or small AIC populations typically have very few clinical providers and need to employ an "all-hands-on-deck" approach to healthcare. At times, ITCs at such institutions need to put their telehealth duties on hold to assist with clinical care outside the context of telehealth. Designating some ITCs as no-bid, no-pull would also promote a patient-centered approach for AICs. Having the same individual ITC in the same location every day helps maintain continuity of care because they can build rapport with AICs, and the AICs know where to go to ask questions about their appointments or treatment. HSD

might consider maintaining institutions' authority to assign clinical tasks that are unrelated to telehealth to their ITCs at Care Level 1-2 facilities provided the institutions assign such duties when telehealth coordination services are not urgently needed or backlogged.

HSD should work with the goal of implementing this recommendation within 5 years**.** It has a strong three-to-five-year vision for the telehealth program that could both improve healthcare outcomes for AICs and produce substantial cost-savings. While the forthcoming dedicated telehealth positions will help advance that vision, there will still be few ITCs. All but one of the forthcoming positions were authorized in one year. HSD should continue requesting FSA positions and/or hiring additional non-FSA positions in its Telehealth Program in the coming years to realize its full potential. Implementing this recommendation within five years would put the necessary employee resources in place to support HSD's future vision.

- ***Priority (Top Priority):*** The BOP would significantly reduce its expenditures on off-site medical trips if every institution had access to telehealth services. This recommendation would add greater certainty that trained employees are in place to support HSD's five-year future vision for the Telehealth Program. This recommendation requires additional resources to implement.

Recommendation 6.2 (Process): Include the following elements in the forthcoming HSD program statement on telehealth: Purpose; Applicability; Authorities and References; Policy; Responsibilities; Procedures; Historical Notes; Definitions; Applicable Standards; Privacy and Recordkeeping; No Private Right Statement; and Point of Contacts. Continue to engage with robust telehealth policies from other organizations to inform HSD's draft program statement. Adhere to the following philosophy on flexibility to support this recommendation: Maintain flexibility in the final policy by including guidance in the place of requirements for the institutional level, where possible. For example, the BOP's Program Statement on Patient Care makes suggestions about the membership of institution URCs but does not set forth requirements about that membership. This allows employees to work within the constraints (e.g., mission-focus, staffing, and security levels) of their respective institutions.

- ***Rationale:*** HSD currently lacks a policy to govern the Telehealth Program. Instead, it is governed by memorandums addressing narrow topics, as discussed in the Background section. This makes it difficult to set standards and drive uniformity across the regions and institutions. Completing the policy in 12 months will support the dedicated telehealth positions as they are filled and tasked with further implementation of the Telehealth Program.

  HSD has already connected with IHSC to learn about topics it should address in its telehealth policy. It can supplement that knowledge by reviewing policies from other organizations like CDCR, including the summary of effective policy elements provided in the Benchmarks Using Telehealth section of this report above.
- ***Priority (Medium):*** A telehealth policy could set forth, at least in part, the BOP's vision for the Telehealth Program, standard operating procedures, and roles and responsibilities. This recommendation should not require additional monetary resources.

Recommendation 6.3 (Technology): Develop and implement a national training curriculum on clinical and technological topics in the Telehealth Program using the "quick guides" that FMC Lexington maintains on both types of topics. Assign RTAs to conduct virtual training sessions on the curriculum for institutions in their respective regions. HSD should implement the training immediately after it completes its planned purchase of more telehealth carts, sends them to institutions, and those institutions have connected network cables to the carts. It should also continue using employees from institutions with robust telehealth procedures and operations, and experience, to support other institutions with nascent telehealth operations.

- ***Rationale:*** Some employees at institutions lack experience using telehealth carts. This can be related to technical setup, troubleshooting audio, video, and internet connectivity issues, as well as using certain medical instruments. This issue is compounded by the variation in types of telehealth carts that a given institution has. Depending on the model, a telehealth cart can be free-standing, wall-mounted, or intended for use as a desktop unit. Oftentimes, institutional employees also have questions about coordinating with their CMSC's providers and the different clinical procedures for different types of specialty consults. Providing a standardized training curriculum would help to promote consistency in practice across the Telehealth Program and help HSD determine which telehealth carts are inoperable due to user error rather than manufacturing defects.
  HSD should administer the training virtually rather than in person because, somewhat counterintuitively, institutional employees can work hands on with their equipment in real-time rather than watching someone else use it in-person. This also allows the trainers to identify the specific models of telehealth carts a given institution is using and provide tailored guidance for those models.
- ***Priority (Medium):*** Implementing this recommendation will facilitate HSD efforts to set up new telehealth operations at institutions more rapidly. It will not require significant additional resources because training can be administered virtually and in a short amount of time. However, this recommendation is not likely to result in impacts that HSD can measure directly like cost-savings.

Recommendation 6.4 (Technology): Develop standardized set of performance metrics for the Telehealth Program and require institutions with telehealth operations to track data associated with each of them. The performance metrics should address costs and cost-savings, volume and efficiency, and patient outcomes. Create or select a single software application for institutions to enter that data in and set forth rules for data entry practices to ensure they can be amalgamated and analyzed at the Central Office level. Require institutions to report telehealth data to the RTAs on a regular basis (e.g., monthly or quarterly). Perform the two actions below on data projection and continuous improvement to further the impact of this recommendation.

1. (Process) Conduct a survey to update internal analysis on the status of the Telehealth Program's implementation across the institutions in 2022. Update projections for cost-savings attributable to the Telehealth Program and make projections for the next five years.
2. (Process) Use the performance data to implement a continuous improvement process, track accomplishments, and demonstrate progress to decision-makers in Central Office, the Department, and Congress.

- ***Rationale:*** Metrics should provide information about the quantity and quality of telehealth provided to AICs and their health outcomes, as well as costs and cost avoidance. HSD can use them to identify cost drivers in off-site medical services and opportunities for cost avoidance. These practices would improve HSD's ability to request and justify additional resources to expand the Telehealth Program. Some examples of performance metrics to consider are:
  - Number of telehealth appointments and clinics completed
  - Cost of off-site medical trip
  - Cost of telemedicine appointment
  - Costs avoided on correctional officer time for off-site trips[344]
  - Costs avoided on provider rate for telehealth vs in-person
  - Average length of time from request to completed appointment for telehealth
  - Average length of time from request to completed appointment off-site
  - Clinical outcomes associated with completed care
  - AIC survey ratings of quality of care completed

  Instituting a continuous improvement process for the Telehealth Program will help HSD to devise the steps it needs to take to improve based on its performance data. It will also help HSD to identify and articulate its resource requirements and accomplishments. The National Academy of Public Administration's report entitled "Organizational Assessment for U.S. Forest Service Research and Development" (2019) explains continuous improvement processes within the context of strategic planning and provides guidance for their implementation.[345]

  HSD should work to implement this recommendation within the next 16 months after the new dedicated telehealth positions are filled, then implement the actions related to projections and continuous improvement during the following budget performance cycle.

- ***Priority (Medium):*** Enhances ability to identify cost drivers and observe where cost avoidance opportunities present themselves, as well as justifies more resources for the telehealth program to produce greater cost avoidance on outside medical trips.

Recommendation 6.5 (Technology): Conduct cost-benefit analyses to assess the value of renovating institution floor plans to create dedicated telehealth spaces in institutions with telehealth programs.

- ***Rationale:*** Many institutions as organized lack the space needed and/or appropriate spaces for telehealth equipment. Some telehealth carts are in individual offices, and others are in medical triage rooms rather than a separate exam room or other form of dedicated space. However, there are institutions that have spacious conference rooms that go unused most days or other spaces could be repurposed and equipped for telehealth. Implementing

[344] It is essential that HSD set a standard methodology for calculating this number for comparability. For example, all cost avoidance calculations assume that an off-site medical trip requires two correctional officers for escort.

