



FEBRUARY 2022

# MEDICAL RELEASE FROM INCARCERATION: A STUDY OF COMPASSIONATE RELEASE, PAROLE, AND FURLOUGH

PREPARED BY

**2021 HOUSE RESOLUTION  
51 TASK FORCE**

# I. Executive Summary

The Louisiana House of Representatives created the bi-partisan, interbranch “House Resolution 51 Task Force” in June 2021 to study the efficacy of the current eligibility, recommendation, and approval processes for medical parole, medical treatment furlough, and compassionate release.<sup>1</sup> Representatives of the Louisiana Department of Public Safety and Corrections (DPS&C), the Louisiana Sheriff’s Association (LSA), the Louisiana Department of Health (LDH), and the Governor’s office, along with members of the state legislature, physicians at private and state medical facilities who treat incarcerated patients, family members of impacted incarcerated persons, crime survivors, family members of victims, and other stakeholders and experts in incarceration policies comprise the Task Force.<sup>2</sup>

To prepare this report, the full Task Force conducted four public meetings. The Task Force also created three subcommittees, namely data analysis, statutory and policy review, and national standards and comparison, to provide more in-depth analysis and discuss potential policy recommendations. In addition, appointed Task Force members received data, information, input, and guidance from a broad range of stakeholders across the state, including DPS&C medical staff, law enforcement officials, medical professionals, LDH and Medicaid staff, formerly and currently incarcerated individuals and their families, justice reform advocates, and victim advocates.

The Task Force found that despite Louisiana’s aging and medically vulnerable prison population, the medical parole, medical treatment furlough, and compassionate

release programs resulted in the release of less than 0.6% of people housed in DPS&C facilities between 2018 and 2021. As a result, Louisiana’s taxpayers are expending unnecessary funds to continue incarcerating and providing healthcare for individuals whose significant healthcare expenses, which totaled \$96.3 million for FY 2020, would be covered by Medicaid or Medicare if they were released.<sup>3</sup> Due to the severity of illnesses required to participate in the above programs and the accompanying eligibility requirements based on significant physical impairment, these individuals likely would not pose a high risk of a threat to public safety.

Examining nationwide practices, along with quantitative and substantive data on medical releases in Louisiana, the Task Force recommends that Louisiana lawmakers adopt a comprehensive set of reforms to improve the eligibility, recommendation, and approval processes for medical parole, medical treatment furlough, and compassionate release. These reforms would simplify eligibility criteria, standardize medical definitions and assessment processes, improve communication between treating physicians and DPS&C facilities, and streamline the review process. These reforms would also ensure consistency across medical release programs and custodial facilities, enhance medical outcomes for incarcerated individuals, prioritize prison beds and in-prison medical care for those who pose a serious threat to public safety, and result in overall cost savings for Louisiana taxpayers.

## II. Statement of the Problem

### A. Demographics and Medical Conditions

Louisiana has an aging and sick prison population.<sup>4</sup> As of June 30, 2021, DPS&C reported that Louisiana's total prison population is approximately 26,000.<sup>5</sup> Of these, approximately 13,000 are housed in DPS&C facilities while DPS&C contracts with parish jails to house the remaining roughly 13,000 people.<sup>6</sup>

In part due to high incarceration rates and historical sentencing practices, Louisiana's state prison population has aged rapidly, contributing to a steady rise in prison medical costs—much of which is spent to care for geriatric people.<sup>7</sup> In 2019, the average age of people serving sentences post-conviction in

**“The hospital really caught my attention because when someone gets sick and close to dying, they would put them in a room by themselves. [They would leave them] in a cold room in a bed, hook the tubes up, and they would leave them in a cold room by themselves. I was like wow, I pray and hope that I never get sick and die in this place, because when you think about it nobody wants to die alone. And there was no button to touch like they do in a regular hospital room where you have something to bring the nurse in. There was none of that. This person is just laying in that room by themselves. It was just heartbreaking to me.”**

*Checo Yancy, HR 51 Task Force Vice Chair and formerly incarcerated individual at Louisiana State Penitentiary where he co-founded the hospice program*

Louisiana was 40 years old (up from 36.1 years old in 2014).<sup>8</sup> Approximately 15% of people under DPS&C custody in 2019 were 55 years of age or older<sup>9</sup> and accounted for 69% of deaths in DPS&C facilities between 2015 and 2019.<sup>10</sup> By comparison, roughly 11% of people in federal custody are 56 years of age or older.<sup>11</sup>

Louisiana leads the nation in life without parole sentences:<sup>12</sup> Approximately 4,400 people in DPS&C custody, representing roughly 17% of Louisiana's prison population, are serving life sentences.<sup>13</sup> More than half of those serving life sentences in DPS&C facilities (54%) are 50 years or older.<sup>14</sup> Similarly, 52% of the 63 people serving a capital sentence are 50 years or older.<sup>15</sup> This population of elderly individuals serving long sentences has the highest healthcare costs and place the heaviest fiscal burdens on the state.

