NOTE
HANDLE WITH CARE: CONSTITUTIONAL STANDARDS FOR INFORMATION SHARING IN MEDICAL-CORRECTIONAL TRANSITION

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> "[T]he extreme complexity of medicine has become more than an individual clinician can handle. But not more than teams of clinicians can handle."
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> -Atul Gawande[1]

INTRODUCTION

Ruben Nunez arrived at the San Diego county jail in August 2015, bearing a sheaf of papers that should have saved his life.[2] Nunez had been transferred from a hospital, and those papers contained all the instructions needed for a new set of doctors to keep him healthy. But the handoff from hospital to jail failed, and Nunez died in pre-trial detention. Mr. Nunez suffered from a number of life-threatening conditions, which were all described in his medical records. But, due to a lack of time or attention, the jail doctors missed this information in the thick stack of papers. If, instead, the jail had used a system that more effectively flagged those life-threatening symptoms, Mr. Nunez might still be alive. Despite this failure, the County asserts that its jail uses

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1. Ezra Klein, An Interview With Atul Gawande, Wash. Post (June 23, 2009), http://voices.washingtonpost.com/ezra-klein/2009/06/an_interview_with_atul_gawande.html.

2. Kelly Davis & Jeff McDonald, *Lapses in Treatment, Medical Care Spell Horrific Ends for Mentally Ill Inmates*, SAN DIEGO UNION TRIB. (Sept. 23, 2019), https://www.sandiegouniontribune.com/news/watchdog/story/2019-09-21/lapses-in-treatment-medical-care-spell-horrific-ends-for-mentally-ill-inmates.

modern systems to manage inmate treatment.[3] But San Diego's jail, like many correctional institutions across the country, chose paper over digital tools designed to handle transitions of medical care. All inmates, especially those most vulnerable, deserve a safe transition of care; it is past time for prisons and jails to adopt the tools that allow for an effective transition.

Prior to his incarceration, Nunez threw a rock through a window, was found incompetent to stand trial, and committed to a state hospital for stabilization.[4] Psychiatrists developed a plan to manage symptoms of his schizophrenia, including polydipsia, which is a pathologically excessive and dangerous thirst.[5] Nunez was transferred from the hospital, and a nurse processed Nunez upon his arrival to the jail; two psychiatrists oversaw his continuing treatment.[6] All three clinicians had access to internal electronic medical records, but relied on Nunez's paper medical record to understand his prior medical history and treatment.[7] The paper instructions mentioned compulsive drinking five separate times, and the hospital's careful management of this symptom.[8] The hospital's records clearly stated that he should not be allowed access to tap water because of his psychiatric condition. Nevertheless, the jail placed Nunez in a standard cell with free access to tap water.[9] He drank himself to death within days.[10] Like many other at-risk inmates, Ruben Nunez was warehoused without basic medical accommodations.[11]

Nunez's death is representative of a broader pattern.[12] Jails and

3. Letter from William D. Gore, Sheriff, San Diego Cnty. Sheriff's Dep't., to Disability Rights California at 8 (Apr. 24, 2018), https://www.disabilityrightsca.org/system/files/file-attachments/DRCReport-FinalResponse-OCRd.pdf.

4. Jeff McDonald, *ACLU Intervenes in Federal Lawsuit to Unseal Records Related to 2015 Jail Death*, SAN DIEGO UNION TRIB. (May 14, 2019), https://www.sandiegouniontribune.com/news/courts/story/2019-05-14/aclu-intervenes-in-federal-lawsuit-to-unseal-records-related-to-2015-jail-death.

5. Davis, *supra* note 2.

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *See* Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says*, N.Y. TIMES (Feb. 11, 2015), https://www.nytimes.com/2015/02/11/us/jails-have-become-warehouses-for-the-poor-ill-and-addicted-a-report-says.html (reporting that mental illness contributes to longer-term jail stays).

12. *See* Aaron J. Fischer et al., DISABILITY RIGHTS CALIFORNIA, SUICIDES IN SAN DIEGO COUNTY JAIL: A SYSTEM FAILING PEOPLE WITH MENTAL ILLNESS 12 (2018), https://www.disabilityrightsca.org/system/files/file-attachments/SDsuicideReport.pdf (finding

prisons are not typically designed for medical treatment,[13] and correctional medicine is not transparent, which perpetuates failures in the transition of vulnerable prisoners.[14] Nonetheless, jails and prisons have a constitutional obligation to provide adequate medical care to all detainees—those convicted and those awaiting trial. Each foreseeable, preventable death of a detainee defies that obligation.

The Eighth Amendment prohibition on "cruel and unusual punishment" requires that correctional institutions provide healthcare to detainees.[15] But inadequacies in inmate healthcare violate the Eighth Amendment only when corrections officials' actions constitute "deliberate indifference to serious medical needs of prisoners."[16] Detainees alleging deliberate indifference must prove that an official "knows of and disregards an excessive risk of inmate health or safety."[17] As a result of the deliberate indifference standard, corrections officials and institutions are insulated from liability for preventable deaths unless they knew of and ignored the risk of harm to an inmate.

This Note argues that corrections officials' failure to adopt reasonable standards for transitions of care creates a systemic risk inconsistent with their constitutional duties under the Eighth Amendment. A transition of care is a hand-off from one institutional healthcare provider to another. Transitions of care are particularly dangerous for vulnerable inmates—persons with serious medical needs that require accommodation to be safely held in custody. Transitions of care are increasingly enabled by digital networks that share health information,[18] thanks in large part to mandates arising from the

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that screening for mental health needs upon entry into jail is extremely important but often overlooked).

13. *Id.* at 9.

14. *See Suicide in North Carolina Jails: 2019 Jail Suicide Report,* DISABILITY RIGHTS N.C. (2020), https://disabilityrightsnc.org/wp-content/uploads/2020/06/Report_Suicide-in-NC-Jails_June-2020.pdf (finding unsafe conditions and a lack of mental health care in North Carolina jails); *see* Christine Wilmsen & Beth Healy, *When Inmates Die of Poor Medical Care, Jails Often Keep It Secret*, WBUR INVESTIGATIONS (Mar. 23, 2020), https://www.wbur.org/investigations/2020/03/23/county-jail-deaths-sheriffs-watch (noting that circumstances of inmate deaths are often withheld from the public); *see generally Dangerous Conditions in Prisons/Jails*, MARSHALL PROJECT (Oct. 14, 2020), https://www.themarshallproject.org/records/1350-dangerous-conditions-in-prisons-jails (a curated collection of investigative reporting showing dangerous conditions in correctional institutions).

15. U.S. CONST. amend. VIII; Estelle v. Gamble, 429 U.S. 97, 103 (1976) (finding an "obligation to provide medical care for those whom [the state] is punishing by incarceration").

16. *Estelle*, 429 U.S. at 104.

17. Farmer v. Brennan, 511 U.S. 825, 837 (1994).

18. *See infra* Part II.B (discussing the adoption of technology for sharing medical records in

HITECH Act of 2009.[19] The Act used a series of short-term direct subsidies and long-term incentive payments to encourage the adoption of electronic health records.[20] Since HITECH, instructions for transitions of care are increasingly easy to find and use.[21] Although HITECH did not apply directly to correctional institutions, corrections officials must nevertheless adapt to changing standards by providing "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards."[22] Therefore, correctional institutions expose themselves to liability by neglecting to adopt common tools *specifically designed* to manage movement of vulnerable people between institutions.[23]

The risk to the lives of vulnerable detainees across the United States should be obvious. Nearly half of U.S. detainees have a chronic medical condition.[24] People with serious mental illness are ten times more likely to inhabit a state jail than a state hospital.[25] Vulnerable detainees suffer disproportionately from harsh correctional practices and are especially sensitive to poor conditions of confinement.

Meanwhile, electronic systems that streamline and share health information are tools vital for combatting public health crises, including

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all 50 states based on federal government mandates and incentives).

19. Prashila Dullabh et al., *The Evolution of the State Health information Exchange Cooperative Agreement Program: State Plans to Enable Robust HIE*, NORC AT THE UNIV. OF CHI. (Aug. 2011), https://www.healthit.gov/sites/default/files/pdf/state-health-info-exchange-program-evolution.pdf (noting that HITECH "created unprecedented new funding and incentives for the adoption" of electronic health records and health information exchanges).

20. *Id.*

21. *See, e.g.*, *Patient Lookup – PatientCare 360®*, CORHIO, https://www.corhio.org/services/health-information-exchange-services/for-ltc-skilled-nursing-and-home-health/patient-lookup-patientcare-360-2 (last visited Mar. 3, 2021) (Although the process of accessing an HIE varies by state, the process of accessing a patient record is straightforward for a provider, and easily integrated into the intake process. For example, Colorado's Health Information Exchange offers a web-based 'Community Health Record' that allows access to patients based on a lookup of name, birthday and other unique identifiers. A streamlined Continuity of Care Document may then be downloaded to a computer or imported directly into the Electronic Medical Record.).

22. U.S. v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987).

23. *See infra* Part IV.A (applying the *Estelle* standard to the growth of technology to facilitate transitions of care).

24. Evelyn Malave, *Prison Health Care after the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 NYU L. REV. 700, 704 (2014); LAUREN M. MARUSCHACK, ET AL., BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES, 2011–12, at 1 (2016), https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.

25. Michael McCarthy, *US Jails Hold 10 Times More Mentally Ill People Than State Hospitals, Report Finds*, BMJ (April 10, 2014), https://www.bmj.com/content/348/bmj.g2705.

water contamination,[26] opioid addiction,[27] and the COVID-19 pandemic.[28] Prisoners are affected by these same issues, but many jails and prisons remain stuck in the paper world of yore. When reviewing an inmate's hard-copy medical file, providers who assess a case too quickly can come away thinking *routine schizophrenia* instead of something actionable, like *water restriction*. Such errors are more common when there is a gap between correctional and medical systems—as when prisons rely on a mix of clumsy paperwork and more consistent computer systems to handle medically sensitive transitions. Now that mainstream medicine has adopted tools that facilitate a more seamless transition of care, jails and prisons must address those gaps.