[345] See pages 41-47; 50 in: National Academy of Public Administration. *Organizational Assessment for U.S. Forest Service Research & Development*. Washington, D.C., 2019. https://s3.us-west-2.amazonaws.com/napa-2021/studies/us-forest-service-assessment-of-research-development-function/Final_NAPA_Report_11.6.19.pdf.

this recommendation would prevent bulky equipment from getting in the way of health service departments' operations unrelated to telehealth. FMC Lexington's telehealth suites allow it to conduct multiple telehealth appointments simultaneously. This infrastructure also helps it be so efficient that employees can schedule clinics for providers to see multiple patients rather than individual appointments. The result is improved timeliness of care and cost-savings in the form of employee time and lower medical bills per AIC, as billing rates for clinics are usually lower per patient than individual appointments. This activity would also benefit the BOP by identifying underutilized space that can be allocated more efficiently to activities other than telehealth.

- ***Priority (Medium):*** Institutions can use employee time and facility space more efficiently to improve timeliness of care and save on medical bills and off-site medical expenditures. This recommendation requires additional resources in the short-term and preserves resources in the long-term.

Recommendation 6.6 (People): Encourage local employees to bring telehealth providers from their respective CMSCs and supplementary contracts into the institutions to promote effective coordination between the two groups.

- ***Rationale:*** FMC Lexington employees improved their working relationship with telehealth providers from UK by inviting them into the institution. This practice afforded the UK providers the opportunity to familiarize themselves with the institution's telehealth employees and prospective patients, layout, and operations. FMC Lexington employees found that informing UK providers resulted in more efficient and effective telehealth appointments. UK providers began to make more precise requests that were easier for institution employees to act on because they considered how healthcare operations in corrections differ from those in community healthcare settings.

  Institutions might use other or additional methods to engage with providers in the community that are part of their respective CMSCs. For example, organizing community stakeholder forums, participating in local health fairs, and contributing to training programs for community healthcare providers by offering Continuing Medical Education credits on correctional healthcare practices to local providers.

- ***Priority (Low):*** Implementing this recommendation would create marginal benefits for the efficiency of telehealth appointments and help institutions retain contract providers. This recommendation requires relatively little additional resources to implement.

Recommendation 6.7 (Process): Encourage institutions or groups of institutions to partner with multi-state telehealth organizations.

- ***Rationale:*** Some institutions are challenged to secure telehealth services from community providers due to lack of supply and the structure of comprehensive medical services contracts. As noted above, institutions have comprehensive medical services contracts that preclude them from seeking telehealth services from providers outside of those contracts. Thus, institutions do not have direct access to the full supply of providers in their local and regional markets.[346] Once their comprehensive medical contracts

[346] Comprehensive medical services contracts contain provisions that prevent institutions from contracting with other providers for healthcare services.

services expire or can be renegotiated, institutions could contract with multi-state telehealth organizations and exempt those services from such restrictive provisions in their comprehensive medical services contracts going forward. Multi-state telehealth organizations consist of providers licensed across multiple states and/or located in different states. This makes them better suited to provide telehealth services to multiple institutions within any given region including those in communities lacking providers. HSD should work to implement this recommendation during the next several years as current medical service contracts expire.

- ***Priority (Medium):*** Implementing this recommendation would improve access to, and timeliness of, care for AICs located in isolated institutions, thereby reducing those institutions' risk profile.

Recommendation 6.8 (Process): Follow guidance from the literature on change management and organizations that are subject matter experts on telehealth in implementing the forthcoming organizational structure for the Telehealth Program.

- ***Rationale:*** As noted, HSD plans to complete a written policy and advance hiring actions to better establish an organizational structure and standard operating procedures for the Telehealth Program. It aims to fill most of its new positions by the end of this fiscal year. Since organizational change is often fraught with difficulties related to ownership, communication, continuity of operations, and culture, the text below lists sources that may help HSD to guide the Telehealth Program through a more efficient and effective transition. It should utilize these principles on an ongoing basis with particular emphasis during the first 18 months of implementation.

Literature

- The literature on organizational theory and change management discuss guiding principles like span of control (preventing one individual from supervising too many individuals or programs), recommended steps for implementing organizational change, and key indicators of success in change efforts. This report provides a synthesis of that literature and the sources it is derived from in Appendix H.

Telehealth Organizations*

- NIJ provides a roadmap for implementing telehealth in correctional facilities and cost estimation tools for telehealth.
- ATA provides guidance for pressure-testing telehealth systems to enhance data security and continuous employee training on risk identification.
- HHS publishes materials that telehealth organizations can use in implementing data security, language accessibility in treatment, billing, and appointment procedures for different healthcare specialties.

*Refer to the Effective Practices section for summaries of, and links to, these resources.

- ***Priority (Medium):*** Implementing this recommendation will increase the speed of implementation, pre-empt resistance to change, and promote appropriate span of control. However, it will not produce many directly measurable benefits like cost-savings. It will

increase the speed of implementation, pre-empt resistance to change, and prevent too many direct reports.

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Conclusion

This report provides an independent and comprehensive assessment of healthcare as provided by the Bureau of Prisons (BOP) to adults in custody (AICs). This one-year study was concluded by a joint team consisting of researchers from Jefferson Consulting Group and the National Academy of Public Administration. The team reviewed documents, dashboards, and reports used by the Bureau. The team conducted several hundred individual interviews with BOP employees working in Central Office, regional offices, and in institutions. The team made 3–5–day visits to 12 of the Bureau's 121 institutions, affording opportunities to interview over 170 AICs, examine equipment and facilities, and observe mental and physical intake procedures, treatment and clinics. Finally, the team engaged with external organizations to learn about other healthcare practices. These sources of comparative information include select state correctional institutions, other federal agencies, and a private hospital system.

The study's scope of work reviewing healthcare practices is wide ranging and has three distinct parts. Task 1 is a charge to review medical and mental health processes from the point an AIC enters the BOP through release. Not surprisingly, this chapter is the longest and most extensive. Two additional project tasks are more specific, and those chapters are shorter. Task 2 is an assessment of the current utilization review process compared with other healthcare systems. Task 3 is an assessment of the current telemedicine process.

At the outset, it is helpful to offer five important factors that characterize the operating environment, and which impact the provision of healthcare.

- This is a large enterprise to lead and direct. It has 121 institutions located across the contiguous U.S., Hawaii, the District of Columbia, and Puerto Rico. It has more than 37,000 employees and over 158,000 AICs.
- Health conditions of the incarcerated population tend to be far more varied and acute than the general population.
- The average number of AICs in each institution is about 1,306,[347] which is a sizable patient population for the relatively small number of healthcare professionals available as caregivers for each institution (note that, unlike community medicine, the Bureau cannot quickly and easily call on temporary doctors, nurses, and other medical professionals to fill gaps).
- Providing healthcare inside institutions is rendered more complicated by several factors unique to prisons. These include but are not limited to (1) challenges to recruit and retain healthcare professionals wishing to care for the incarcerated; (2) due to security concerns, an imperative to maintain safety whenever "outside the walls" clinical visits need to be provided; and (3) security lockdowns inside institutions, which occur frequently in many, restrict AIC movement and thus exert additional work responsibilities on healthcare employees to deliver care, perform ongoing procedures, and deliver critical medicines to AICs daily at each individual cell.

[347] This figure is an estimate and is calculated by dividing the total number of AICs (using 158,000) by the number of institutions (121).

- Financial constraints in the form of annual fluctuations in levels of congressional appropriations result in challenges to long-term planning and investments into healthcare improvements and can leave unfunded promising new projects that can improve healthcare.

While the previous five issues are not exhaustive, they provide a basis and context from which readers may draw important conclusions for this report. As a starting point, there is an overarching view that the current cohort of about 2,900 Health Services employees seek to provide the very best of physical and mental healthcare to AICs. Team interviews with both employees and AICs underscore this professional commitment to provide quality care equitably among AICs. While all have received security training and always have protective equipment while at work, each person the team observed approached AIC care with the utmost respect and professionalism. This factor is an important starting point to this assessment, which both commends good practices and identifies with specific recommendations how healthcare could improve.