Many individuals in DPS&C custody are diagnosed with chronic medical conditions.<sup>16</sup> In FY 2020, roughly 6,000 people incarcerated in DPS&C facilities had hypertension, over 400 had heart disease, about 1,200 had been diagnosed with diabetes, roughly 1,600 had chronic obstructive pulmonary disease (COPD), and about 300 had cancer.<sup>17</sup> In FY 2020, no less than 61% of the population in any DPS&C facility was receiving medication; at some DPS&C facilities, nearly 90% of the prison population was receiving medication.<sup>18</sup>

Louisiana prisons also have higher than average rates of death compared to other states.<sup>19</sup> From 2015 to 2019, 558 incarcerated people died in DPS&C facilities in Louisiana;<sup>20</sup> 94.62% of those deaths were related to medical illness, with heart disease

(33.63%) and cancer (18.90%) being the leading causes of medically-related deaths.<sup>21</sup> Less than half of known medical deaths were related to a pre-existing medical condition that was diagnosed before the person was taken into custody.<sup>22</sup> In addition 158 people died in state prisons in Louisiana during 2020, an increase from 112 people in state prisons (up 41%) in 2019.<sup>23</sup>

**B. Fiscal Burden and Medicaid Coverage**

DPS&C is required to provide medical healthcare—consistent with community standards—to the approximately 13,000 people incarcerated in DPS&C facilities.<sup>24</sup> In FY 2020, DPS&C had roughly \$96.3 million in medical expenditures, an increase from the approximately \$81 million in medical expenditures in FY 2019 and a 25% increase from 2015.<sup>25</sup> DPS&C’s FY 2021-2022 budget devotes 13% of the total budget, or \$54,294,891, to health services.<sup>26</sup> An additional 1% of the total budget, or \$3,688,606, is allocated to diagnostic services.<sup>27</sup> These expenditures are

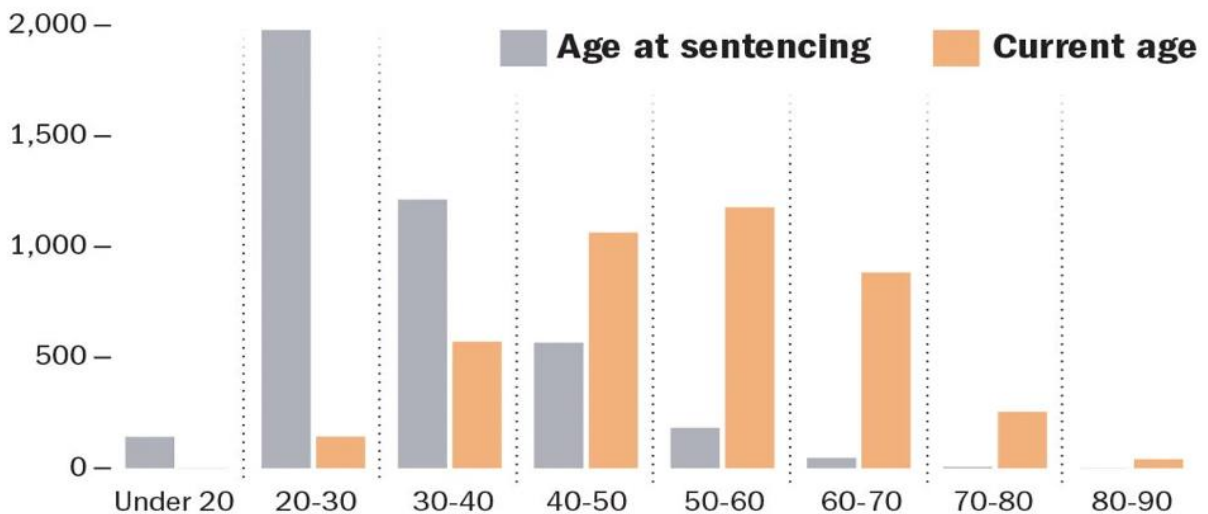
with the highest medical expenses: The Chief Financial Officer for DPS&C noted recently that “we have one individual in our system that costs us \$3.7 million a year in pharmaceutical costs.”<sup>28</sup>

Medicaid coverage for incarcerated individuals is limited by policies set forth by the Centers for Medicare & Medicaid Services (CMS).<sup>29</sup> Pursuant to CMS, Medicaid will not cover healthcare services for incarcerated people, unless that person is admitted as an in-patient to an outside hospital for twenty-four or more hours.<sup>30</sup> Notably, Louisiana suspends Medicaid eligibility for incarcerated persons, rather than closes benefits, thereby facilitating more efficient coverage when needed for external admissions and medical release programs. A complete mortality analysis of formerly incarcerated Louisiana Medicaid members is included in Attachment A.

Following the expansion of Medicaid in July of 2016, Louisiana Medicaid, the Medicaid managed care organizations, and DPS&C developed a streamlined method to enroll people being released from the state’s

**An aging population of Louisiana lifers**

A look at the number of prisoners serving life sentences and their ages:



Source: Louisiana Department of Public Safety and Corrections Staff graphic

Figure 1

Medicaid program. Once a release date is captured in the Medicaid system, that person is re-linked to a health care plan if they are eligible for Medicaid coverage.