Part I describes Eighth Amendment requirements for medical transitions involving correctional healthcare providers. Part II provides an overview of standard practices in correctional healthcare as compared with mainstream medical transitions. Part III describes obstacles to correctional medical treatment that are ameliorated by effective communication with non-correctional medical providers. Part IV applies the Eighth Amendment standard to medical information systems used in the corrections context. Finally, Part V proposes reforms to improve the connectivity of jails and prisons in a national ecosystem of health information sharing.

I. THE EIGHTH AMENDMENT PROHIBITS HEALTH-INDIFFERENT TRANSITIONS AS CRUEL & UNUSUAL PUNISHMENT

Prisoners have a constitutional right to adequate medical care.[29] As medicine continues to advance, the minimum acceptable standard of

26. *See, e.g.*, David Wahlberg, *Flint Doctor Used Epic Systems Records to Expose Lead Crisis,* WIS. ST. J. (Jan. 30, 2016), https://madison.com/wsj/news/local/health-med-fit/flint-doctor-used-epic-systems-records-to-expose-lead-crisis/article_ef462592-f27b-5ed0-a2ff-33232902ab74.html (reporting on the use of virtual health records in connection to the Flint water crisis).

27. *See, e.g.*, COLIN KONSCHAK & DAVE LEVIN, SANSORO HEALTH, THE EVOLVING ROLE OF HEALTH IT IN FIGHTING THE OPIOID CRISIS, 3–5 (2017), https://www.sansorohealth.com/wp-content/uploads/2018/08/Evolving-Role-of-Health-IT-in-Fighting-Opioid-Crisis-Divurgent-1.pdf (reporting on the use of virtual prescription drug monitoring programs).

28. *See, e.g.*, David Gurwitz, *Repurposing Current Therapeutics for Treating COVID 19: A Vital Role of Prescription Records Data Mining*, DRUG DEV. RESEARCH (2020), at 1 (discussing data mining health records to combat symptoms of COVID-19); *see also* Rebecca Robbins, *Hospital Records Hold Valuable Covid-19 Data. Making it Usable is Time-consuming Work*, STAT (May 27, 2020), https://www.statnews.com/2020/05/27/mass-general-brigham-covid19-genetics-biobank/ (discussing use of hospital records for COVID-19 research).

29. *See* Estelle v. Gamble, 429 U.S. 97, 103 (1976) ("These elementary principles establish the government's obligation to provide medical care for those it is punishing by incarceration.").

medical care rises because the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[30] This gradually enhances the standard of care that prison healthcare providers are obligated to deliver. As a result, inmates often receive accommodations for medical purposes that would have been rejected in previous eras.[31] A key limitation on Eighth Amendment healthcare claims is the requirement that detainees prove a "deliberate indifference to serious medical needs" by corrections officials.[32] Thus, corrections officials avoid liability unless a prisoner can show that the government intentionally ignored a medical issue. Even under such a lenient rule, systemic failure to account for medical information from other institutions makes a finding of deliberate indifference more likely. Therefore, jails and prisons that ignore Eighth Amendment requirements during inmates' transitions create a substantial legal risk by failing to heed clear warnings relating to medical vulnerability.

A. The Constitution Guarantees Prisoners Receive Medical Attention

The right to healthcare during incarceration is founded on the principle that "deliberate indifference to the serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."[33] In *Estelle v. Gamble*, the Court created a three-part test to determine whether corrections officials violate the Eighth Amendment, requiring inmates to show (1) a serious medical need, (2) officials' deliberate indifference to the need, and (3) that the indifference caused an injury.[34] The Fourteenth Amendment applies this standard to the states, such that county jails and state prisons are subject to the "deliberate indifference" standard as well.[35]

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30. Trop v. Dulles, 356 U.S. 86, 101 (1958).

31. *See*, *e.g.*, Helling v. McKinney, 509 U.S. 25, 35 (1993) (holding that excessive levels of secondhand smoke violated a prisoner's Eighth Amendment rights).

32. *Estelle*, 429 U.S. at 104.

33. *Id.* (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

34. *See id.* ("We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983." (citing Gregg v. Georgia 428 U.S. 153, 173 (1976))).

35. Robinson v. California, 370 U.S. 660, 675 (1972) (Douglas, J., concurring) (citing Francis v. Resweber, 329 U.S. 459, 463 (1947)); *see also* E.D. v. Sharkey, 928 F.3d 299 (3d Cir. 2019)

Estelle is noteworthy for both the right it established, and the low standard of care it permitted while finding that right. Inmate J.W. Gamble was assigned to a work detail unloading a truck when a bale of cotton fell on him.[36] Prison medical staff provided pain relievers for a month before mandating that he return to work, despite his back "hurting as much as it had the first day . . . ."[37] Gamble refused to work and was relegated to solitary confinement because of this refusal.[38] Two months later a medical assistant diagnosed Gamble with a heart problem requiring hospitalization, in addition to high blood pressure, migraines, and ongoing pain.[39] The Court recognized Gamble's right to medical treatment, but held that no jailers or medical staff were sufficiently indifferent to his pain to constitute an Eighth Amendment violation.[40] Prison officials avoided Eighth Amendment liability by permitting medical judgement to drive Gamble's treatment and by acting to address his known medical issues.[41]

Estelle makes clear that corrections officers may disregard some of inmates' medical complaints without violating the Eighth Amendment. Permission to discount certain complaints is somewhat justifiable in the corrections context, where complete deference to inmate complaints would burden already limited prison resources. Despite the prison's less-than-compassionate treatment of Gamble, they did intervene in his health crisis: three physicians assessed Gamble's recovery during ten appointments following his back injury.[42] Gamble received muscle relaxants and pain relievers, and the prison allowed him to remain on bed rest.[43] The prison was not deliberately indifferent because its response to Gamble's ailments was guided by professional medical

(extending the deliberate indifference standard to cover immigration detainees and other forms of civil detention).

36. *Estelle*, 429 U.S. at 99.

37. *Id.* at 100.

38. *See id.* at 101 (noting that Gamble was kept in periods of "administrative segregation" and "solitary confinement").

39. *Id.*

40. *Id.* at 104 ("We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)); *see also id.* at 107 ("Even applying these liberal [pleading] standards, however, Gamble's claims against Dr. Gray, both in his capacity as treating physician and as medical director of the Corrections Department, are not cognizable under [the deliberate indifference standard of] § 1983.").

41. *See id.* at 107 ("A medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment.")

42. *Id.* at 107.

43. *Id.*

judgement.[44]

Correctional healthcare decisions following *Estelle* created a circuit split on standards for determining what qualifies as "serious medical need" under the Eighth Amendment. The Eleventh Circuit applies an objective test based on documentation and perception, defining a serious medical need as one "diagnosed by a physician and mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[45] The Ninth Circuit uses a functional standard, involving a "condition [that] could result in further significant injury or the 'unnecessary and wanton infliction of pain.'"[46] The Second Circuit crafted a more variable test that looks to a "non-exhaustive list" of factors, including a reasonable physician's assessment, the effect of a condition on daily life, and the presence of chronic pain.[47] According to any of these standards, correctional medical providers are required to take notice of either diagnoses of other physicians, or else apply their own judgement after reviewing some set of medical data.

Once a serious medical need is identified, health practitioners working for a correctional institution must treat patients with a reasonable standard of medical care.[48] This standard of care must be "reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards"[49] and is governed by national standards, state law, and judicial precedent.[50] State laws on the standard of care vary, embracing either (a) a uniform national standard for certain specialties and procedures, (b) a standard based on treatment in a similar community, or (c) an assessment of reasonable action in similar circumstances.[51] Local practices do not

44. *Id.* The Court left the question of liability for non-medical prison officials to be determined on remand.

45. Hill v. Dekalb, 40 F.3d 1176, 1187 (11th Cir. 1994) (quoting Laaman v. Helgemoe, 437 F. Supp. 269, 311 (D.N.H. 1977)).

46. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006) (citing McGuckin v. Smith, 974 F.2d 1050, 1059 (9th Cir. 1991)).

47. Brock v. Wright, 315 F.3d 158, 162 (2d Cir. 2003) (citing Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998)).

48. *See* BRIAN GLICK ET AL., JAILHOUSE LAWYER'S MANUAL 710 (11th ed. 2017) (finding that the patient must have been denied "necessary medical help" in order to state a claim).

49. U.S. v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987).

50. Page Keeton, *Medical Negligence – The Standard of Care*, 10 TEX. TECH L. REV. 351, 361 (1979) ("During the past twenty years, successive changes have been made in different states regarding the appropriate standard of care for physicians only some of which have been generally accepted").

51. *See, e.g.*, Robbins v. Footer, 553 F.2d 123, 129 (D.C. App. 1977) (describing parameters

conclusively determine the standard of care but can demonstrate the possibility and practicability of an action given the common "skill and knowledge normally possessed" by local medical providers.[52]

Some circuits have found that the Eighth Amendment imposes treatment obligations that extend beyond the walls of a correctional institution. In *Wakefield v. Thompson*, the Ninth Circuit held that the state must provide inmates receiving medical care with enough medicine "to cover their transition to the outside world."[53] In 2019, the Second Circuit found that "common sense and experience [support the] theory that discharge planning is part of in-custody care" while assessing a group of released inmates' right to receive medical records, medication, and a continuity of care plan.[54] The court determined that "a fact-finder could infer 'reckless disregard' beyond mere negligence or medical malpractice" because the prison failed to provide discharge planning information to vulnerable inmates.[55] These holdings demonstrate the Eighth Amendment's incorporation of medical progress, which requires corrections officials to accommodate inmates and share information in accordance with modern practices.

Amidst these evolving standards, correctional institutions can mitigate the risk of liability by providing medical staff with straightforward instructions: act like you would at any other medical institution as much as possible and inform officials when something goes wrong. In short, the correctional institution must permit the exercise of professional medical judgement and not consciously ignore expert advice, or else risk a finding of deliberate indifference to the medical treatment that a clinician deems necessary to treat a detainee.