Notwithstanding the positive starting point, there remain many actions that can be taken to improve care. This report has 70 in total. Rather than list all of them in this chapter, it is best to highlight seven important focus areas that capture most of the recommendations. Distilling the list of proposed actions in a summary manner can enhance a view of key issues on which to focus going forward. While not fully comprehensive enough to capture each of the report's recommendations, the following seven focus areas offer a reasonable set of themes:

1. **Communications**: Synergies and creativity are gained from encouraging and fostering a culture characterized by a robust exchange of views and ideas from all dimensions and layers of the organization and must include truthful assessments of performance that can lead to improvement. Healthy communication fosters teamwork and advances new ways to provide quality healthcare.
2. **Training**: Training that advances mutual respect for and understanding of the diverse set of employee responsibilities existing within an institution can serve to enhance interactions across boundaries, such as security personnel working with greater understanding of the needs of physical or mental healthcare employees, and vice versa. An institution, which is a quintessential closed environment, can operate with greater efficiency and effectiveness when all employees recognize and appreciate how their jobs are integrated, rather than siloed.
3. **Financial Management**: More detailed and timely healthcare-related financial data, starting at each institution and filtering to regional offices and Central Office is an important tool in managing healthcare costs and can reveal how higher quality healthcare might be provided.
4. **Collaboration**: Rather than assessments of healthy respectful collaboration among various department employees (e.g., Correctional Services, Psychology, Recreation, or Health Services, for example) being more a function of personalities of department leaders in particular institutions, opportunities exist to establish a more effective training and work culture that leads to more of a consistent practice that is characterized in each of the 121 institutions as healthy and thoughtful. Such an environment starts with each team's

leader who is committed to seeing a healthy integrated workplace, where all parts of the organization perform better as a result.

5. **Organizational Wellness**: While this is a focus of a future phase of the team's work with the BOP, it is inevitable that some recommendations touch upon how employees can benefit from actions directed to enhance work/life balance, focus on professional development, and allow for professional skills to be used to the maximum extent possible.
6. **Electronic Health Records**: Improving healthcare within a complex and ever-changing prison environment as large as this is inextricably linked to the quality of the electronic health record system. This report draws attention to such issues as ease of use for providers, which can be improved, and thus more timely care provided. Additionally, there are findings that can lead to better and more complete medical records to enhance AIC care.
7. **Utilization Review and Telemedicine**: The two chapters focused on these topics speak for themselves with recommendations to enhance these important processes. In some respects, this report commends and encourages continued efforts to expand and advance these two areas that are important to providing comprehensive care.

Given the large number of individual recommendations, care has been given to dividing them into priority levels, recognizing that implementation will require planning, sequencing, funding, and staffing to successfully implement them over time. Each recommendation is categorized as deemed as low, medium, high, or top priority based on the assessment methodology described in chapter 2. The following table offers a summary distribution of the report's recommendations.

Task	Number of Recommendations	Top Priority	High Priority	Medium Priority	Low Priority
Healthcare Quality Assessment	57	10	13	18	16
Utilization Review	5	0	1	3	1
Telemedicine	8	1	0	6	1
Total	**70**	**11**	**14**	**27**	**18**

Table 7: *Summary distribution of the report's recommendations.*
(Source: Table created by the team)

This assessment contains dozens of recommendations on how to enhance efficiencies in providing healthcare to AICs (Task 1), many of which call for changes in process or procedure, some minor in scale, and others requiring greater effort. Successful implementation is dependent upon detailed planning and quality communication to employees. Some of these opportunities are low cost and can incrementally enhance initiatives aimed at better tracking healthcare costs that may lead to both improved stewardship of financial resources and further enhance the healthcare enterprise.

The report commends and encourages ongoing efforts, particularly regarding telemedicine. BOP leaders see the value of this instrument as a force multiplier, care accelerator, and as a cost

containment tool. Strong leadership is clearly at the helm of this program's development and expansion. This report offers an independent source of support for this initiative.

Given the broad scope of actions from Phase 1, the subsequent phases of this study will expand upon Phase 1's findings by addressing broader organizational issues, drawing lessons from Norway's correctional system (Phase 2) to improve healthcare and custody integration within the BOP. The ongoing effort in Phase 3 will focus on developing a post-assessment transition plan to help implement recommended improvements and foster a "Culture of Care" for both employees and AICs. Additionally, Phase 3 will focus on assessing the BOP's capacity as an integrated healthcare system, identifying staffing and leadership needs, and enhancing employee safety and wellness to align with overall system improvements.

Given both the integrated and geographically diverse features of the Bureau's operations, as well as its command-and-control functional environment, actions called for in this report will require a collaborative effort across the Bureau, involving engagement and input from all divisions. It is imperative that the leadership of HSD work extensively with senior divisional counterparts to understand and plan appropriately as implementation inevitably impacts colleagues across the institutions, regions, and Central Office. As such, implementation must be seen as an integrated set of actions with maximal exchange of ideas, concerns, and opportunities to enhance success. The top leadership of the Bureau must be prominently seen to set the tone for this organization to continue on its trajectory to perform its mission ever better. This study makes clear that there remain many opportunities to improve healthcare for this unique and medically challenged population. The fact that this report was requested by the BOP can be deemed as evidence of its leaders' aim to improve performance.

Unfortunately, and like any other organization, there are powerful external variables that impact in no insignificant ways how BOP can provide timely and quality healthcare to its 158,000 or more AICs. These include the often fluctuating and insufficient amount of appropriated funds approved by Congress; where institutions are located (often in rural areas far from many every day services); the requirement for on-site work (in a period when remote work is often preferred); issues impacting recruitment and retaining employees such as cost of living and market-based compensation for medical professionals; aging equipment and infrastructure; and lockdowns that often occur and disrupt schedules, obstruct safe movement, and hinder opportunities to provide quality care.

The report's most impactful recommendations cast light on the challenges faced with insufficient financial resources. That said, it is clear from this analysis that there are several low-cost opportunities to incrementally enhance efficiencies and effectiveness in providing healthcare to AICs. Dozens of recommendations are provided that fall into this category: how the Bureau may be able to do more with the resources available - without overworking current employees.

However, provision of quality and timely healthcare, which is undoubtedly a high priority for BOP leaders, cannot be accomplished only by tweaking current processes. Rather, congressional provision of increased funding for the Bureau is an inevitable and important part of achieving an objective to provide quality healthcare for the nation's incarcerated population.

It is within such a context that this report is provided to an organization that seeks opportunities to advance the well-being of both employees and AICs. After all, one day many of these patients will be our neighbors.

Appendices

Appendix A: Team Biographies

Allan Burman, *President of Jefferson Solutions*. Dr. Allan Burman has been a transformative leader since establishing Jefferson Solutions, the government consulting practice of the Jefferson Consulting Group, in 1996. His leadership has seen Jefferson providing a spectrum of services, including analysis, program management, and acquisition assistance to over 70 government agencies. Dr. Burman's distinguished government career includes policy roles in the Office of the Secretary of Defense and the White House's Office of Management and Budget (OMB). As the Administrator for Federal Procurement Policy in OMB, a Senate-confirmed position, he was a pioneer in establishing performance-based contracting and emphasizing outcome-focused federal management practices.

His accolades include being a Fellow of the National Academy of Public Administration, past Chairman of the Procurement Round Table, a Board Advisor at the National Contract Management Association, and a Senior Advisor to Government Executives at the Partnership for Public Service. His educational background includes a PhD from George Washington University, a Master's degree from Harvard, a Fulbright Fellowship at the University of Bordeaux, France, and a Bachelor's degree from Wesleyan University.

Autumn Vea, *Director of Healthcare Consulting*. Autumn N. Vea is a seasoned healthcare strategist with over 17 years in the public health sector, specializing in corrections, community healthcare, Medicaid, and child welfare systems. She holds a Master of Arts in Management from Wayland Baptist University and a Bachelor of Arts in Criminal Justice from the University of Alaska, Anchorage. Autumn's expertise in assessment, planning, policy development, and cross-sector collaboration is underscored by her ability to transform complex healthcare systems, a talent refined through critical roles at the Alaska Mental Health Trust Authority, the Department of Corrections, and the Department of Health, State of Alaska.

As the Director of Healthcare Consulting at Jefferson Consulting Group, Autumn is recognized for her innovative, data-driven assessment and decision-making practices. She leads initiatives that reduce recidivism, manage healthcare programs, and drive regulatory reforms through the implementation of integrated healthcare models. Her commitment to improving population health outcomes through public health methodology and policy development is evident in her leadership role at Jefferson and on the non-profit boards she serves. As the BOP Senior Project Director, Autumn spearheads the assessment and recommendations of a unified national correctional health and wellbeing system to enhance outcomes for both BOP employees and adults in custody.