From January 1, 2017 to December 31, 2021, the Louisiana Department of Health received 15,869 applications<sup>31</sup> through the Pre-Release Enrollment Program and processed or enrolled 14,994 members. Over 90% of enrollees receive full benefits upon release. Members are pre-linked to the health plan of their choice prior to release and receive documentation at the DPS&C facility, with aims to minimize gaps in care after release. Members needing more advanced medical care may be placed at an assisted living or nursing facility if needed, or provided with in-home hospice care.

Transferring some of the significant financial burden from DPS&C to Medicaid by releasing more elderly, sick, and other high needs incarcerated patients would lead to significant cost savings to the state, in addition to freeing limited DPS&C medical staff resources for treating the rest of the prison population.<sup>32</sup>

In 2017, the Louisiana Justice Reinvestment Task Force found that “a small number of

**“I would say over the years that I was there and did medical parole, I may have been successful on maybe 10 cases. And I saw some guys who we didn’t get it done fast enough and they transitioned to death. We didn’t make it. It was heartbreaking.”**

*Checo Yancy, HR 51 Task Force Vice Chair and formerly incarcerated individual at Louisiana State Penitentiary where he co-founded the hospice program*

Louisiana prisoners with serious medical needs were costing the Department of Corrections (and ultimately taxpayers) millions of dollars each year. Because Medicaid eligibility is suspended during periods of incarceration under federal law, costly treatment for prisoners with cancer, heart disease, and other chronic or urgent medical conditions is paid for entirely with state tax dollars.”<sup>33</sup> Considering these findings, the Louisiana Justice Reinvestment Task Force recommended creating the medical treatment furlough program in effect today.<sup>34</sup> However, as described below, eligibility for medical treatment furlough has been restricted and it has been seldom used since the program was first enacted.

### **C. Medical Release Programs Available in Louisiana**

Louisiana employs three distinct processes to release incarcerated people with serious medical issues for healthcare and hospice care outside of a prison: compassionate release,<sup>35</sup> medical parole,<sup>36</sup> and medical treatment furlough.<sup>37</sup> As highlighted by the COVID-19 pandemic, current statutory requirements and policies significantly limit the use of these medical release mechanisms. In 2021, 17 people were approved for release through these programs, including 9 individuals approved for compassionate release, 4 individuals approved for medical parole, and 4 individuals approved for medical treatment furlough. Since 2006, a total of 243 people have been released through these mechanisms.

Several factors contribute to Louisiana’s rate of compassionate release, medical parole, and medical treatment furlough releases, including 1) restrictive eligibility criteria, 2) inconsistent medical definitions, 3) lack of public information and data on medical release programs, 4) limited referrals, due in part to 5) a complex review and approval process.

Recognizing the restrictions on eligibility for medical release, a lack of data on how medical release is utilized in state-run facilities, and the absence of a clear mechanism for treating physicians at private or state medical facilities to recommend or initiate medical release, the Louisiana legislature created the Task Force to examine the efficacy of current eligibility requirements, recommendation processes, and review processes for medical release.

In examining the data, testimonials, and national best practices included in this report, the Task Force identified five key areas of policy and statutory recommendations: 1) eligibility, 2) initiation of consideration, 3) review and decision-making, 4) post-release planning and transition, and 5) tracking and reporting outcomes.



# III. Background on Medical Release

Louisiana provides medical release to eligible incarcerated individuals with serious medical conditions and terminal illnesses through three distinct processes: (1) Compassionate Release; (2) Medical Parole; and (3) Medical Treatment Furlough. Medical Parole and Medical Treatment Furlough are statutorily defined at La. Stat. Ann. § 15:574.20 and are also subject to internal DPS&C Policy. Compassionate Release is statutorily authorized at La. Stat. Ann. § 15:833.2 and prescribed by DPS&C Health Care Policy HCP41. The relevant forms pertaining to medical release and referenced below are provided in Attachment B.

## A. Compassionate Release

DPS&C Policy provides for Compassionate Release whereby an individual may be granted a “temporary leave of absence from secure custody for limited (medical) purposes” for the remainder of their sentence, with diminution of sentence if otherwise eligible, subject to revocation.<sup>38</sup>

### A.1 Eligibility

To qualify for Compassionate Release, an individual must be **terminally ill** or a **limited mobility offender**.<sup>39</sup>

- Terminally ill means that the individual has been diagnosed with a terminal illness and death is expected within 60 days.<sup>40</sup>
- Limited mobility offenders are individuals who, due to an underlying medical condition, are unable to perform activities of daily living without significant assistance or are confined to a bed or chair, including but not limited to prolonged coma and mechanical ventilation.<sup>41</sup>

### A.2 Additional Restrictions

In general, Compassionate Release will not be granted if the prisoner’s condition was present at the time of sentencing, unless his or her overall condition has significantly deteriorated since that time.<sup>42</sup> In addition, individuals sentenced to death are not considered for Compassionate Release.<sup>43</sup>