B. Ignoring Known Healthcare Instructions Constitutes Deliberate Indifference

Corrections officials cannot avoid responsibility for healthcare by willfully ignoring systems that communicate inmate health needs. Even

for a national standard); Slezak v. Girzadas, 522 N.E.2d 132, 135–36 (Ill. App. 1988) (discussing the locality standard); Chapel v. Allison, 785 P.2d 204, 210 (Or. 1990) (describing a broad "similar circumstance" test for general practitioners) (citing Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 253 (Md. 1975)).

52. McMullin v. United States, 515 F. Supp. 2d 909, 910 (E.D. Ark. 2007) (citing RESTATEMENT (SECOND) OF TORTS § 299A (AM. LAW INST. 1965)).

53. 177 F.3d 1160, 1165 (9th Cir. 1999).

54. Charles v. Orange Cnty., 925 F.3d 73, 82–83 (2d Cir. 2019); *see infra* Part V (providing a full discussion of how a discharge planning requirement relates to the sharing of inmate health information).

55. *Charles*, 925 F.3d at 89.

the subjective deliberate indifference standard "does not mean that [corrections] officials will be free to ignore obvious dangers to inmates."[56] Instead, officials may be liable for inaction with "knowledge of a substantial risk of serious harm."[57] Therefore, when corrections officials know that instructions for treatment of a vulnerable inmate exist, those officials must incorporate those instructions into the treatment of an inmate. Ignoring such instructions for care disregards the judgement of a prior medical provider and creates a substantial risk of serious harm in the correctional institution receiving the vulnerable inmate.

Mental health concerns, such as prevention of self-harm, present an additional challenge for institutions that are already stretched thin from managing more benign conditions.[58] As a result, corrections officials are forced to triage mental health issues with limited time and incomplete information. In *Gregoire v. Class*, the Eighth Circuit scrutinized an inmate's suicide while in a state penitentiary.[59] The decedent, George Bouska, had called his ex-wife on the day of his death and communicated his suicidal ideation.[60] His ex-wife then called to report the issue to a prison case manager, Butch Joffer, who checked Bouska's file and delayed intervention for an hour, during which Bouska killed himself.[61] In determining that Joffer was not liable under a deliberate indifference standard for his failure to take action in time, the court relied on the fact that Bouska's ex-wife did not communicate any clinical history, only his current suicidal intent.[62] The court absolved Joffer of liability because he took account of readily available information, which did not reference Bouska's past mental health issues.[63]

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56. Farmer v. Brennan, 511 U.S. 825, 842 (1994).

57. *Id.*

58. *See* Jorg Pont et al., *Dual Loyalty in Prison Health Care*, 102 AM. J. OF PUB. HEALTH 475, 475–80 (2012) (finding substantial risk of medical ethics violations resulting from a deficit in local resources); *See* Irina Franke et al., *Prison Mental Healthcare: Recent Developments and Future Challenges*, 32 CURRENT OPINION IN PSYCHIATRY 342, 342–47 (2019) (describing increasing challenges in the face of mental health crises).

59. 236 F.3d 413, 415 (8th Cir. 2000).

60. *Id.* at 416.

61. *Id.*

62. *See id.* at 417–18 ("There are no allegations or indications from the record that Joffer knew of Bouska's previous classification ass a suicide risk . . . the only fact concerning Bouska's suicide risk which Joffer knew of, and thus relevant to evaluating Joffer's conduct, was the phone call from [his ex-wife].").

63. *See id.* at 419 ("There are no allegations or indications from the record that Joffer knew of Bouska's previous classification as a suicide risk, of his hospitalization and treatment for depression, or his alleged earlier suicide attempt . . . .")

Gregoire demonstrates that correctional institutions must account for medically relevant communications, even if they cannot prevent every incident of self-harm. Here, the court repeatedly referenced that the prison records lacked details about Bouska's mental health history, and that his ex-wife did not communicate his mental health history or past suicidal ideation.[64] Importantly, the court noted that "the only information Joffer had about the risk of Bouska's suicide was the phone call from [his ex-wife]."[65] The lack of a critical event prompting immediate action and the relatively short period between the call and the suicide supported the court's decision to grant qualified immunity to Joffer and prison officials.[66] The Eighth Circuit thus implied that reading instructions for inmate care (and acting reasonably in response to those instructions) is a defense to deliberate indifference.

Medical staff providing direct services to inmates are similarly required to act reasonably when presented with instructions for care. In *Pardue v. Fromm*, the Seventh Circuit assessed an Eighth Amendment claim of failure to adequately restrain an inmate.[67] Inmate Max Cole was designated for "potential suicide precautions" but was then left alone in a room with plastic bags, which he later used to kill himself.[68] Here, the court determined that the doctors' exercise of medical judgement and reasonable triage precluded a finding of deliberate indifference, even though medical staff should not have left Cole the tools to kill himself.[69] Specifically, the court noted that "[l]iability may be imposed only when the decision by the professional is such a substantial departure from the accepted professional judgement, practice or standards as to demonstrate that the person responsible did not base the decision on such a judgement."[70] In particular, Cole's physician satisfied that standard by "review[ing] Cole's medical chart and conduct[ing] an independent mental status examination."[71] Here, because the physician assessed available

64. *See id.* at 416 ("Joffer's case file on Bouska contained no mention of previous suicide threats or attempts or the fact that he was briefly placed on suicide watch. Nor did it contain medical or mental health information, information from Bouska's health screening form, or Psychology Intake Interview Summary.").

65. *Id*.

66. *See id.* at 419 (noting that Joffer's actions should be evaluated "in light of the information he possessed at the time").

67. Estate of Cole by Pardue v. Fromm, 94 F.3d 254, 257 (7th Cir. 1996).

68. *Id.* at 258.

69. *See id.* at 263 (holding that Cole's physician's treatment was not a substantial departure from accepted standards).

70. *Id.* at 262 (quoting Youngberg v. Romeo, 457 U.S. 307, 323 (1982)).

71. *Id.* at 257 (later clarifying that the due diligence allowed an inference that the doctor

information and used his professional judgement, the court found that he was not deliberately indifferent.

Inmates can also "establish deliberate indifference by showing that officials intentionally interfered with [their] medical treatment."[72] Prison physicians interfere with medical treatment by consistently disregarding a serious medical need.[73] When prison officials knowingly deprive an inmate of necessary treatment, that act is also deliberately indifferent.[74] Similarly, when prisons ignore recommendations for intervention, including transfer to a hospital, that act may constitute intentional interference with treatment in violation of the Eighth Amendment.[75]

At minimum, correctional institutions have a duty to heed known communications from other medical providers and to avoid interfering with necessary care. The Eighth Amendment does not require *perfect* healthcare and, indeed, often excuses actions that fall beneath the normal standard of medical care. But the exchange of information about serious medical needs is more common and less burdensome than ever before. Thus, under the Eighth Amendment, which accounts for changing standards of "dignity, civilized standards, humanity, and decency,"[76] correctional medical providers must not only base their treatment on available instructions for care, but also adopt case management practices consistent with modern medical standards.

"made a medical judgement that Cole did not need the suicide precautions attendant to 'high risk suicide' classification . . . [reaching a] subjective conclusion regarding the risk Cole posed to himself.").

72. Lopez v. Smith, 203 F.3d 1122, 1132 (9th Cir. 2000) (citing Estelle v. Gamble, 429 U.S. 97, 105 (1976)).

73. *See id.* ("Lopez's medical records show that when he returned to Corcoran, a doctor at the prison confirmed the hospital's instructions that he receive a liquid diet through a straw. Yet in his affidavit, Lopez states that he received a blended diet, consisting of pureed food that he was unable to drink through a straw. Lopez also stated that he complained to prison officials, but that they declined to change his diet. These allegations, viewed in the light most favorable to Lopez, are sufficient to support a finding that prison officials intentionally interfered with his previously prescribed medical treatment.").

74. *See* Tolbert v. Eyman, 434 F.2d 625, 626 (9th Cir. 1970) (describing deliberate indifference as encompassing "treatment so cursory as to amount to no treatment at all" after prison physicians intercepted properly prescribed medication and refused to distribute it to an inmate).

75. *See* Brown v. District of Columbia, 514 F.3d 1279, 1284 ("After Dr. Rafford notified prison officials of Brown's need for immediate hospitalization, they failed to transfer him for sixty days while he continued to suffer from gallstones. Presented with these claims, we do not hesitate to conclude that Brown alleges an Eighth Amendment violation.").

76. Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968).

II. MODERN TECHNICAL STANDARDS CREATE A HIGHER STANDARD OF CARE

Prisons and jails frequently employ electronic health records (EHR) to manage inmate medical treatment.[77] When implemented in the corrections context however, these EHR systems typically lack connections to outside medical providers. Indeed, as of 2018, less than five percent of state Departments of Corrections could exchange structured medical data through their EHR.[78] Mainstream medicine is better connected by far. The HITECH Act of 2009 triggered a dramatic modernization of medical information technology among healthcare providers in the United States.[79] Providers and state governments installed EHRs and began to connect them, allowing information to flow with the patient. Following a decade of building connections, every state now operates at least one Health Information Exchange (HIE) with basic competence in simplifying transitions of care.[80] Healthcare providers use these exchanges to share life-saving information, including Continuity of Care Documents (CCD), which contain the medical history and instructions for care of a patient.[81] The CCD standardizes transitions of care by ferrying data across institutional, technical, geographic, and clinical boundaries. Simplifying health information transactions in this fashion is critical to providing accommodations that protect an increasingly sensitive incarcerated population.[82]

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77. *See infra* Part II.A.

78. *See* Gregory T. Woods et al., *Accessing Prison Medical Records in the United States: A National Analysis, 2018*, 34 J. GEN. INTERNAL MED. 2331, 2331 (2019) ("Most DOCs offered copies of medical records by mail (42/44, 95.5%) or fax (31/44, 70.5%). Fewer states had the capacity to send records through email (14/44, 31.8%) or via an electronic record system (2/44, 4.5%).").

79. Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226 (2009) (codified in scattered sections of 42 U.S.C.).

80. *State Health Information Exchange Cooperative Agreement Program,* OFF. NAT'L COORDINATOR FOR HEALTH INFO. TECH. (Apr. 29, 2019), https://www.healthit.gov/topic/onc-hitech-programs/state-health-information-exchange (listing funds allocated to states beginning in 2010 to build HIE systems); *see generally* Julia Adler-Milstein et al., *A Survey of Health Information Exchange Organizations in the United States: Implications for Meaningful Use*, 154 ANNALS OF INTERNAL MED. 666 (2011) (describing the current challenges in more specialized regional exchanges).