Janine Karo, *Senior Research Analyst*. Janine Karo is a qualitative researcher who has worked exclusively in the healthcare industry since 2021. As a Senior Research Analyst on this project, she provides research direction, project management structure, and editorial guidance to shape site visits and report creation. Previously at Jefferson, she has supported multiple USAID

institutional support contracts from an administrative and operational perspective. She holds a Bachelor of Arts in Linguistics and Chinese, as well as a Master of Arts in Language and Communication from Georgetown University.

Brenna Isman, *Director of Academy Studies*. Ms. Isman has worked for the Academy since 2008 and provides oversight across the Academy's studies. She recently served as the Project Director for the Academy's project that assisted a national regulatory and oversight board in developing and implementing its strategic plan. She also recently directed the Academy's statutorily required assessments of the National Aeronautics and Space Administration's (NASA) use of its Advisory Council and the Environmental Protection Agency's practices for determining the affordability of regulatory mandates, as well as the Academy's organizational assessments of the U.S. State Department's Office of Inspector General and the Amtrak Office of the Inspector General. Ms. Isman has served as a Senior Advisor on strategic plan development for the Postal Regulatory Commission (PRC) and Social Security Administration (SSA), and organizational change consulting support for the Coast Guard. Her prior consulting experience includes both public and private sector clients in the areas of communication strategy, performance management, and organizational development. Prior to joining the Academy, Ms. Isman was a Senior Consultant for the Ambit Group and a Consultant with Mercer Human Resource Consulting facilitating effective organizational change and process improvement. She holds a master of business administration (MBA) from American University and a Bachelor of Science in Human Resource Management from the University of Delaware.

Roger Kodat, *Senior Project Director*. Mr. Kodat has led more than 40 projects for the Academy. He brings twenty years of commercial and investment banking experience with JPMorgan Chase, and six years of senior level federal government experience at the Department of the Treasury. Appointed by President George W. Bush in 2001 to serve as Deputy Assistant Secretary of Treasury, he was responsible for Federal Financial Policy. Some of his tasks at Treasury included policy formulation for the 2006 Postal Accountability and Enhancement Act; rule making and oversight of Federal loan and loan guarantee programs; and management of the Federal Financing Bank (a $32 billion bank at that time). Mr. Kodat holds a Bachelor of Science in Education from Northwestern University and both an MBA in Finance and Master of Arts (MA) in Political Science from Indiana University.

Kyle Romano, *Senior Research Analyst*. Kyle has provided research support for more than ten Academy studies, including work for the Department of Energy, National Park Service, and the National Oceanic and Atmospheric Administration. Kyle's focus areas include strategic planning, change management, research and development, and environmental policy. He graduated from the Indiana University School of Public and Environmental Affairs with a master's in public administration. Kyle's graduate program also included client-based projects with local governments and programs. He attended the University of Central Florida for his undergraduate studies, where he earned a bachelor's in political science and a bachelor's in legal studies.

Kate Kellen, *Senior Research Associate*. Kate Kellen graduated from Gonzaga University in 2022 with bachelor's degrees in political science, international relations, and Spanish. Ms. Kellen participated in a study for the National Institutes of Health (NIH) reviewing their Central Services function and developing a service catalog for internal use. The purpose of this engagement was to

improve the Central Services function, eliminate duplication, and develop resources for educating the employees on the services provided. Ms. Kellen supported the team by handling administrative tasks, scheduling engagement with NIH and benchmarking agencies, writing a portion of the report, and editing and formatting the report. Ms. Kellen studied the labor and employee relations office of the Federal Aviation Administration (FAA) and provided recommendations for comprehensive change management. Ms. Kellen conducted research on the FAA's labor and employee relations, reviewed benchmarking agencies, handled scheduling, led administrative tasks, and presented final briefings to FAA leadership.

Nadia Faour, *Senior Research Associate.* Nadia Faour joined the Academy in March 2023 as a Research Associate. She serves on studies for the National Science Foundation and the United States Agency for International Development Office of Inspector General. Ms. Faour graduated from George Mason University with a B.A. in Global Affairs concentrating in global inequalities and responses.

Appendix B: Panel Advisory Group (PAG) Biographies

Kristine Marcy (PAG Chair), Former President and Chief Executive Officer, National Academy of Public Administration; Consultant, McConnell International; Chief Operating Officer, Small Business Administration; Senior Counsel, Detention and Deportation, Immigration and Naturalization Service; Former positions with U.S. Department of Justice: Assistant Director for Prisoner Services, U.S. Marshals Service; Associate Deputy Attorney General, Office of the Deputy Attorney General. Acting Director, Deputy Director, Office of Construction Management and Deputy Budget Director, U.S. Department of the Interior; Deputy Assistant Secretary, Office of Civil Rights, U.S. Department of Education; Assistant Director, Human Resources, Veterans and Labor Group, U.S. Office of Personnel Management.

Harold Clarke, Recently retired Director, Virginia Department of Corrections. Former Commissioner, Massachusetts Department of Corrections; Secretary, Washington State Department of Corrections; Director, Nebraska Department of Correctional Services; Former Positions with Lincoln Correctional Center: Unit Administrator, Unit Manager; Former Positions with Nebraska State Penitentiary: Warden, Deputy Warden, Associate Warden/Custody, Assistant Superintendent, Rehabilitation Counselor/Supervisor, Institutional Counselor and Parole Advisor.

Roderick Hickman, Roderick Hickman's primary interest is in improving the delivery of government services to the public in a manner that recognizes the diverse needs of our communities. I specifically want to evaluate and improve the delivery of services to those that are incarcerated or have been previously incarcerated and their families. This issue has numerous impacts on our communities, i.e., fiscal, quality of life, availability of limited government services to all citizens, homelessness, mental health treatment, children services, etc. Positively impacting this small segment of our community will have expediential results.

Deborah Parham Hopson, Deborah Parham Hopson is the Senior Public Health Scientist and Director, Center for Public Health Systems Innovation at The MayaTech Corporation. MayaTech is a small business consulting and technical services firm with a focus on supporting the improvement of public health delivery systems to local, national, and international populations in high need. Prior to joining MayaTech in 2018, Dr. Hopson served as the Senior Health Advisor for the Health Resources and Services Administration (HRSA). She also served as the director of HRSA's HIV/AIDS Bureau for many years during which she was responsible for managing the $2.4 billion Ryan White HIV/AIDS Program which provided funds for medical care, treatment and support services for over ½ million uninsured and underinsured people living with HIV (PLWH) disease in the United States and U.S. Territories.

Clark Kelso, Clark Kelso is a prominent figure in judicial administration in California, having collaborated closely with the state's judicial leadership, as well as Senate, Assembly, and Executive Branch leaders to enhance and reform the California Judiciary and the administration of justice. He served as a consultant and reporter for various significant initiatives, such as the Blue Ribbon Commission on Jury System Improvement and the Business Courts Study Task Force. In addition, he was a primary consultant on trial court unification and authored the Deskbook on the Management of Complex Litigation, a valuable resource for California judges. His contributions

to the administration of justice earned him the Bernard E. Witkin Amicus Curiae award in 1998. Clark Kelso has also held various high-level positions in California's Executive Branch, receiving recognition and awards for his transformative work, including his appointment as federal receiver for California's prison medical care system, charged with making changes in that system to bring it into conformity with constitutional minimums. He is a distinguished legal professional and an accomplished individual in the field of public administration.