**“One common barrier is that the facility often wants to see the patient again themselves, to reassess, requiring transportation back and forth. This delay is frustrating as they are not trusting our opinions as medical professionals. It’s not a streamlined process. It would be helpful if there were clear guidelines that we could go by to get things done efficiently.”**

*Dr. Daniel Brady - Attending physician at a community hospital*

### A.3 Procedure

Any treating health care practitioner or staff member with knowledge of an individual’s terminal illness or limited mobility may initiate the process of recommending an individual for compassionate release.<sup>44</sup> A treating health care practitioner may initiate the process by completing a Medical Criteria Screening Form (HCP41-a) and submitting it to the Facility<sup>45</sup> Medical Director.<sup>46</sup>

The Facility Medical Director evaluates every Medical Criteria Screening Form and advises whether the individual meets, or

does not meet, the medical criteria for compassionate release consideration.<sup>47</sup> If the Facility Medical Director determines that the medical eligibility criteria are met, he or she completes a portion of the Recommendation for Compassionate Release Form (HCP41-b) and submits it to the Unit Warden for review.<sup>48</sup>

Once a recommendation for compassionate release is received by the Unit Warden, the Unit Warden ensures that an interdisciplinary team provides input on the recommendation, including a public safety risk assessment.<sup>49</sup> This assessment includes review of the individual's conduct while incarcerated, any indications that he or she represents a low risk to him/herself or to society. Each member of the interdisciplinary team provides information relative to their discipline. The interdisciplinary team at each institution is appointed by the Warden<sup>50</sup> and consists, at a minimum, of representatives from the following areas: Warden (or designee), Medical Department (nurse or healthcare practitioner), Mental Health Department (social worker), Classifications (staff member who reviews an individual's housing and programming needs), and Security (staff member who reviews the institutional record).<sup>51</sup>

The Unit Warden also evaluates the recommendation for compassionate release and provides information on the individual's offense/conviction and available information regarding his or her time incarcerated.<sup>52</sup> Thereafter, the Unit Warden may recommend an individual for compassionate release by submitting the Recommendation for Compassionate Release Form (HCP41-b) to the DPS&C Chief Nursing Officer for processing.<sup>53</sup>

The DPS&C Medical Director then evaluates the recommendation for

**“In my experience, reaching out to DOC medical directors and facility directors has been well-received from the DOC's standpoint. The initial step in doing that that outreach is pretty smooth but after that everything becomes very opaque. I often don't know what to do afterwards, particularly for patients that are very sick and I don't know if they will die while they are waiting. It's heartbreaking to think they might go to back the facility and die there instead of having the chance to be with friends and family. I wish there was bilateral communication between us and the DOC - in some ways these are our shared patients.”**

*Dr. Anjali Niyogi - Attending physician at a community hospital and Chair of the HR 51 Taskforce*

compassionate release for compliance with applicable law and policy and may recommend the individual for compassionate release to the DPS&C Secretary.<sup>54</sup> If recommended, the DPS&C Secretary may grant release, seek additional information, or decline to grant compassionate release.<sup>55</sup> The DPS&C Secretary does not review applications not recommended by the DPS&C Medical Director.

#### *A.4 Discharge*

The parameters of compassionate release discharge depend on the underlying eligibility criteria:

- Terminally ill individuals, as defined above, may be discharged to a health care facility or a home-setting which is able to meet the needs of the individual.<sup>56</sup>



- Limited mobility offenders, as defined above, must be discharged to a healthcare facility.<sup>57</sup>

Additionally, upon approval for compassionate release, the individual is supervised through visits by the Division of Probation and Parole.<sup>58</sup> If the individual's condition has improved such that they would not be eligible for compassionate release, the Division of Probation and Parole must report these findings to the DPS&C Medical Director within five business days.<sup>59</sup>

The term of compassionate release is for the remainder of the individual's sentence, with diminution of sentence if otherwise eligible, subject to revocation.<sup>60</sup>

In addition, when compassionate release is approved, the Unit Warden notifies the victim or the victim's family by certified mail of the individual's release.<sup>61</sup>

#### A.5 Revocation

**On November 24th my phone rang and it was him. He looked like he wanted to cry. He said someone was there to put shackles on him again. I could hear the man in the back saying 'Call DCI, call DCI, call DCI.' They just didn't want to tell us that [his compassionate release] was revoked. He was probably a little better and so he could go back to jail. They say that his probation got revoked because he was too close to his victim's home – The distance was too close from our address. All of this was on Thanksgiving Eve. We were on our way over there to spend it with him. Then he called to say he was being shackled up.**

*Elrico and Heather Alex, brother and sister-in-law of incarcerated patient*

DPS&C Policy provides that compassionate release may be revoked due to an improvement in condition, discharge from a healthcare facility, or absconding.<sup>62</sup>

## B. Medical Parole

Medical Parole is a statutory program administered by DPS&C by which an eligible individual may be released for a term of parole equivalent to the remainder of the individual's sentence without diminution of sentence for good behavior, subject to revocation.