81. *See* 42 C.F.R. § 482.43(e) (2009) (establishing CCDs as the technical standard for exchange of patient information) (comments available at: https://www.federalregister.gov/d/2019-20732/p-337); *see also A Quarter Billion Records Exchanged*, EPIC INDUS. BUZZ (Mar. 21, 2016), https://www.epic.com/epic/post/1507 (describing the volume of documents exchanged on one software vendor's HIE platforms).

82. Franke, *supra* note 58.

But twelve years after HITECH, the carceral health system remains exceptionally insular and digitally disconnected from hospitals and community medical providers. By and large, correctional institutions have not adopted data sharing practices that are considered best practices in the medical community—like exchanging CCDs for vulnerable individuals.[83] Institutional resistance to correctional-medical connections is increasingly difficult to square with a comprehensively connected private and public health system. The Eighth Amendment implies such connections must not be refused without good reason, especially to the extent that methods of sharing digital health information are considered a medically necessary practice.

A. The Criminal Justice System Uses Modern Systems Manage Internal Health Information

National crises in mental health and drug addiction have put new pressures on corrections officials to properly care for inmates' health. Simultaneously, the fruits of investment in EHR systems over the past decade have made it easier to understand how to keep vulnerable people healthy throughout incarceration. These systems lay a foundation for greater communication between correctional and mainstream medical providers. EHRs have spread through the criminal justice system but have yet to be networked in ways that mitigate the risk of transition for vulnerable detainees.

The Department of Health and Human Services (HHS) applies information sharing rules from the Health Information Portability & Accountability Act (HIPAA) to both prisoners and the general public. HHS's final rule implementing HIPAA "removed the exception [that exempted] individually identifiable health information of inmates [from the Act]."[84] As a result, prisons and jails transmitting electronic

83. *See generally* John D. D'Amore et al., *How the Continuity of Care Document Can Advance Medical Research and Public Health*, 102 AM. J. PUB. HEALTH e1 (2012) (noting the widespread adoption of the CCD standard by EHR developers to address common barriers to information sharing among medical providers); *See also* John D'Amore, *Interoperability Progress and Remaining Data Quality Barriers of Certified Health Information Technologies*, 2018 AM. MED. INFORMATICS ASSN. ANN. SYMP. PROC. 358, 358 (noting that ability to share medical data is "essential to improve care quality and efficiency" and that "a majority of hospitals and physicians can electronically share data").

84. Standards for Privacy of Individually Identifiable Health Information; Protected Health Information, 65 Fed. Reg. 82,496 (Dec. 28, 2000); *see also generally* Melissa M. Goldstein, *Health Information Privacy and Health Information Technology in the US Correctional Setting*, 104 AM J. PUB. HEALTH 803 (2014) (discussing applicability of HIPAA to correctional settings).

health information became "covered entities" obligated to meet standards of information privacy, security and portability while managing inmate health information.[85] The sole remaining "security carveout" allows withholding inmate health information which would "jeopardize the health, safety, security, custody or rehabilitation [of inmates] or the safety of [correctional employees]."[86] Overall, HIPAA standardized correctional and non-correctional information sharing under a consistent regulatory structure, which includes a patient-centered right to access and transfer medical information.[87]

HIPAA provided a legal foundation in corrections consistent with the mainstream health system's requirements, which encouraged jails and prisons to implement commercial EHRs. As early as 2013, the Federal Bureau of Prisons adopted a single EHR to coordinate inmate health information across all federal prisons.[88] Today, the Federal "Offender Management Suite" incorporates a variety of functions including an EHR that is integrated with other modules like case management, food services, and investigations.[89] The integrated platform allows employees to access information according to their customized role, in either correctional operations, medical care, or a hybrid of the two. At the state level, Iowa, Michigan, and North Carolina have adopted the same EHR software used by the Federal Bureau of Prisons.[90] Meanwhile Georgia, Texas, and New York are among the states who have purchased or created their own software for similar purposes.[91]

When state and local governments fail to adopt an EHR, it falls on

85. 45 C.F.R. § 160.103 (2002) (defining a HIPAA covered entity as any health care provider who transmits a variety of electronic health information, including referral authorization and reports of injury).

86. 45 C.F.R. § 164.524(a)(2)(ii) (2014) provides a security focused exception to the right to access medical records from correctional institutions.

87. 45 C.F.R. § 164.524(a)(1) (2014) contains a general right of access that extends to inmates provided security concerns do not apply.

88. SONYA D. THOMPSON, FED. BUREAU OF PRISONS, PRIVACY IMPACT ASSESSMENT FOR THE BUREAU ELECTRONIC MEDICAL RECORDS INITIATIVE 2 (2013), https://www.bop.gov/foia/bemr.pdf.

89. *Offender Management Suite*, ADVANCED TECHS. GRP., https://a-t-g.com/offender-management-suite-103 (last visited Mar. 3, 2021).

90. *Our Partners*, ADVANCED TECHS. GRP., https://a-t-g.com/our-partners-104 (last visited Mar. 3, 2021).

91. *See* Michelle Martelle et al., *Meaningful Use of an Electronic Health Record in the New York City Jail System*, 105 AM J. PUB. HEALTH 1752 (2015) (noting that the New York City jail system successfully uses EHR technology to deliver improved patient care); *see also* Goldstein, *supra* note 84, at 803 (noting the use of a single EHR platform for correctional institutions in Georgia and Texas).

the local correctional health services provider to bridge this gap. For example, the largest provider of correctional health services in the United States, Corizon, offers consulting services to help their customers implement an EHR.[92] Despite a push to modernize correctional case management systems, jails and prisons have adopted EHRs at lower rates than other healthcare providers.[93] Reports on jails who are just beginning to "go electronic" indicate that stragglers may continue to rely on paper medical records for some time.[94] Despite these gaps, EHRs are widely used by larger correctional health contractors and many state departments of corrections.[95]

Jails and prisons across the country possess digital tools to manage inmate health, even without national standards for the *exchange* of stored information.[96] The Eighth Amendment supplies a workable national guideline to share information necessary for medical care, which is further supported by regulatory standardization of health information under HIPAA.[97] In short, botched transitions of care are less acceptable under the Eighth Amendment when they can be addressed by information sharing that is routine in a non-correctional context. Although correctional institutions are generally reluctant to share information, their insularity is increasingly at odds with modern medical practice.

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92. *Choosing Corizon Health*, Corizon Health, https://www.corizonhealth.com/Choosing-Corizon/Technology (last visited Nov. 3, 2020) ("Corizon Health has worked with many of the major EHR vendors for implementations and can leverage that experience to advise and assist our clients in selecting the best EHR solution for their facility(ies).").

93. *See* Goldstein, *supra* note 84, at 803 (summarizing a 2011 study which "showed a range of technological sophistication among prison facilities, with rare use of EHRs. Furthermore, there is very little electronic exchange of health information within correctional systems or between systems and community providers").

94. *See, e.g.*, Leah Ingram Eagle, *Inside the Walls: Technology, Personnel Highlight Behind-the-Scenes Operation at Shelby County Jail*, 280 LIVING (Jan. 25, 2020), https://280living.com/news/inside-the-walls-technology-personnel-highlight-behind-the-scenes-operation-at-shelby-county-jail/ (remarking over ten years after HITECH that "[a] new piece of technology to the jail is using an Electronic Medical Records (EMR) program. According to the nurse supervisor, it will allow the medical staff to better care for the inmates and track them medically in a way they have never been able to do in the past").

95. Martelle, *supra* note 91 ("In jails and prisons, adoption of EHRs has mirrored that of community providers, with large systems making headway before smaller ones.").

96. Ben Butler, *Health Information Exchange between Jails and Their Communities: A Bridge That Is Needed under Healthcare Reform*, PERSPECTIVES IN HEALTH INFO. MGMT. (Jan. 2014), http://bok.ahima.org/doc?oid=301194#.XoTwh4hKiUk; *see also* Benjamin Harris, *How HIE can improve mental healthcare in prison*, HEALTHCARE IT NEWS (Feb. 28, 2020), https://www.healthcareitnews.com/news/how-hie-can-improve-mental-healthcare-prison.

97. Lester N. Wright, *Health Care in Prison Thirty Years after* Estelle v. Gamble, 14 J. CORRECTIONAL HEALTHCARE 31, 32 (2008); *see also supra* Part I.A.

B. Mainstream Medicine Relies on Modern Tools for Exchange of Medical Instructions

Medical enterprises rely on systems to coordinate care that are different in kind and more effective than the rows of filing cabinets more common in prior eras. The HITECH Act of 2009 began a process of modernization that provided hospitals with more than $25 billion to adopt EHRs and then become "Meaningful Users" of the systems.[98] Today, hospitals must share standardized health data as a condition of receiving Medicaid and Medicare funds (which make up a substantial portion of national healthcare spending).[99] Systems that connect EHRs to one another now facilitate transitions of care between U.S. healthcare providers.

To understand this system, consider what healthcare providers commonly exchange on information sharing networks: Continuity of Care Documents.[100] CCDs are snapshots in time, capturing the vital details of a specific clinical interaction in a standardized digital format. Imagine two hospitals on opposite sides of the country and how their physical paperwork might differ. Beyond superficial formatting and ordering of data, medical records reflect clinical best practices, state regulation, and processes tailored to the local community. When transitions use a paper process, a hard copy is forwarded and then reentered in a new system (which introduces a risk of transcription errors) or scanned in as stored images (with a risk of missing content in an unfamiliar format). The CCD is a digital medical summary with a neutral format that solves these problems.[101] This format works across EHRs, and standardizes how medical providers access critical information.

CCDs are shared predominantly via Healthcare Information Exchanges (HIEs) which function as a trusted intermediary for medical information.[102] When stored on an HIE, CCDs are more easily

98. Marsha Gold & Catherine McLaughlin, *Assessing HITECH Implementation and Lessons: Five Years Later*, 94 MILBANK Q., 654, 655–57 (2016).