Appendix C: List of Interviewees

Central Office:

1. **L. Burns,** Senior Deputy Assistant Director, Admin Division
2. **CAPT S. Cohen,** Chief of Occupational Health and Safety
3. **CAPT M. Crockett**, Chief Health Technology
4. **G. Fearday**, Assistant Administrator for Admin Reentry
5. **L. Geter,** Assistant Director of Programs Division
6. **CAPT M. Gielski,** Section Chief of Quality
7. **S. Grimes,** Executive Assistant for RSD
8. **J. Hemingway,** Senior Deputy Assistant Director for HR Management
9. **CAPT M. Holliday,** Chief Dietician
10. **CAPT M. Hulett,** Chief Nurse
11. **RDML M. Kleiman,** Psychology Transition Chief
12. **RDML M. Johnson,** Chief Dentist
13. **T. Kennon,** Deputy Procurement Executive
14. **Dr. D. Lewis,** Chief Psychiatrist
15. **A. McFarrin,** National Food Service Administrator
16. **K. Murrell,** Deputy Director, Program Review Division
17. **C. Nastro,** Senior Deputy Assistant Director in Program Review Division
18. **CAPT C. Nemeti,** Chief Social Worker
19. **Dr. K. Pistro,** Assistant Director, Reentry Services Division
20. **J. Potope,** National HSA
21. **W. O'Regan,** Chief Financial Management
22. **B. Reynolds,** Chief MH Services and Acting Administrator Psych Services
23. **CAPT T. Rodriguez,** Chief Pharmacist
24. **S. Salem,** Senior Deputy Program Director
25. **CDR C. Schuler,** Chief Population and Correctional Health
26. **Dr. M. Shaw,** Chief Health Programs
27. **Dr. E. Stahl,** Executive Medical Director
28. **CAPT BJ Saunders,** Chief Physical Therapist
29. **S. Thompson,** Assistant Director, Information Technology and Data Division

Regional Offices:

30. **K. Bagwell,** North Central Regional HSA
31. **J. Bennet,** Western Regional Computer Services Coordinator
32. **J. Bratschi,** Regional HR Administrator
33. **D. Burnisky,** Mid Atlantic Regional Correctional Services Administrator
34. **Dr. A. Burgett,** South Central Regional Psychology Administrator
35. **J. Burkett,** Southeast Regional Correctional Services Administrator
36. **J. Cooper,** North Central Regional Correctional Program Administrator
37. **Dr. T. Duvall,** Mid-Atlantic Regional Psychology Administrator
38. **J. English,** Southeast Regional HSA
39. **L. Fick,** North Central Regional Comptroller
40. **F. Fletcher,** Regional HR Administrator
41. **A. Fortenberry,** Southeast Regional Correctional Program Administrator
42. **Dr. J. Gabel,** North Central Regional Psychology Administrator
43. **H. Tellez,** South Central Regional Director
44. **R. Hollingsworth,** Northeast Regional Correctional Services Administrator
45. **C. Hubbard,** Western Regional Correctional Program Administrator

46. **K. Legget,** Southeast Regional Computer Service Coordinator
47. **S. Morseman,** Regional Correctional Program Administrator
48. **D. Nee,** Mid-Atlantic Regional Computer Services Coordinator
49. **Dr. C. Ortega,** Northeast Regional Psychologist
50. **R. Gilliam,** Western Regional HSA
51. **T. Reed,** Western Regional Comptroller
52. **D. Rhodes,** South Central Regional Correctional Services Administrator
53. **M. Rios-Marques,** Western Regional Director
54. **G. Ryle,** Mid-Atlantic Regional HSA
55. **G. Schlottman,** Regional Education Administrator
56. **B. Sinclair,** Northeast Regional Comptroller
57. **CAPT S. Smith**, South Central Regional HSA
58. **S. Stokes,** Northeast Regional Correctional Program Administrator
59. **Dr. J. Thomas,** Southeast Regional Psychology Administrator
60. **G. Travers,** Northeast Regional HSA
61. **J. Welsh,** Regional Education Administrator
62. **J. White,** Western Regional Correctional Services Administrator
63. **Dr. B. Winters,** Western Regional Psychologist

Institutions:

FDC SeaTac:

64. **H. Barron,** Warden, FDC SeaTac
65. **C. Caughill,** Case Manager, FDC SeaTac
66. **G. Cho,** Supervisor Attorney, FDC SeaTac
67. **G. Davalos**, Chief Human Resources FDC SeaTac
68. **G. Dera Quito**, Contracting Officer, FDC SeaTac
69. **R. Figuroa**, RN, FDC SeaTac
70. **Dr. M. Haynick,** Chief of Psychology, FDC SeaTac
71. **CAPT Houtz,** Captain, FDC SeaTac
72. **Dr. C. James,** Psychologist/ Drug Abuse Program Coordinator, FDC SeaTac
73. **Dr. Ryan Nybo,** Forensic Psychologist, FDC SeaTac
74. **K. Posalski**, AHSA, FDC SeaTac
75. **J. Razo**, Recreation Coordinator, FDC SeaTac
76. **J. Yeverino-Flores,** Contract Physician, FDC SeaTac

FCC Coleman:

77. **T. Aulozzi,** Health Services Coordinator, FCC Coleman
78. **Dr. Archer,** Acting Clinical Director, FCC Coleman
79. **A. Ballestros,** Staff Psychology Coordinator, FCC Coleman
80. **M. Berman,** Acting complex HSA, FCC Coleman
81. **J. Benz,** RN, FCC Coleman
82. **L. Boodoo,** NP, FCC Coleman
83. **Dr. C. Brodehl,** Deputy Chief Psychologist
84. **J. Broton,** Warden, FCC Coleman
85. **Dr. T. Brown,** Staff Dental Officer, FCC Coleman
86. **E. Carlton,** Warden, FCC Coleman
87. **J. Carman,** Assistant HSA, FCC Coleman
88. **S. Cooke,** QIIPC RN, FCC Coleman

89. **B. Cornett,** Telehealth Coordinator, FCC Coleman
90. **J. De Guzman,** NP, FCC Coleman
91. **M. Franco**, Recreation Assistant supervisor**,** FCC Coleman
92. **K. Franco,** Contract Physician Coleman
93. **G. Georges,** Assistant HSA, FCC Coleman
94. **Dr. K. Gomez**, Contract Physician, FCC Coleman
95. **Dr. T. James,** Chief Psychologist, FCC Coleman
96. **G. Losse,** Assistant HSA FCC Coleman
97. **A. Mai,** Rotating Chief Pharmacist FCC Coleman
98. **McIntyre,** Operations Lieutenant, FCC Coleman
99. **A. Mendoza,** Warden FCC Coleman
100. **Mendez,** Medical Records Tech, FCC Coleman
101. **J. Middendorf,** Supervisor Attorney FCC Coleman
102. **Dr. J. Nieto,** Chief Dentist, FCC Coleman
103. **C. Morris-Veasey,** Chief Dentist, FCC Coleman
104. **J. Pippin,** QIIPC Consultant, FCC Coleman
105. **M. Piquion,** Nurse Practitioner, FCC Coleman
106. **M. Sterling,** Registered Nurse, FCC Coleman
107. **Suazo- Cruz,** Registered Nurse, FCC Coleman
108. **L. Wilson,** Complex HR Manager, FCC Coleman
109. **S. Withers,** Complex Warden, FCC Coleman

USP Lee:

110. **Dr. L. Baily,** Psychologist, USP Lee
111. **S. Bowman,** Staff Nurse, USP Lee
112. **J. Caroll,** HR Manager, USP Lee
113. **R. Collins,** Unit Manager, USP Lee
114. **J. Gilbert,** Health Services Coordinator, USP Lee
115. **J. Gilly,** Warden, USP Lee
116. **A. Hubbard,** Assistant HSA, USP Lee
117. **A. Rutherford**, HSA, USP Lee
118. **S. Scott,** Registered Nurse, USP Lee
119. **Dr. K. Wasim,** Chief Phycologist, USP Lee

FCC Allenwood:

120. **M. Arviza,** Medium Warden, FCC Allenwood
121. **Dr. S. Barkauskas,** Chief Dentist, FCC Allenwood
122. **J. Bennett-Meehan,** HAS, FCC Allenwood
123. **Blanton,** Tx Specialist, FCC Allenwood
124. **B. Bushman,** Clinical Director, FCC Allenwood
125. **Dr. S. Camp,** Chief Psychologist, FCC Allenwood
126. **D. Christensen,** Complex Warden, FCC Allenwood
127. **Dr. S. Decker,** Advanced Care Level Coordinator, FCC Allenwood
128. **Dennis,** Reintegration Unit FCC Allenwood
129. **E. Donlin,** AHSA, FCC Allenwood