### B.1 Eligibility

To be eligible for medical parole, an individual must be **terminally ill** or **permanently disabled**.<sup>63</sup>

- Terminally ill is defined as being diagnosed with a terminal illness and having a life expectancy of less than one year. In addition, the qualifying medical condition is usually permanent in nature and carries a poor prognosis.<sup>64</sup>
- Permanently disabled is defined as unable to engage in any substantial gainful activity by reason of any medically determinable physical impairment that is permanently irreversible or can be expected to result in death.<sup>65</sup>

### B.2 Additional Restrictions

Pursuant to the 2017 amendments to the Medical Parole Statute, medical parole is not available to anyone serving a sentence for first- or second-degree murder, or to anyone serving a death sentence.<sup>66</sup> Additionally, medical parole consideration shall not be given to any individual whose medical condition was present at the time of sentencing unless that condition has significantly deteriorated since that time.<sup>67</sup>

Furthermore, no DPS&C employee may recommend that a permanently disabled or terminally ill individual's sentence be commuted due to his or her qualifying medical condition.<sup>68</sup>

### B.3 Procedure

Any treating health care practitioner or staff member with knowledge of an individual's terminal illness or limited mobility may initiate the process of recommending an individual for

**“My job is to medically make the decision. Of course, from a medical standpoint, I think [a patient] should be able to go. I'm never really aware of what their charges were and I prefer not to, sometimes I have no choice but to know what their charges were, what their crimes were. But my decision is based on their medical problems, their medical history. Their prison records and everything else, I don't know about any of that and I prefer not to know. So, I mean of course I want them all to leave because I think that but I don't know the whole entire picture about all their other prison records and all that. From a medical standpoint, I do want them to be able to get out and be with their family, but I don't also know what their crimes entailed, what their disciplinary records were and all that.**

*Cindy Park, Nurse Practitioner at LSP who is directly involved in initiating the process of Compassionate Release/Medical Parole/Medical Furlough*

compassionate release.<sup>69</sup> A treating health care practitioner may initiate the process by completing a Medical Criteria Screening Form (HCP4I-a) and submitting it to the Facility Medical Director.<sup>70</sup>

The Facility Medical Director evaluates every Medical Criteria Screening Form and advises whether the individual meets, or does not meet, the medical criteria for medical parole consideration.<sup>71</sup> If the Facility Medical Director determines that the medical eligibility criteria are met, he or she completes a portion of the Recommendation for Medical Parole or Medical Treatment Furlough form (HCP4I-c) and submits it to the Unit Warden for review.<sup>72</sup>

Once a recommendation for medical parole is received by the Unit Warden, the Unit Warden ensures that an interdisciplinary team provides input on the recommendation, including a public safety risk assessment.<sup>73</sup> The interdisciplinary team is not defined in the medical parole statute.

The Unit Warden also evaluates the recommendation for medical parole and provides information on the individual's crime, criminal history, length of time served in custody, institutional conduct, any indications that the individual represents a low risk to himself or society, and how the individual's medical condition related to their overall risk to society.<sup>74</sup> Thereafter, the Unit Warden may recommend an individual for medical parole by submitting the Recommendation for Medical Parole or Medical Treatment Furlough Form (HCP4I-c) to the Department's Chief Nursing Officer for processing.<sup>75</sup>

The DPS&C Medical Director then evaluates the recommendation for medical parole for compliance with applicable law

and policy and may recommend the individual for medical parole to the DPS&C Secretary.<sup>76</sup> The DPS&C Secretary may recommend the individual for medical parole and forward the case to the Committee on Parole, seek additional information, or deny medical parole.<sup>77</sup>

For applications recommended by the DPS&C Secretary, ultimate authority to grant or deny medical parole rests solely with the Committee on Parole.<sup>78</sup> The Committee on Parole may also require additional medical evidence prior to rendering a decision.<sup>79</sup> If granted, the Committee on Parole may also establish additional conditions of medical parole.<sup>80</sup> Additionally, for medical parole to be granted to an individual, the Committee on Parole must determine that he or she does not pose a threat to public safety.<sup>81</sup>

If an individual is denied medical parole by the Committee on Parole, he or she may apply for rehearing within the time frame applicable to parole denials generally.<sup>82</sup> The minimum time to request a rehearing varies from 6 months to two years depending on an individual's underlying conviction.<sup>83</sup>

#### *B.4 Discharge*

An individual granted medical parole may be discharged to a health care facility or to a residential location.<sup>84</sup>

The term of release on medical parole is the remainder of the individual's sentence, without diminution of sentence for good time.<sup>85</sup>

An individual granted medical parole must be supervised by routine visits by the Division of Probation and Parole.<sup>86</sup>

#### *B.5 Revocation*

Medical parole may be revoked for an

improvement in condition such that the individual would no longer be eligible or violation of any condition of parole.<sup>87</sup>