99. *See Scoring, Payment Adjustment, and Hardship Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 30, 2020, 9:21 AM), https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship (explaining that eligible hospitals must report measures they have taken to promote "interoperability").

100. *HL7/ASTM Implementation Guide for CDA R2-Continuity of Care Document (CCD) Release 1*, HEALTH LEVEL SEVEN INT'L, https://www.hl7.org/implement/standards/product_brief.cfm?product_id=6 (last visited Mar. 3, 2021).

101. *Id.*

102. *See generally What is HIE?*, OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH

accessible in "the cloud" available to healthcare providers.[103] States began creating HIE systems in March 2010 using funds provided by HITECH. All states received grants (ranging from $4 million to $29 million) to "rapidly build capacity for exchanging health information across the health care system both within and across states."[104] The Centers for Medicare & Medicaid Services created programs under HITECH,[105] which "place[d] an emphasis on health information exchange between providers" by implementing "new requirements for the electronic exchange of summary of care documents[.]"[106] A revision to the program in 2017 began to enforce specific benchmarks for effective transitions of care, and penalties for non-compliance.[107]

Federal intervention to improve communication of health information spurred meaningful systemic change.[108] By 2017, 90 percent of hospitals receiving Medicare funds were electronically exchanging

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INFORMATION TECHNOLOGY, https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie (last visited Jan. 29, 2021) (describing the utility of an HIE and basic technical standards enabling those benefits).

103. *See, e.g.*, *WISHIN Pulse Community Health Record*, WIS. STATEWIDE HEALTH INFO. NETWORK (WISHIN), https://www.wishin.org/Solutions/HospitalsandHealthSystems/WISHINPulse.aspx (last visited Jan. 29, 2021); *see also* TJ. Winden et al., *Care Everywhere, a Point-to-Point HIE Tool: Utilization and Impact on Patient Care in the ED*, 5 APPLIED CLINICAL INFORMATICS 388, 393 (2014) ("Our results show that physicians perceive HIE, specifically [Care Everywhere], to be an invaluable asset in the [Emergency Department].).

104. *State Health Information Exchange Cooperative Agreement Program*, OFF. NAT'L COORDINATOR FOR HEALTH INFO. TECH. (May 3, 2020), https://www.healthit.gov/topic/onc-hitech-programs/state-health-information-exchange.

105. *2017 Modified Stage 2 Program Requirements for Providers Attesting to their State's Medicaid EHR Incentive Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage2MedicaidModified_Require.

106. *Stage 2 Overview Tipsheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1, 4 (Aug. 2012), https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2Overview_Tipsheet.pdf.

107. *Stage 3 Eligible Hospitals, Critical Access Hospitals, and Dual-Eligible Hospitals Attesting to CMS Health Information Exchange Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 2018), https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf

108. *See Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap*, OFF. NAT'L COORDINATOR FOR HEALTH INFO. TECH., at *x* (Mar. 28, 2019), https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf (noting that, as of 2015, "approximately 41 percent of hospitals nationwide routinely [had] electronic access to necessary clinical information from outside providers or sources when treating an individual . . . . [A]pproximately 78 percent of hospitals electronically sent a summary of care document and 56 percent received a summary of care document.").

health information with at least one external provider.[109] Over half could integrate that information into their EHR with no manual entry.[110] In that same year, over 70 percent of hospitals connected to at least one *national* HIE that crosses regional borders.[111] The nationwide trend of HIE adoption makes crucial information more accessible to all medical providers who treat a given patient.

State-specific mandates[112] combined with federal incentives to push medical providers across the country to transact in digital health information.[113] Accessing CCDs through an HIE now gives healthcare providers a foundation for a patient's treatment plan, rather than starting from scratch. Vulnerable patients with complex medical needs no longer have to cart around suitcases of paper to facilitate adequate care. Physicians can rely on peer notes when assessing unreliable narrators like children or individuals with developmental disabilities. Emergency departments can pull a sufficient medical record based on any identification found on unconscious patients. In short, the benefit of these systems is obvious—modern transitions of care save lives.[114]

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109. *Annual Update on the Adoption of a Nationwide System for the Electronic Use and Exchange of Health Information*, OFF. NAT'L COORDINATOR FOR HEALTH INFO. TECH. & DEP'T OF HEALTH & HUMAN SERVS., 1, 9 (2018), https://www.healthit.gov/sites/default/files/page/2018-12/2018-HITECH-report-to-congress.pdf.

110. *Id.*

111. Kate Monica, *70% of Hospitals Participated in Nationwide HIE Networks in 2017*, EHR INTELLIGENCE (Dec. 20, 2018), https://ehrintelligence.com/news/70-of-hospitals-participated-in-nationwide-hie-networks-in-2017.

112. *See, e.g.*, MD. CODE REGS § 10.37.07.03 (2011) (containing an outright requirement to connect to a government-run HIE); *see also* VT. STAT. ANN. tit. 18, § 702 (2010) (requiring collaboration with a state HIE to receive public health funding); *see also* Frank Irving, *Five Ways States Mandate Health Information Exchange*, EHR INTELLIGENCE (Dec. 17, 2015), https://ehrintelligence.com/news/5-ways-states-mandate-health-information-exchange (describing various states' approaches to incorporating HIE).

113. *See Hospitals Participating in the CMS EHR Incentive Programs*, OFF. FOR THE NAT'L COORDINATOR FOR HEALTH INFO. TECH. (Aug. 2017), https://dashboard.healthit.gov/quickstats/pages/FIG-Hospitals-EHR-Incentive-Programs.php (last visited Sept. 27, 2020) (showing 98% nationwide compliance with a program requiring health information exchange by hospitals eligible for Medicaid funds).

114. *See, e.g.*, Raj Leventhal, *Study: HIE Reduces Unplanned Hospital Readmissions, ED Visits in Western NY*, HEALTHCARE INNOVATION (Feb. 17, 2020), https://www.hcinnovationgroup.com/interoperability-hie/health-information-exchange-hie/news/21125779/study-hie-reduces-unplanned-hospital-readmissions-ed-visits-in-western-ny (stating that integration of HIE services into medical practices' workflows reduced unplanned readmissions by 10.2% and reduced the rate of ED visits by 13.3%); *see also* AM. HOSP. ASS'N, SHARING DATA, SAVING LIVES: THE HOSPITAL AGENDA FOR INTEROPERABILITY 1, 3 (Jan. 2019), https://www.aha.org/system/files/2019-01/Report01_18_19-Sharing-Data-Saving-Lives_FINAL.pdf (noting that "[f]or the best outcome, it is imperative that accurate, standardized, accessible and exchangeable health information from all sources accompany patients every step of the way").

III. HEALTH INFORMATION EXCHANGES PROTECT VULNERABLE PRISONERS

The Hippocratic oath to do no harm is complicated for doctors working in the criminal justice system because the doctor-patient relationship is compromised by security measures that often harm inmate patients.[115] Medicine and punishment coexist uneasily because "[h]ealth care is required by the Constitution but is not a core competency" of corrections officials.[116] Nonetheless, prisons and jails use electronic medical records and other sophisticated systems to track inmate needs. However, these correctional health systems are less effective when disconnected from external healthcare providers who may possess a better understanding of a given prisoner's needs.

Vulnerable prisoners require specialized health accommodations. Consequently, the methods that corrections officials use to triage medical needs are critically important to keeping prisoners healthy. If an inmate's needs are not met, they may be exposed to a dangerous or life-threatening environment. Jails pose a unique danger to at-risk individuals due to high turnover of detainees and limited access to medical accommodations.[117] In correctional institutions, scarce resources and harsh default conditions make collaboration between medical providers essential to keep vulnerable prisoners safe.

Detainees are more medically needy than the general population,[118] and there is a deficit of clinicians to address those needs.[119] More

115. *See* Note, *The Psychology of Cruelty: Recognizing Grave Mental Harm in American Prisons*, 128 HARV. L. REV. 1250, 1251 (2015) (describing the pernicious effects of solitary confinement); *see also* Lauren Brinkley-Rubinstein et al., *Association of Restrictive Housing During Incarceration with Mortality After Release*, 2 JAMA NETWORK OPEN 1, 8 (2019) ("[P]eople who had spent any time in restrictive housing during incarceration in a state prison in North Carolina were significantly more likely to die of all causes in the first year after release than those who did not.").

116. Kimberly Leonard, *Privatized Prison Health Care Scrutinized*, WASH. POST (July 21, 2012), https://www.washingtonpost.com/national/health-science/privatized-prison-health-care-scrutinized/2012/07/21/gJQAgsp70W_story.html?utm_term=.ce341fae1bfc (quoting Mark Hale, president and chief executive of Wexford Health Sources, a correctional medical provider).

117. *See, e.g.*, Steve Coll, *The Jail Health-Care Crisis*, NEW YORKER (Feb. 25, 2019), https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis ("Jails have a much higher turnover rate than prisons, where inmates generally serve long sentences. . . large numbers of people booked into custody are in a state of distress . . . [m]any jails are in rural or poor counties where administrators complain that they have neither the resources to hire, train, and supervise doctors and nurses in the particular demands that their facilities require.").

118. *See* Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 668–69 (2009) (finding that detainees have higher rates of medical and mental health issues than the general U.S. population).

119. *See* Valerio Bacak & Greg Ridgeway, *Availability of Health-Related Programs in Private*

problematic still is the severe resource constraint in prisons which results from those issues: Correctional medical providers have limited time to fully understand an inmate's health needs.[120] Since providers have scarce time to spend with a prisoner, inmates who do not have a clearly documented medical need must advocate for themselves during intake and sick calls. Intake screening is intended to identify health risks and is most often performed by a nurse or medical assistant based on a checklist, which might not include specific issues flagged by previous medical providers. Sick calls allow inmates to advocate for themselves over time, but may also cost inmates money, making it less likely that inmates will report medical issues after the free initial screening.[121]

In both the screening and sick call setting, clinicians must decide which health-focused interventions are necessary and which are impractical in the context of a security-focused correctional environment. Prisoners suffering from an addiction are frequently denied access to medications that stave off withdrawal.[122] Inmates with mental illnesses are often restricted to solitary confinement, despite the fact that it often exacerbates their illness.[123] Infection risks are left to fester when medical staff lack space to isolate sick inmates.[124] Under the current system, vulnerable inmates often struggle in the typically harsh environment unless a busy clinician takes the time to lobby for an exception on their behalf. Implementing an HIE-connected EHR

and Public Prisons, 24 J. CORRECTIONAL HEALTH CARE 62, 62 (2017) ("More than 1.5 million men and women . . . serve sentences in frequently understaffed and overcrowded facilities.").