130. **M. Erb,** Senior Officer Specialist, FCC Allenwood
131. **J. Greene,** Low Warden, FCC Allenwood
132. **S. Greene,** Advanced Care Level Psychologist, FCC Allenwood
133. **S. Hernandez,** PA, FCC Allenwood
134. **T. Hugar,** Computer Services, FCC Allenwood
135. **E. Klinfelter,** Captain, FCC Allenwood
136. **G. Moser,** Contract Specialist, FCC Allenwood
137. **J. Moyle**, Paramedic, FCC Allenwood
138. **N. Myers,** HSA Assistant, FCI Allenwood
139. **J. Nearhood,** Contract Licensed Practical Nurse, FCC Allenwood
140. **Dr. M Ring,** Acting Secure MH Stepdown Program Coordinator, FCC Allenwood
141. **B. Rocco,** Chief Pharmacist, FCC Allenwood
142. **J. Stoltz,** PA, FCC Allenwood
143. **S. Snook,** NP (FCI), FCC Allenwood
144. **R. Williams,** Correctional Officer, FCC Allenwood
145. **J. Witmer,** Senior Officer Specialist, FCC Allenwood

FCI Milan:

146. **S. Allison,** Supervisory Attorney, FCI Milan
147. **Dr. K. Aulepp,** Clinical Director, FCI Milan
148. **L. Battle,** QIIPC, FCI Milan
149. **A. Bozeman,** Operations Lieutenant, FCI Milan
150. **Dr. B. Blazer,** Chief Dentist, FCI Milan
151. **C. Dennis,** Supervisory Contracting Specialist, FCI Milan
152. **R. Dixon,** Electronic Technician, FCI Milan
153. **J. Fleenor,** RN, FCI Milan
154. **J. Gilsdorf,** NP, FCI Milan
155. **P. Hernandez,** RN, FCI Milan
156. **S. Horn,** Medical Trip Officer, FCI Milan
157. **N. Kovar,** HSA, FCI Milan
158. **R. Lea,** Unit Team Manager, FCI Milan
159. **R. Moore,** Hygienist, FCI Milan
160. **M. Peek,** RN, FCI Milan
161. **E. Rardin**, Warden, FCI Milan
162. **E. Roskam,** Correctional Officer, FCI Milan
163. **A. Rowe,** Senior Officer Specialist, FCI Milan
164. **Concepcion Serrato,** Recreation Supervisor, FCI Milan
165. **K. Scholl,** RN, FCI Milan
166. **M. Stoddard,** SIS Support Technician, FCI Milan
167. **S. Stotzke,** HSAA, FCI Milan
168. **Dr. A. Tobias,** Chief Psychologist, FCI Milan
169. **U. Udegbunam,** NP, FCI Milan
170. **C. White,** RN, FCI Milan

USP Canaan:

171. **D. Antenori,** Senior Officer Specialist, USP Canaan
172. **K. Bucklaw,** QIIPC, USP Canaan
173. **L. Burns,** HSAA, USP Canaan
174. **R. Carey,** PA, USP Canaan
175. **J. Cassetori,** Dental Hygienist, USP Canaan
176. **K. Compton,** Human Resources Manager, USP Canaan
177. **K. Cox,** FSA MOUD Social Worker, USP Canaan
178. **S. Davitt,** HSAA, USP Canaan
179. **T. Fox,** Recreation Supervisor, USP Canaan
180. **Dr. S. Garavuso,** Staff Psychologist, USP Canaan
181. **F. Garza,** USP Canaan Warden
182. **Dr. R. Hartland,** Chief Dentist, USP Canaan
183. **T. Horeis,** Chief Pharmacist, USP Canaan
184. **B. Koza,** Correctional Officer, USP Canaan
185. **Patrick O'Kane,** Captain, USP Canaan
186. **J. Simonson,** HSA, USP Canaan
187. **C. Stefalo,** Unit Manager, USP Canaan
188. **J. Veina,** AHSA, USP Canaan
189. **Dr. J. Vogt,** Challenge Program Psychologist, USP Canaan
190. **H. Walters,** PA, USP Canaan
191. **P. Zdziarski, RN,** USP Canaan

MCC San Diego:

192. **N. Asgari,** Health Information Technician, MCC San Diego
193. **Dr. C. Brown,** Chief Dental Officer, MCC San Diego
194. **R. Campos,** Warden, MCC San Diego
195. **T. Ferguson,** Recreation Specialist, MCC San Diego
196. **L. Gonzales,** Captain, MCC San Diego
197. **J. Hale,** Licensed Vocational Nurse, MCC San Diego
198. **J. Jareugui,** Forensic Psychologist, MCC San Diego
199. **B. Julian**, QIIPC Consultant, MCC San Diego
200. **M. Kruger,** HAS, MCC San Diego
201. **Dr. Z. Lizarazo,** DAP-C, MCC San Diego
202. **E. Martinek,** Attorney, MCC San Diego
203. **Dr. L. Padala,** Chief Psychologist, MCC San Diego
204. **M. Paredes,** UR nurse Consultant, MCC San Diego
205. **M. Sandoval,** Unit Manager, MCC San Diego
206. **Dr. R. Shahla,** Contract Psychiatrist**,** MCC San Diego
207. **Dr. B. Snyder,** Chief Pharmacist, MCC San Diego
208. **R. Sapozhnikov,** Clinical Director, MCC San Diego
209. **M. Taylor**, HSAA, MCC San Diego
210. **E. Ziegler,** NP, MCC San Diego

FMC Carswell:

211. **A. Adebayo**, Psychiatric NP, FMC Carswell
212. **Dr. C. Allison,** Chief Psychiatrist**,** FMC Carswell
213. **A. Backus,** Respiratory Therapist, FMC Carswell
214. **N. Bahr,** Social Worker, FMC Carswell
215. **L. Barlett,** Director of Nursing, FMC Carswell
216. **A. Burgos,** X-ray Tech, FMC Carswell
217. **L. Cabrera**, Medical Records Admin Specialist, FMC Carswell
218. **M. Chano,** HSA, FMC Carswell
219. **A. Cintron,** Clinical Nurse, FMC Carswell
220. **E. Cottrell,** Administrative Unit Manager**,** FMC Carswell
221. **K. Carpenter,** Occupational Therapist, FMC Carswell
222. **C. Dao,** Deputy Chief Pharmacist, FMC Carswell
223. **Dr. H. Favela,** Chief Dental Officer, FMC Carswell
224. **Dr. C. Feliciano,** Chief Psychologist, FMC Carswell
225. **I. Flores,** HSAA, FMC Carswell
226. **B. Galindez,** Clinical Nurse Manager, FMC Carswell
227. **J. Grimard,** Supervisory Nurse, FMC Carswell
228. **W. Jean,** Staff Physician, FMC Carswell
229. **S. Lee,** Attorney, FMC Carswell
230. **Dr. J. Miller,** Staff Physician, FMC Carswell
231. **M. Nored,** Senior Regional HR Administrator, FMC Carswell
232. **M. Perez,** QIIP Nurse, FMC Carswell
233. **R. Taylor,** Rec Supervisor, FMC Carswell
234. **T. Rule,** Warden, FMC Carswell
235. **F. Serrano,** Clinical Nurse Manager/ UR nurse, FMC Carswell
236. **Dr. M. Serrano-Mercado,** Clinical Director**,** FMC Carswell
237. **L. Smith,** Captain, FMC Carswell
238. **S. Smith,** NP OBGYN, FMC Carswell
239. **M. Stabelin,** Physical Therapist, FMC Carswell
240. **G. Timmons,** Physical Therapist, FMC Carswell
241. **M. Williams-Brown,** Occupational Therapist, FMC Carswell

FTC Oklahoma:

242. **T. Adcock,** Executive Staff, FTC Oklahoma
243. **R. Edmonds,** MR Specialist, FTC Oklahoma
244. **L. Franks,** RN in R&D, FTC Oklahoma
245. **Dr. Hamburger,** Chief Pharmacist, FTC Oklahoma
246. **M. Jackson,** Captain, FTC Oklahoma
247. **Dr. Knight,** Chief Dentist, FTC Oklahoma
248. **M. Kokel,** Recreational Specialist, FTC Oklahoma
249. **L. Lyons,** Head of R&D, FTC Oklahoma
250. **Morrow,** RN, FTC Oklahoma
251. **Nunez-Else,** HR Manager, FTC Oklahoma