### **C. Medical Treatment Furlough**

Medical Treatment Furlough is a statutory program administered by DPS&C by which an eligible individual may be released for a term equivalent to the remainder of the individual's sentence without diminution of sentence for good behavior, subject to revocation.<sup>88</sup> Medical treatment furlough allows for the release of incarcerated individuals to health care facilities for medical care and treatment.<sup>89</sup>

Following Governor Edwards' signing of the Justice Reinvestment Package in 2017 and Senate Bill 139 amending La. Stat. Ann. § 15:574.20, medical treatment furlough was created as an alternative to medical parole and compassionate release.<sup>90</sup> At the time of its enactment, medical treatment furlough was expected to save Louisiana millions of dollars because many eligible individuals would receive Medicaid benefits. Medical treatment furlough was amended in 2018 by Act No. 573.<sup>91</sup> Notably, the 2018 amendments reduced eligibility by making individuals sentenced for a conviction of first degree murder ineligible.<sup>92</sup>

#### *C.1 Eligibility*

Individuals who are ineligible for release on medical parole and are determined to be **limited mobility offenders** may be considered for medical treatment furlough.<sup>93</sup> Pursuant to DPS&C policy on medical treatment furlough, a limited mobility offender is one who, due to an underlying condition, is unable to perform activities of daily living without assistance or is bedbound, including but not limited to prolonged coma or mechanical ventilation.<sup>94</sup> In addition, limited mobility

offenders must require rehabilitative and/or ongoing skilled nurse care to complete activities of daily living.<sup>95</sup>

### *C.2 Additional Restrictions*

Medical treatment furlough is unavailable to anyone serving a sentence for first degree murder or a death sentence.<sup>96</sup> Additionally, medical treatment furlough consideration shall not be given to any individual whose medical condition was present at the time of sentencing unless that condition has significantly deteriorated since that time.<sup>97</sup>

Furthermore, no DPS&C employee may recommend that a limited mobility offender's sentence be commuted due to his or her limited mobility.<sup>98</sup>

### *C.3 Procedure*

Any treating health care practitioner or staff member with knowledge of an individual's terminal illness or limited

**“I know there are processes in place, like medical parole and medical treatment furlough, but they are underutilized. I don't quite know how as a treating physician to do anything but keep them in a very expensive hospital setting for their medical safety, but there should be more thought as to what we can do without using up healthcare dollars or DOC dollars. Sometimes they just need a skilled nursing level at a LTAC facility where there is more consistency in their care.”**

*Dr. Anjali Niyogi - Attending physician at a community hospital and Chair of the HR 51 Taskforce*

mobility may initiate the process of recommending an individual for compassionate release.<sup>99</sup> A treating health care practitioner may initiate the process by completing a Medical Criteria Screening Form (HCP41-a) and submitting it to the Facility Medical Director.<sup>100</sup>

The Facility Medical Director evaluates every Medical Criteria Screening Form and advises whether the individual meets, or does not meet, the medical criteria for medical treatment furlough consideration.<sup>101</sup> If the Facility Medical Director determines that the medical eligibility criteria are met, he or she completes a portion of the Recommendation for Medical Parole or Medical Treatment Furlough form (HCP41-c) and submits it to the Unit Warden for review.<sup>102</sup>

Once a recommendation for medical treatment furlough is received by the Unit Warden, the Unit Warden ensures that an interdisciplinary team provides input on the recommendation, including a public safety risk assessment.<sup>103</sup> The interdisciplinary team at each institution is appointed by the Unit Warden<sup>104</sup> and consists, at a minimum, of representatives from the following areas: Warden (or designee), Medical Department (nurse or healthcare practitioner), Mental Health Department (social worker), Classifications (staff member who reviews an individual's housing and programming needs), and Security (staff member who reviews the institutional record).<sup>105</sup>

The Unit Warden also evaluates the recommendation for medical treatment furlough and provides information on the individual's crime, criminal history, length of time served in custody, institutional conduct, any indications that the individual represents a low risk to himself or society, and how the individual's medical condition

related to his overall risk to society.<sup>106</sup> Thereafter, the Unit Warden may recommend an individual for medical treatment furlough by submitting the Recommendation for Medical Parole or Medical Treatment Furlough Form (HCP41-c) to the Department's Chief Nursing Officer for processing.<sup>107</sup>

The DPS&C Medical Director then evaluates the recommendation for medical treatment furlough for compliance with applicable law and policy and may recommend the individual for compassionate release to the DPS&C Secretary.<sup>108</sup> The DPS&C Secretary may recommend the individual for medical treatment furlough and forward the case to the Committee on Parole, seek additional information, or deny medical treatment furlough.<sup>109</sup>

If recommended by the Secretary, ultimate authority to grant or deny medical treatment furlough rests solely with the Committee on Parole.<sup>110</sup> The Committee

**“In addition to the standard factors our Board considers, the medical staff of the DPS&C provide a great deal of information including video documentation of an offender’s condition in advance of hearings. Also on the day of the hearing a medical professional from the housing facility is present to answer questions from our Board Members. Our Board is committed to addressing the needs of offenders with medical and mental health ailments within the confines of the law.”**