120. *See* Sasha Abramsky and Jamie Fellner, *Ill-equipped: U.S. Prisons and Offenders with Mental Illness*, HUMAN RIGHTS WATCH 94–97 (2003) (noting particular issues with availability of psychiatrists for medication management given large inmate populations on psychiatric medication); *see* Brian Sonenstein, *All 50 States Report Prison Understaffing*, PRISON LEGAL NEWS (Apr. 1, 2020) https://www.prisonlegalnews.org/news/2020/apr/1/all-50-states-report-prison-understaffing/.

121. *See* Wendy Sawyer, *The Steep Cost of Medical Co-pays in Prison Puts Health at Risk*, PRISON POL'Y INITIATIVE (Apr. 19, 2017), https://www.prisonpolicy.org/blog/2017/04/19/copays/ (noting that part of the reasoning behind requiring a co-pay is to "force [incarcerated people] to make difficult choices.").

122. *See* Steve Horn, *Opioid Epidemic Impacts Prisons and Jails*, PRISON LEGAL NEWS (Sept. 5, 2019), https://www.prisonlegalnews.org/news/2019/sep/5/opioid-epidemic-impacts-prisons-and-jails/ (citing a study by the National Sheriff's Association which found that only around 270 out of 3,100 local jails nationwide offered medication-assisted treatment to treat opioid dependency).

123. Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & L. 104, 104–05 (2010).

124. *See* David Brand, *At Least 167 NYC Inmates, 114 Jail Staffers Now Have COVID-19*, QUEENS DAILY EAGLE (Mar. 30, 2020), https://queenseagle.com/all/2020/3/30/at-least-167-nyc-inmates-114-jail-staffers-now-have-covid-19 (describing how an outbreak of COVID-19 spread rapidly at an overcrowded Rikers Island in New York City).

would allow that busy clinician to more easily access critical health information, understand how to care for an inmates, and communicate ongoing issues to other healthcare providers. The resulting transparency would reveal hidden harms and unmet medical needs.

IV. THE EIGHTH AMENDMENT REQUIRES ENGAGEMENT WITH AVAILABLE INSTRUCTIONS FOR MEDICALLY SENSITIVE TRANSITIONS

Several states require healthcare providers to connect to an HIE, while other states defer to the judgement of individual clinicians rather than categorically mandate HIE connectivity.[125] In every state, however, national regulations and prevailing medical practice have pushed the exchange of medical information into a mainstream national standard of care.[126] This trend has a downstream effect on constitutional requirements for transitions of care into a jail or prison.[127] Correctional institutions must not ignore instructions contained in a CCD when those instructions are necessary to avoid denial, delay, or interference with medical treatment under the Eighth Amendment. Reliance on discarded medical practices (like paper-based transitions) injures vulnerable inmates who are shuffled between institutions in a disorganized way.[128] Failure to account for correctional treatment in an individual's health history is particularly harmful given that incarceration is itself an adverse health event.[129] Correctional

125. Michael Hochman et al., *Health Information Exchange After Ten Years: Time for A More Assertive, National Approach*, HEALTH AFFAIRS (Aug. 14, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190807.475758/full/.

126. *Hospitals Participating in the CMS EHR Incentive Programs*, OFF. FOR THE NAT'L COORDINATOR FOR HEALTH INFO. TECH. (Aug. 2017), https://dashboard.healthit.gov/quickstats/pages/FIG-Hospitals-EHR-Incentive-Programs.php (last visited Sept. 27, 2020) (By 2017, a state-by-state survey showed that over 95% of hospitals and associated clinics eligible for HITECH incentive payments could exchange electronic health information.).

127. *See infra* Part IV.A.

128. *See, e.g.*, Scarver v. Litscher, 434 F.3d 972, 975 (7th Cir. 2006) (describing a botched transition of care between prisons where prison officials "knew when they bought Scarver back from Florence . . . that he would be at risk of severe distress. Probably they should have known, but that would make them guilty merely of negligence and not of deliberate indifference . . . . Of course they soon realized that Scarver was in serious distress because of his mental illness. But there is no indication that they attributed this to the [harsh conditions imposed by the new environment] . . . . and they state without contradiction that Florence had not forwarded any of its records of Scarver's conduct there to the Wisconsin authorities, who may not have known that he had behaved better at Florence than he was behaving at Supermax.").

129. Chelsea Davis & David Cloud, *Bridging the Gap: Improving the Health of Justice-Involved People Through Information Technology*, VERA INST. JUSTICE 7 (Feb. 2015), https://www.prisonpolicy.org/scans/vera/samhsa-justice-health-information-technology.pdf.

institutions have a pragmatic incentive and constitutional duty under the Eighth Amendment to exchange medical information, using systems that the medical community has adopted, like sharing CCDs with state-based HIEs. For example, Wisconsin (home of one of the largest EHR developers, Epic) has already connected almost all of its correctional institutions to an HIE.[130] Meanwhile, states like Missouri (home to another large EHR developer, Cerner) and North Carolina list no correctional institutions connected to their state HIE.[131] Correctional failure to adopt modern medical information sharing practices increases the risk of harm to inmates and thus violates the Eighth Amendment when this failure frustrates medical treatment.

A. Prisons' Refusal to Adopt Modern Information Sharing Standards Interferes with Medical Treatment

Prison officials who reject connection to HIEs are deliberately indifferent when that rejection denies, delays, or intentionally interferes with medical treatment.[132] The fact that every state has an HIE in place highlights how absurd it is when jails and prisons plead mere ignorance after known medical issues cause harm. In a 2006 case prior to HITECH's adoption, the Seventh Circuit found no constitutional liability for an inmate's death based on a lack of actual knowledge that conditions of confinement caused harm.[133] Critically, the court observed that, after making substantial efforts to assist the inmate, the healthcare providers "did not know what more to do" because a treatment plan used successfully at his prior institution was not provided to the new prison.[134] But in areas where HIE use is widespread, these institutions have digital access to the patient's previous plan of care. Today, corrections officials have a better system for understanding vulnerable inmates—their medical providers can

130. *Wishin Participant Map*, WIS. STATEWIDE HEALTH INFO. NETWORK (WISHIN), https://www.wishin.org/ParticipatingProviders/WISHINParticipantMap.aspx (last visited Jan. 29, 2021).

131. *NC HealthConnex Participant Map,* N.C. HEALTH INFO. EXCH. AUTH., https://hiea.nc.gov/patients/nc-healthconnex-participant-map (last visited Jan. 29, 2021); *Participating Members*, SHOW-ME HEALTH INFO. NETWORK OF MO., https://www.shineofmissouri.com/Patient-Resources/Participating-Providers.aspx (last visited Jan. 29, 2021).

132. Lopez v. Smith, 203 F.3d 1122, 1132 (9th Cir. 2000) (citing Estelle v. Gamble, 429 U.S. 97 (1976)) ("Prison officials are deliberately indifferent to a prisoner's serious medical needs when they 'deny, delay, or intentionally interfere with medical treatment.'").

133. *See Scarver*, 434 F.3d at 977 ("Scarver has failed to cite evidence to overcome the defendants' denials that they knew these conditions were making his mental illness worse.").

134. *Id.* at 975.

access tools like an HIE.

The Eighth Amendment standard of medical care changes over time, and correctional institutions must respond by adopting tools that clinicians need to do their jobs.[135] For example, certain medical supplies are required by regulation of correctional facilities.[136] A stethoscope or bandage are vital tools kept in-house to satisfy local medical standards, while inmates might be transferred to a hospital for a surgery or an X-ray.[137] The question for corrections officials is where tools like the HIE database sit along this spectrum. For instance, imagine a prison housing a diabetic inmate in 1960, the same year the glucose test strip was invented. Few would have faulted a prison for failing to stock the brand-new technology. But after the technology became widely available, a warden may have been deliberately indifferent for refusing to keep the necessary test strips on hand because it may have imperiled the diabetic inmate's health. Likewise, today, if a prison fails to keep pace with industry record keeping standards, the prison would be liable for violating the constitutional guarantee of adequate care.

More than ten years after HITECH, HIEs more closely resemble a commonly needed diagnostic aid than a novel tool. The implementation of an HIE in every state implies that the technology has been widely adopted. Clearly then, prisons are behind the curve. If correctional clinicians already possess the infrastructure needed to inform a transition of care (like a computer, an electronic medical record, and an internet connection), then corrections officials should avoid placing obstacles (like restrictive information sharing policies, or outright refusal to connect to an HIE) between medical providers and the routine use of readily available tools.

The failure of corrections officials to heed communications from non-correctional healthcare providers may constitute deliberate indifference to an inmate's medical needs.[138] Courts look to the information communicated by other providers when determining the

135. *See supra* Part II.A (discussing the evolving medical standard of care and implications for technological progress).

136. *See, e.g.,* OHIO ADMIN. CODE § 5120:1-8-09 Standards for Jails in Ohio, Medical/Mental Health 5120:1-8-09 (requiring equipment considered medically necessary for a receiving screen among other essential services, while permitting referrals for emergency treatment and specialized services).

137. *See id.*

138. *See supra* Part I.B (discussing the requirement to heed known instructions for medical care); *see also* Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982), *rev'd on other grounds*, 515 U.S. 472 (1995) (holding that ignoring inmate health concerns may constitute deliberate indifference).

degree of indifference to a serious medical need.[139] In other words, the court asks, "What information did the prison have about the inmate at the time the incident occurred?" A correctional institution that categorically fails to account for the most common and simplest form of communication, the CCD, must have an effective alternative process to comply with the Eighth Amendment. An alternative process that does not provide the benefits of a CCD in a transition of care would logically deny, delay, or interfere with medical treatment of some vulnerable inmates. Any inmates injured in a transition under such an inadequate system could rely on the systemic communication failure to satisfy the deliberate indifference standard for an Eighth Amendment claim.