252. **V. Olden,** NP, FTC Oklahoma
253. **T. Rainey,** AW, FTC Oklahoma
254. **Roberts,** MR Specialist, FTC Oklahoma
255. **R. Sheffield,** Unit Counselor, FTC Oklahoma
256. **J. Smith,** HR Manager, FTC Oklahoma
257. **L. Stolarzyk,** HSA, FTC Oklahoma
258. **Dr. Thomas,** Clinical Director, FTC Oklahoma
259. **Dr. K. Thomas,** Staff Psychologist, FTC Oklahoma
260. **Dr. Torres,** Chief Psychologist, FTC Oklahoma
261. **K. Zook,** Warden, FTC Oklahoma

FCC Florence:

262. **A. Alvarado**, PHS Lieutenant, FCC Florence
263. **A. Armijo,** AW, FCC Florence
264. **S. Bennet,** QIIPC RN, FC Florence
265. **Dr. Broby,** Chief Pharmacist, FCC Florence
266. **A. Boulware**, AW, FCC Florence
267. **Cillicio,** Warden, FCC Florence
268. **J. Coulter-Rodriquez,** Complex Psychologist, FCC Florence
269. **Dixon,** Warden, FCC Florence
270. **H. Dunderman**, Complex Business Administrator, FCC Florence
271. **M. Galazen,** Recreation Supervisor, FCC Florence
272. **A. Haight,** Reentry Services Coordinator, FCC Florence
273. **S. Hendricks,** QIIPC RN, FCC Florence
274. **K. Keller,** Complex HSA, FCC Florence
275. **Lepe,** Warden, FCC Florence
276. **C. Lindgren,** MR Tech, FCC Florence
277. **S. Mills,** MR Specialist, FCC Florence
278. **S. Nation,** MR Tech, FCC Florence
279. **B. Reeves,** RN, FCC Florence
280. **H. Rhea,** Attorney, FCC Florence
281. **Dr. Roberts,** Chief Dentist, FCC Florence
282. **S. Marlor,** Clinical Social Worker, FCC Florence
283. **B. Schuler,** RN, FCC Florence
284. **M. Shields,** Staff Psychologist, FCC Florence
285. **M. Starr,** Warden, FCC Florence
286. **J. Sturgill,** Captain, FCC Florence
287. **J. Toelle,** Acting Assistant HR Manager, FCC Florence
288. **C. Wisman,** Paramedic, FCC Florence

FCI Aliceville:

289. **B. Blankensopp,** RN, FCI Aliceville
290. **M. Condra,** Contract Mammography Tech, FCI Aliceville
291. **T. Conrad,** HSA, FCI Aliceville
292. **M. Daniel,** PHS Social Worker, FCI Aliceville

293. **S. Davis,** Medical Records Tech, FCI Aliceville
294. **Dr. G. DeJesus,** Resolve coordinator, FCI Aliceville
295. **Dr. Delong,** Chief Psychologist, FCI Aliceville
296. **T. Edgeworth,** Case Manager, FCI Aliceville
297. **E. Etheridge,** QIIPC, FCI Aliceville
298. **S. Hunter,** NP, FCI Aliceville
299. **W. Jenkins,** Specialty Population Coordinator, FCI Aliceville
300. **W. Marshall,** Senior Compound officer, FCI Aliceville
301. **O. Mosby,** Captain, FCI Aliceville
302. **F. O'Neal,** Contract Pharmacist, FCI Aliceville
303. **C. Potter,** AHSA, FCI Aliceville
304. **A. William,** HR Manager**,** FCI Aliceville
305. **L. Windham,** Supervisory Contract Specialist, FCI Aliceville

FMC Lexington:

306. **P. Aviles,** Contract X-ray tech, FMC Lexington
307. **M. Cash,** Camp RN, FMC Lexington
308. **G. Crouch,** HSA, FMC Lexington
309. **G. Dowdell,** Lieutenant, FMC Lexington
310. **Dr. J. Erikson,** Chief Pharmacist, FMC Lexington
311. **D. Gill,** Telehealth Coordinator, FMC Lexington
312. **T. Groninger,** Unit Manager, FMC Lexington
313. **Dr. M. Melendez,** Clinical Director, FMC Lexington
314. **Dr. K. Merchant,** Staff Physician, FMC Lexington
315. **Dr. A. Muhammad,** Medical Officer, FMC Lexington
316. **D. Paul**, Warden, FMC Lexington
317. **A. Reid,** Assistant HR Manager, Acting HR Manager, FMC Lexington
318. **Dr. Van Wagoner**, Chief Dentist, FMC Lexington

Benchmarking and Subject Matter Experts:

319. **Mark Allen,** Pay Systems Manager, OPM
320. **Michael Arca,** Assistant Deputy Medical Executive Telemedicine Services, CDCR
321. **CAPT Bigle,** HPMU Chief-Utilization Management, IHSC
322. **Joy Booth,** AD, GAO
323. **Matthew Bulger,** Niskanen Center
324. **Terri Catlett,** Director, Office of Correctional Healthcare, American Correctional Association (ACA)
325. **Benjamin Chu,** Board member, Geisinger Health
326. **Adam Clausen,** Director of Innovation and Social Impact, Social Purpose Corrections
327. **Dr. Georges Benjamin,** Executive Director, American Public Health Association & NAPA Fellow
328. **Billy Commons,** Attorney, GAO
329. **Tracey Cross,** AD, GAO
330. **Elizebeth Dretsch,** Methodologist, GAO
331. **Brandon Fain,** Utilization Management, IHSC

332. **Richard Forbus,** Vice President, Program Development**,** NCCHC
333. **Dr. Kevin Galpin,** Executive Director, Telehealth Services for Veteran Affairs
334. **CAPT C. Garrett,** Health Program Manager Prisons Division, NIC
335. **Gretta Goodwin,** Director, Homeland Security and Justice, GAO
336. **Robert Green,** Executive Director, ACA
337. **Dr. Gwathney,** Deputy CMO, IHSC
338. **Dr. Jo Ivey Boufford,** International Society for Urban Health & NAPA Fellow
339. **Dr. Matthew Hirschfeld,** VP of Specialties & Pediatrician, All Alaska Pediatric Partnership
340. **Jeanne Jacobson,** Senior Policy Analyst, OPM
341. **Larry Jessup,** Branch Chief, ONC
342. **Carey Jones,** Manager, OPM
343. **Valerie Kasindi,** AD, GAO
344. **Dr. Tom Kane,** Former Acting Director of the Bureau of Prisons & NAPA Fellow
345. **Clark Kelso,** Federal Receiver, California Prison Medical Care & PAG member
346. **Michael Machoney,** Manager of Hiring Policy Office, OPM
347. **Dr. Geno Migliaccio,** Associate Dean for Applied Public Health, George Washington University & NAPA Fellow
348. **Susan Morris,** Culture Coach, Social Purpose Corrections & former BOP HR Director
349. **Dr. Woodrow Myers,** Physician & Director**,** Myers Ventures LLC
350. **Thomas Novak,** Senior Advisor State Policy, ONC
351. **Jason Parman,** Human Resources Solutions, OPM
352. **Joseph Ratcliffe,** GS locality pay and special rate requests, OPM
353. **Dr. Rivera,** CMO, IHSC
354. **Brenda Roberts,** Deputy Associate Director, OPM
355. **LCDR Tonya Smith,** Utilization Management, IHSC
356. **Dr. Grace Song,** Deputy Medical Executive, CDCR
357. **Don Specter,** Former Senior Staff Attorney, Prison Law Office
358. **Ron Taylor**, Chief of Prisons Division, National Institute of Corrections

AIC Interviewees (170 total):

- FDC SeaTac - 11
- FCC Coleman - 51
- USP Lee - 6
- FCC Allenwood - 19
- FCI Milan - 13
- USP Canaan - 12
- MCC San Diego - 9
- FTC Oklahoma City - 5
- FMC Carswell - 8
- FCC Florence - 13
- FCI Aliceville - 10
- FMC Lexington - 13

Appendix D: Research Questions

Task A1

- How does the communication and coordination between Central Offices, regional offices, and individual institutions within the BOP's HSD division ensure the effective implementation of healthcare delivery across various levels?
- What does success look like to HSD?
- How does an Adult in Custody (AIC) access the healthcare delivery system in the BOP from entry until release?
- What are the challenges and successes in ensuring continuity of care for AICs throughout their incarceration?
- How does healthcare delivery differ for specialty populations?
- How does the current BOP healthcare model affect the quality of physical and mental health outcomes for AICs from entry to release?
- How does the BOP determine when AICs access outside medical care?
- Where are the opportunities for cost-savings within the healthcare process?
- What are the strengths and challenges for providing healthcare to AICs whose custody status is residential reentry center (RRC) or home confinement?
- How are the recommendations from oversight entities prioritized and how do they influence the quality improvement process of healthcare delivery within the BOP?
- What healthcare data is collected and how is the data analyzed and utilized to make improvements in healthcare efficiency and effectiveness?
- What are the infrastructure limitations to data collection and usage?
- How is data collected and utilized to determine healthcare needs for the specialty populations?
- How does the BOP's healthcare delivery system and processes compare to other government agencies and non-governmental agencies?