*Francis Abbott – Executive Director, Louisiana Board of Pardon & Committee on Parole*

on Parole may require additional medical evidence prior to rendering a decision.<sup>111</sup> The Committee on Parole may also establish additional conditions of medical treatment furlough.<sup>112</sup> Additionally, for medical treatment furlough to be granted to an individual, the Committee on Parole must determine that he or she does not pose a threat to public safety.<sup>113</sup>

If an individual is denied medical treatment furlough by the Committee on Parole, he or she may apply for rehearing within the time frame applicable to parole denials generally.<sup>114</sup>

#### *C.4 Discharge*

An individual granted medical treatment furlough may be discharged only to a health care facility and not to a residential location.<sup>115</sup>

The term of release on medical treatment furlough is the remainder of the individual’s sentence, without diminution of sentence for good time.<sup>116</sup>

An individual granted medical treatment furlough must be supervised by routine visits by the Division of Probation and Parole.<sup>117</sup>

#### *C.5 Revocation*

Medical treatment furlough may be revoked for an improvement in condition such that the individual would no longer be

eligible or violation of any condition of parole.<sup>118</sup>

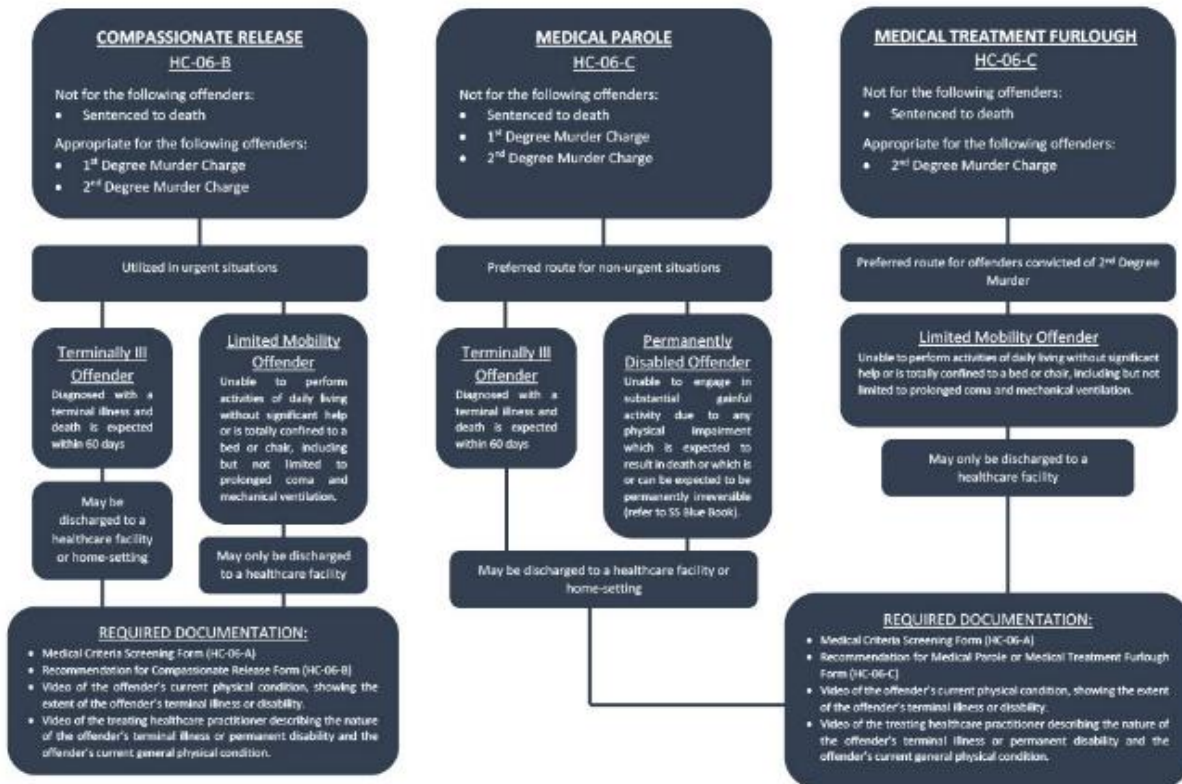


Figure 2



# IV. Key Findings

To comply with its legislative directive in HR 51, the Task Force collected and analyzed data to study the efficacy of the current eligibility requirements, recommendation processes, and review processes for compassionate release, medical parole, and medical treatment furlough. The Task Force also surveyed community doctors and conducted interviews with DPS&C staff, community doctors, formerly incarcerated individuals, family members of incarcerated individuals, crime victims, and professionals with experience navigating Louisiana’s medical release system to provide substantive evidence regarding the efficacy of current processes.