Willful blindness is not a defense to intentional interference with prisoner medical treatment.[140] Corrections officials should be wary of patterns of failure in paper transitions of care and should carefully consider requests by medical staff to simplify or modernize transitions. A policy that broadly inhibits access to medical information constitutes deliberate indifference. To avoid harming inmates and concomitant Eighth Amendment liability, corrections officials must enable their medical staff to take the same steps as any other medical provider to understand and act on the medical history of a given patient.

B. Compromises Necessary for Correctional Triage Do Not Excuse Systematic Departure from the Standard of Care for Medical Transitions

Prison policies that abrogate constitutional rights must be "reasonably related to legitimate penological interests" to avoid liability for resulting harms.[141] Under this rule, correctional healthcare mandated by the Eighth Amendment is exempt from some mainstream medical practices that affect institutional security and safety.[142] The penological interest exception must be justified by "discretion to devise reasonable solutions to problems" that threaten "safety and order" in

139. *Id.*

140. *Id.*; *see also* Wilson v. Seiter, 501 U.S. 294, 305 (1991) (holding that prison officials must consider a constellation of relevant conditions because "[s]ome conditions of confinement may establish an Eighth Amendment violation 'in combination' when each would not do so alone" when the combination would impact an identifiable human need).

141. Shaw v. Murphy, 532 U.S. 223, 229 (2001) (citing Turner v. Safley, 482 U.S. 78, 89 (1987)).

142. *See supra* Part III (discussing principles of medicine affected by security-focused institutions).

detention centers.[143] However, corrections officials remain liable for botched transitions of care when their interference with medical treatment (through restrictive or ineffective medical information-sharing policies) is not penologically justified.

HIE connections do not negatively impact penological interests.[144] While health information systems and connections do cost money, the cost excuse is less compelling in the corrections context because a "lack of financing is not a defense to the failure . . . to provide minimum constitutional standards" in corrections.[145] Even if budget issues were an appropriate defense to constitutional claims, the start-up cost of an HIE connection for an entire jail or prison[146] is reasonable when compared to health expenditures per inmate,[147] and such connections are heavily subsidized by the federal government.[148] Additionally, many HIEs offer low-cost options including internet-based access to CCDs.[149] Some state governments even subsidize costs entirely for public or nonprofit providers like departments of corrections, or situationally during health crises requiring broad-based action to safeguard public health.[150]

The primary statute governing inmate medical information, HIPAA, reaffirms that corrections officials cannot unjustifiably interfere with communication that is vital for medical treatment.[151]

143. Florence v. Bd. of Chosen Freeholders of the Cnty. of Burlington, 566 US 318, 326 (2012).

144. *See* Ben Butler, *Implementing and Integrating Health IT Solutions within a Correctional Environment*, 21 J. INTEGRATED DESIGN AND PROCESS SCI. 47, 53 (Nov. 22, 2017) (discussing an effective implementation and typical obstacles, which do not include safety and order issues that qualify as penological interests).

145. Carty v. Farrelly, 957 F. Supp. 727, 744–45 (D.V.I. 1997) (quoting Inmates of Allegheny County Jail v. Wecht, 699 F. Supp 1137, 1146 (1988)).

146. *See* Butler, *supra* note 96 (describing in Case Study 2 a $20,000 fee for connection to a county HIE as part of a strategic effort to reduce recidivism).

147. Matt McKillop, *Prison Health Care Spending Varies Dramatically by State*, PEW TRUSTS (Dec. 15, 2017), https://bit.ly/32STm64 (finding an average nationwide healthcare cost per inmate of $5,720 annually, with states varying from a high of $19,796 in California, to a low of $2,173 in Louisiana).

148. Ben Butler, *New HIE Funding Opportunities for Corrections: Health Information Technology's Role in Reducing Mass Incarceration,* CMTY. ORIENTED CORRECTIONAL HEALTH SERVS. (Mar. 2016) (noting that, beginning in 2016, correctional health providers "could participate in the 90% federal matching rate (90/10) for state activities to promote [HIE] for the coordination of care).

149. *See* Butler, *supra* note 96 (describing in Case Study 1 a web-portal to an HIE that cost $25 per month per healthcare provider).

150. *Announcing Free Access to WISHIN Pulse*, WIS. ST. HEALTH INFO. EXCH. NETWORK (May 6, 2020), https://wishin.org/ResourceCenter/FREEAccesstoWISHINPulse.aspx.

151. *See* 45 C.F.R. § 164.524(a)(2)(ii) (2014). (providing a security-focused exception as the only out for correctional institutions seeking to withhold medical information from the inmate

Still, some corrections officials argue that refusing to share health information among medical providers is justified because it reduces institutional security.[152] It does not. Specifically, neither CCD use nor an HIE connection harms the "health, safety, security, custody or rehabilitation [of inmates] or the safety of [correctional employees]" which are the only bases for an exception to medical information sharing under HIPAA.[153] At intake, a physician reviewing a CCD is simply informing themselves of what happened prior to the detainee's arrival, and perhaps validating the detainee's answers. The narrow data set contained in a CCD sent to an HIE does not contain any details that inmates themselves are not aware of. Therefore, release of a CCD for medical treatment does not increase risks to institutional security.

Unfortunately, correctional-medical transparency is unjustifiably limited by de facto practices in several states. Louisiana, an extreme example, refuses to share prisoner medical records without a court-enforced subpoena, even with other medical providers treating an inmate following release.[154] Louisiana's outright refusal to share medical information violates the spirit of the federal prohibition on "data blocking" in healthcare.[155] More importantly, unnecessary obstacles to accessing medical information threatens to harm detainees through delay, denial, or interference with prisoner medical treatment in violation of the Eighth Amendment.[156] Louisiana's aberrant standard demonstrates how state practices control correctional-medical transitions[157]—at least until courts have an opportunity to review those specific practices in the context of an injured prisoner.

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themselves); *see also* Charles v. Orange Cnty., 925 F.3d 73, 73 (2d Cir. 2019) (holding that failure to release sufficient medical information post-incarceration violates the Eighth Amendment.).

152. *See, e.g.*, Jeffrey Keller, *Reader Question: How Should We Handle Inmate Requests for their Medical Records?*, JAIL MED., July 10, 2015, https://www.jailmedicine.com/reader-question-how-should-we-handle-inmate-requests-for-their-medical-records/ ("Some jails have used [HIPAA's correctional exception] to issue blanket denials to all inmate requests for medical records.").

153. 45 C.F.R. § 164.524(a)(2)(ii) (2014).

154. *See* Woods et al., *supra* note 78 ("Five [Departments of Corrections] . . . did not allow patients to access their own records without a subpoena and one state, Louisiana, required subpoenas from both patients and providers.").

155. 21st Century Cures Act, Pub. L. No. 114-255 § 4004 (2016) (defining prohibited information blocking by healthcare providers as a practice that is "unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information").

156. Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

157. *See* Woods et al., *supra* note 78 (finding that less than half of states could sending a record without using physical paperwork, and that most states charged by the page for hard copy records.).

In short, Congress has recognized that health information sharing is vital to the continuity of care, and the HIPAA exemption corrections officials invoke to withhold medical records is not applicable to the narrow dataset traded on an HIE. The Eighth Amendment prohibits corrections officials from interfering with inmate care: They must recognize the risks of failing to share medical information consistently, which is not offset by a security benefit.[158] As medical providers in rural and resource-challenged areas make progress in connecting to one another, correctional medical providers wield a feeble justification for failure to do the same.[159] Where corrections officials neglect to share medical information in the most common and consistent fashion, the public will justifiably wonder—what are they hiding?

V. A NEW BARE MINIMUM: PREVENTATIVE REFORMS AND LIABILITY FOR BOTCHED TRANSITIONS

Correctional institutions have long been reticent to share information about historically subpar medical services. But that is not a legal defense for failing to adhere to widely accepted medical standards. This Note proposes two solutions. First, state governments should recognize the underutilization of correctional HIE connections and mandate their use to ensure consistency in correctional-medical transitions. States possess legislative tools to proactively protect vulnerable inmates. Second, failure to adhere to baseline standards of care in medical transitions should trigger Eighth Amendment liability. Transitions of care enabled by widespread use of CCDs already make it easier for prisoners to prove a breach of the deliberate indifference standard when corrections officials systematically reject medical information. State courts and the other Circuits should adopt the Second and Ninth Circuit approaches requiring engagement with post-correctional medical providers, and imposing liability for failures in transitions of care.

158. *See supra* Part I.B (discussing Lopez v. Smith, 203 F.3d 1122, 1132 (9th Cir. 2000)).

159. *See* Matt McKillop, *Health Care Continuity After Prison Protects Investments and Progress*, PEW TRUSTS (June 22, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/06/22/health-care-continuity-after-prison-protects-investments-and-progress (noting that records-sharing is a critical tool to help connect incarcerated people with providers on the outside to help safely manage illnesses and medications).

A. State-Based Reforms Would Facilitate Effective Correctional Transitions

There is a straightforward solution to uneven standards that continue to threaten vulnerable inmates: States should mandate the use of HIEs in correctional institutions.[160] State legislatures frequently require law enforcement officials to adopt similar systemic civil rights protections which exceed the minimum constitutional standards set out by the courts.[161] State laws requiring connections between correctional facilities and a state HIE could be modeled on existing statues governing healthcare exchange among non-correctional healthcare providers.[162] Such laws would benefit prisoners and reduce the risk of litigation by embracing the foundations of intake and discharge planning which are now common in mainstream medicine. A healthcare connectivity mandate would reduce dangerous gaps in communication for detainees with complex medical histories, including individuals with disabilities, mental illness, or chronic conditions.