Task A2

- Why has the BOP asked us to look at utilization review?
- What is utilization review, and what is the current BOP utilization review process?
- How does this differ across institutions?
- What are the strengths and challenges with this process?
- What are the liabilities (delay in care, unnecessary care) with this process?
- What are the largest cost drivers within the utilization review process?
- What are the high-volume activities associated with BOP's utilization review process?
- What would having a 3rd party doing UR look like? What benefits would that bring?
- How does the utilization review process at the BOP compare to other entities?
- What are the opportunities to improve this process?

Task A3

- What does BOP's telehealth program look like and how does it work?
- What effective practices can BOP incorporate into its telehealth program from other organizations:
    - Government Healthcare Systems (including State Correctional Systems)?
    - Non-Governmental Healthcare Systems?
- How can BOP make its telehealth plan and policy robust and aligned with best practices?
- What are the strengths and challenges associated with providing telemedicine?
- Can telemedicine providers perform their work remotely and to what extent? What advantages does remote work offer in terms of being competitive in workforce recruitment?
- What indirect effects, positive or negative, could telemedicine produce for BOP in reference to staff capacity?
- How does BOP's internal telemedicine program compare to leading practices in telehealth?
- How does BOP's external telemedicine program compare to leading practices in telehealth?
- What are the barriers to implementing a robust telemedicine program at BOP and what can BOP do to address them?

Appendix E: Institution Visits

Institution Name	Dates Visited
FDC SeaTac	March 25 – March 29
FCC Coleman	April 15 – April 19
USP Lee	April 22 – April 26
FCC Allenwood	April 29 – May 3
FCI Milan	May 13 – May 17
USP Canaan	May 20 – May 24
Federal Transfer Center	June 3 – June 7
MCC San Diego	June 3 – June 7
FMC Carswell	June 10 – June 14
FCC Florence	June 10 – June 14
FCI Aliceville	June 24 – June 28
FMC Lexington	July 8 – July 12

Appendix F: Healthcare Quality Observation Form

Date(s):
Observer:
Facility Observed:
Services Observed: None
Provider Types Observed:
Instructions:

- Apply a reasonable person standard:
  - Consider what an average, prudent individual without medical expertise would deem appropriate and reasonable under similar circumstances.
- Rate each statement using the following scale:
  1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree
- Please provide specific comments or examples under "Observations" for each section.

Safety **Rating** 1 2 3 4 5

- The healthcare area is clean, well-maintained, and free of hazards.
- Safety and emergency protocols are visible, followed, and communicated.
- Equipment is used safely and appropriately.

Observed Strengths:

Observed Challenges:

Timeliness **Rating** 1 2 3 4 5

- Healthcare services are provided in a timely manner.
- Wait times for services are reasonable.
- There are systems to prioritize urgent or emergent medical needs.
- Follow-up and continuity of care are prioritized.

Observed strengths:

Observed challenges:

Equity **Rating** 1 2 3 4 5

- Medical employees display professionalism and promote a culture of care toward AICs.
- There is effective communication between medical employees and AICs, ensuring understanding of treatments and procedures.
- Security and medical employees demonstrate effective teamwork and communication regarding AIC care.

Observed strengths:

Observed challenges:

Patient Centeredness **Rating** 1 2 3 4 5

- Patients are treated with respect, dignity, and compassion.
- The AICs are provided with a space that supports privacy for medical issues and protects the confidentiality of their medical information.
- There are mechanisms for AICs to provide feedback on healthcare services.

Observed strengths:

Observed challenges:

Efficiency **Rating** 1 2 3 4 5

- AICs have clear information on how to access healthcare services.
- Resources are used wisely (staff, space, equipment)
- Workflow and processes minimize waste.
- Administrative processes support clinical efficiencies.
- There is a process for addressing and resolving healthcare complaints.

Observed strengths:

Observed challenges:

Effectiveness **Rating** 1 2 3 4 5

- AICs have access to healthcare services that align with what a reasonable person would anticipate, to include:
    - mental health and substance use disorder programs.
    - special healthcare needs (e.g., chronic conditions, disabilities) are adequately addressed.
    - medications-treatment services consistent with best practices for opioid use disorder.
- Patient outcomes are monitored and addressed.
- Health education materials are available and accessible to AICs.
- There are programs for health promotion and disease prevention among the AIC population.

Observed strengths:

Observed challenges:

Overall Impression **Rating** 1 2 3 4 5

[Provide a summary of your overall impressions, noting any areas of concern or excellence.]

Key Takeaway Recommendations

[Bullet any recommendations for improvements.]

Appendix G: List of Report Recommendations

Please refer to the Final Recommendations for BOP Excel sheet, provided separately.

Appendix H: Change Management Key Success Indicator

	Transforming Organizations* (Abramson/Lawrence)	Heart of Change* (Kotter/Cohen)	Implementation Steps to Assist Mergers and Organizational Transformations* (GAO July 2003)
Best Practices / Lessons Learned	Select the right person	Create a sense of urgency so that people start telling each other "Let's go, we need to change things!"	Ensure top leadership drives the transformation.
	Clarify the mission	Pull together a guiding team powerful enough to guide a big change.	Establish a coherent mission and integrated strategic goals to guide the transformation.
	Get the structure right	Create clear, simple, uplifting visions and sets of strategies.	Focus on a key set of principles and priorities at the outset of the transformation.
	Seize the moment (urgency / right time)	Communicate the vision through simple, heartfelt messages sent through multiple channels so that people begin to buy into the change.	Set implementation goals and a timeline to build momentum and show progress from day one.
	Communicate, communicate, communicate	Empower people by removing obstacles to the vision.	Dedicate an implementation team to manage the transformation process.
	Involve key players	Create short-term wins that provide momentum.	Use the performance management system to define responsibility and assure accountability for change.
	Engage employees	Maintain momentum so that wave after wave of change is possible.	Establish a communication strategy to create shared expectations and report related progress.
	Persevere	Make change stick by nurturing a new culture.	Involve employees to obtain their ideas and gain their ownership for the transformation.

Organizational Transformation Key Success Indicators

1) Ensure top leadership drives the transformation
2) Establish a clear vision and integrated strategic transformation goals
3) Design the organizational structure that will enable the vision
4) Create a sense of urgency, implement a timeline, and show progress from day one
5) Communicate frequently through multiple channels to multiple stakeholders
6) Dedicate a powerful implementation guidance team to manage the transformation process
7) Engage employees to seek their improvement ideas, build momentum, and gain their ownership for the transformation
8) Sustain the effort by nurturing a new culture, rewarding risk, and measuring progress

The Organizational Change Readiness Framework reflects the amalgamation of areas for critical focus according to the change experts listed above. This chart illustrates the synthesis of common areas of importance found in all three change readiness best practice references. The collected works of three independent research projects garnered very similar conclusions, as demonstrated by the color-coding alignment of the similarities.

The publications referenced represent a cross-section of the public sector (Transforming Organizations) and private sector (Heart of Change), with the GAO Report reflecting on both for best practice examples.

Authors of the frameworks above are the thought leaders in Organizational Transformation and Change Management. Research for all three published works includes in-depth academic study as well as work, consulting experience, and data collection with an extensive group of organizations.

Methodology References

- *GAO Report to Congressional Subcommittees, Results-Oriented Cultures: Implementation Steps to Assist Mergers & Organizational Transformations*, GAO-03669, July 2003
- Cohen, Dan and Kotter, John. *"The Heart of Change."* Boston, Harvard Business School Press, 2002.
- *Transforming Organizations*. Edited by Marc A. Abrahamson and Paul R. Lawrence, Lanham, MD. Rowman and Littlefield Publishers, 2001

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