A data-sharing mandate would promote transparency and cooperation between correctional and non-correctional medical providers. This is especially important for prisoners who move between institutions and those who require further medical services after release. Without a centralized system, the differing requirements of jails, prisons, and hospitals (among other healthcare settings) tend to frustrate communication by mixing extraneous with life-saving

160. While a national data sharing mandate would be more consistent and arguably more effective in promoting safe transitions of care, such a statute would face substantial political and legal obstacles. A majority of prisoners occupy state facilities—a regulatory sphere typically reserved for state governments. The federal government may not impose regulations on the states that exceed standards necessary to avoid a specific constitutional harm as declared by the Supreme Court (which has not yet taken up cases relating to the continuity of care). *See, e.g.*, Allen v. Cooper, 140 S. Ct. 994, 1004 (2020) (holding that Congress lacks authority to abrogate states' sovereign immunity when that abrogation "sufficiently connects to conduct courts have held [the Fourteenth Amendment] to proscribe"); *see also* Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 81–83 (2000) (holding that mandates applicable to states under the Americans with Disabilities Act can only support damages claims in areas of traditional state authority when authorized by a statute with congruence and proportionality to a clear constitutional harm). Note however that the federal government may enact similar reforms in the federal prison system (which is already somewhat networked) and the immigration detention system (which has far more gaps).

161. *See, e.g.*, N.Y. Criminal Procedure Law § 60.45(3)(a) (requiring a video recording of confessions to certain crimes); *see also* N.J. STAT ANN. § 40A:14 (2020) (requiring law enforcement officers wear and activate body cameras during certain interactions with the public; *see also* OR. REV. STAT. § 161.205(2) (prohibiting use of chokeholds by corrections officers).

162. *See, e.g.*, VT. STAT. ANN. tit. 18 § 702(2) (2010) (requiring healthcare providers collaborate with Vermont Information Technology Leaders, which facilitates the state HIE).

information during transition. State HIEs can provide a bridge that connects prisoners across these environments. An HIE organization is well positioned to understand where the continuity of medical care fails, and which correctional institutions to prioritize for connection.

Legislators should enact information sharing mandates that require carceral healthcare providers to share information from three key points during incarceration: intake, sick call, and release. By sharing information when inmates interact with medical staff, corrections officials can ensure that their systems are designed to avoid deliberate indifference to known medical needs.

First, a standard medical intake process aided by a CCD would improve the accuracy and efficiency of screening. In the correctional context, screening is vitally important because roughly half of the incarcerated population lives with a chronic medical condition.[163] Correctional institutions receiving inmates from a medical setting (surgery, psychiatric stabilization, drug treatment, etc.) should ensure that medical providers access an HIE and apply insights from a recent CCD to the inmate's new treatment plan. A more consistent option is to implement HIE checks for all inmates on arrival to inform their conditions of confinement. This precaution protects correctional institutions from liability by affirmatively acting on known medical information and thus avoiding deliberate indifference.[164]

Second, state law should require that correctional institutions document ongoing correctional healthcare in an HIE. The sick call system provides an ideal point of contact for this documentation because it necessarily involves inmate-provider interaction. Review and reconciliation of past treatment during sick call would help medical providers spot issues with current treatment, while creating a durable record of care across institutions. Incorporating HIE interaction into the existing sick call process would not further burden institutions, because it could be integrated into existing procedures. If directed by law, corrections officials would ensure that medical providers have access to an HIE/CCD lookup for any medical appointment, and HIE organizations could indicate when prisons or jails are not complying with the mandate.

Third, correctional institutions should be required to push a CCD

163. MARUSCHACK ET AL., *supra* note 24.

164. *See supra* Part I.A (discussing the Eighth Amendment obligation to heed medical instructions).

to their state HIE upon release of an inmate. This is an area of low security risk, but high potential value to the public health system overall. Medical information from the prison, including medications and treatment plans, are needed by healthcare professionals working with inmates on release. When a former inmate seeks assistance from a medical or social service provider back home, those providers may seek the patient's consent to access prior records. State law should require that correctional institutions participate in this continuity of care—informing providers about what happened during incarceration, with the goal of improving the quality and efficiency of care both in and out of custody.

Even if an inmate does not have documented prior medical history, these protocols would avoid deliberate indifference systematically at intake, discharge, and during active medical treatment which may result in transfer to another facility. Such communications with outside medical providers are especially important for prisoners who are not already receiving services from the non-correctional health system.[165] Prisoners experience high rates of medical complications following incarceration.[166] Policymakers focused on this problem should structure data sharing mandates to connect vulnerable inmates with post-custody healthcare. Consistent reporting requirements for specific harms to vulnerable inmates would permit systematic analysis of of strategies to reduce the risks of correctional transitions. In this manner, consistent HIE connections would inform a more effective correctional-medical system.

B. Courts Should Impose Liability for Reckless Transitions Upon Arrival and Release from Custody

Correctional institutions that needlessly obstruct prisoner medical care are liabilities for the governments that fund them because those governments often indemnify corrections officials who harm inmates while acting in their official capacity.[167] Over ten years after the modernization of medical information standards in HITECH, courts

165. *See generally* Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157 (2007) (describing trends in post-corrections fatality that might be mitigated by engagement with post-correctional medical services).

166. *Id.*

167. *See* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1676 n.391 (2003) (noting that "the typical arrangement, usually by statute, is that the correctional agency indemnifies its officers unless the act on which a lawsuit is predicated was outside the 'scope of employment' or was intentional or malicious").

are finally beginning to invalidate correctional policies that inhibit the continuity of medical care. The choice for state and county governments is clear: suffer costly court proceedings on the road to compliance, or else adopt a system to account for the needs of vulnerable prisoners during transition.[168]

Inmates are winning lawsuits based on the failure of correctional institutions to provide a transition of care. Discharge planning is increasingly viewed by the courts as a critical component of in-custody medical care, allowing inmates to sue for post-incarceration injuries.[169] The Second and Ninth Circuits now hold that a right to medical treatment extends beyond prison walls, requiring that corrections officials cooperate with post-correctional medical providers.[170] Simultaneously, some district courts recognize that systemic failures in medical care are sufficient to support an individual inmate's claim of deliberate indifference—even without actual knowledge of that inmate's vulnerability.[171] In circuits without an explicit discharge plan requirement, prisoners might also allege systemic failures at *intake*, especially where a pattern of botched transitions puts officials on notice of systemic danger. While the affirmative duty to provide a discharge plan has not been assessed in every court, constitutional standards for the intake function are well defined, and require prison officials to avoid interference with medical judgement and communication.[172]

Under the prevailing standard, proving deliberate indifference is a herculean task.[173] One that is incongruent with the "evolving standards

168. *See* Ben Butler, *Meaningful Use and Corrections: Unknown Opportunities*, CMTY ORIENTED CORRECTIONAL HEALTH SERVS. (June 2014), https://cochs.org/files/health-it-hie/cochs-meaningful-use.pdf (describing the risks of a correctional healthcare "black box" and the benefits of connectivity with non-correctional providers).

169. *See supra* note 54 and accompanying text (describing factors in the discharge planning requirement).

170. *See* Charles v. Orange Cnty., 925 F.3d 73, 88–90 (2d Cir. 2019) (holding that medically vulnerable detainees may state an Eighth Amendment claim for failure to provide discharge planning); *See* Wakefield v. Thompson, 177 F.3d 1160, 1165 (9th Cir. 1999) (holding that inmates must be provided with medication and other supports necessary to "cover their transition to the outside world."); *see also* E.D. v. Sharkey, 928 F.3d 299, 307 (3d Cir. 2019) (citing the standards laid out in *Charles v. Orange County* to extend deliberate indifference to the immigration context without specifically discussing transitions of care).

171. *See, e.g.*, Caramillo v. Correct Care Sols., 2020 US Dist. LEXIS 85403 at *22 (E.D. Va. 2020) (holding that plaintiffs may adequately plead gross negligence against prison official by alleging facts showing officials are aware of "the dangers posed by an allegedly inadequate medical care system").

172. *See supra*, Part IV.A (discussing the Eighth Amendment mandate to avoid undue interference with medical communication).

173. *See* Shevon I. Scarafile, *Deliberate Indifference or Not: That is the Question in the Third*

of decency that mark the progress of a maturing society."[174] As such, the remaining eleven Circuits should follow the Second and Ninth in imposing Eighth Amendment liability for correctional institutions' failure to provide an adequately modern transition of care in the course of inmate treatment. Circuits considering how the deliberate indifference standard applies to correctional intake and discharge should undertake a factual inquiry to determine the elements of a non-correctional transition of care, and then incorporate those elements into concrete standards for corrections officials.

One shortcoming of this approach is that injunctions that alter prison practices tend to be narrowly drawn.[175] Without legislative action, outdated correctional practices will leave behind prisoners with inadequate access to legal services. If the issue of correctional-medical transition is left to the courts, prison litigation will result in a patchwork of inconsistent Eighth Amendment safeguards. Therefore, both legislative action and judicially mandated reform are needed to secure the wellbeing of inmates as they enter and exit custody.

CONCLUSION

Ineffective transitions of care kill people moving into and out of correctional institutions. The failure to calibrate conditions of confinement to individual needs can seriously harm inmates, even before a finding of guilt or innocence. Modern medicine has developed new tools to manage these risks, and correctional medical providers must adopt the same tools to provide adequate medical care. Medical providers have coalesced around a standard digital format because reliance on inconsistent paper processes costs lives. Jails and prisons are largely capable of transacting in that information, but they most often choose not to. Over ten years after HITECH, state legislatures and the courts should act to ensure that unconstitutional practices in the criminal justice system do not perpetuate bad outcomes in the health system.

Circuit Jail Suicide Case of Woloszyn v. Lawrence County, 51 VILL. L. REV. 1133, 1136 (2006) (noting that plaintiffs seeking to prove "deliberate indifference" bear the burden of illustrating that custodial officers both "knew of the . . . detainee's vulnerability . . . and did not act affirmatively" to prevent harm).

174. Trop v. Dulles, 356 U.S. 86, 101 (1958).

175. Miller v. French, 530 U.S. 327, 333 (2000) ("Under the Prison Litigation Reform Act, a court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of a Federal right, and is the least intrusive means necessary to correct the violation of the Federal right.").

The risk to Ruben Nunez's life at San Diego Central Jail should have been obvious. He arrived from a psychiatric hospital. He carried with him a paper packet that described his vulnerability. It contained scattered instructions on how to keep him healthy. But that document was not enough to keep him alive. Vulnerable prisoners like Ruben deserve more. People deprived of their liberty deserve a modern medical system that handles people with a lot more care.