## A. Data Analysis and Findings

### A.1 Data Sources and Limitations

To capture the findings discussed in this report, the Task Force reviewed and analyzed the following data sources:<sup>119</sup>

- 2006-2017 dataset on Compassionate Release, Medical Parole, and Medical Treatment Furlough provided by DPS&C, including approvals and excluding denials
- 2018-2021 dataset on Compassionate Release, Medical Parole, and Medical Treatment Furlough provided by DPS&C, including both approvals and denials
- Death in custody forms filed by DPS&C with the United States Department of Justice from 2018-2019
- Data provided to LDH/Medicaid on medical releases between 2006 and 2021

Importantly, the findings pertaining to medical releases reflect only those people who were considered for medical release within DPS&C. Data on people that may have been eligible due to medical conditions but were not considered for medical release by DPS&C was not available. In addition, the findings set forth here may not account for all referrals from stakeholders outside the DPS&C (treating physicians, family members, incarcerated patients, attorneys, etc.).

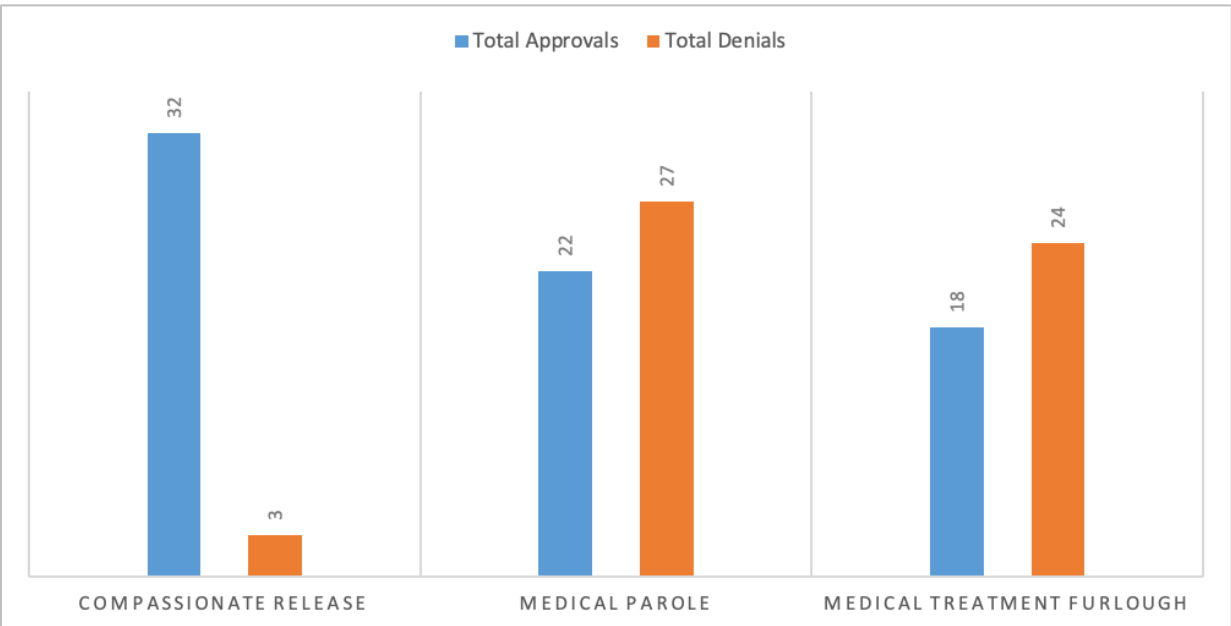
### A.2 Eligibility Requirements

Examination of the current statutes for medical release reveal discrepancies in the definitions setting out the eligibility criteria. For example, under current La. Stat. Ann. § 15:833.2, a diagnosis of “terminally ill” for purposes of compassionate release is defined as “death is expected within 60 days.”<sup>120</sup> Under the eligibility criteria for medical parole set forth at La. Stat. Ann § 15:574.20, “terminally ill” is defined as “having a life expectancy of less than one year.”<sup>121</sup>

Similarly, the statute for medical treatment furlough (La. Stat. Ann. § 15:574.20) defines “limited mobility offender[s]” as

### 2018-2021 Deaths During the Medical Release Process

Between 2018 and 2021, 6 people being considered for medical release died during the process, either during the processing of their paperwork or while awaiting a hearing before the Louisiana Board of Pardons and Parole.



**Figure 3: Total Approvals and Denials**

“individuals who, due to an underlying medical condition, are unable to perform activities of daily living without significant assistance or are bedbound, including but not limited to prolonged coma and mechanical ventilation.”<sup>122</sup> The DPS&C Policy for compassionate release also uses

the term “limited mobility individual” but replaces the word “bedbound” with “confined to a bed or chair.”<sup>123</sup>

### A.3 Overall Release Rates

Between 2006 and 2021, a total of 243 people were released through compassionate release, medical parole, or medical treatment furlough. Specifically, 116 people were granted compassionate release and 109 people were released through medical parole. In addition, 18 people were released through medical treatment furlough since the program’s inception in 2017.<sup>124</sup>

#### A.3.1 Overall Approval and Denial Rates

Between 2018 and 2021, 72 people across 8 DPS&C prisons—representing less than 0.6% of the total population housed in DPS&C facilities (approximately 13,000 people)—were granted some form of medical release. Specifically, 32 people were granted compassionate release, 22 people were granted medical parole, and 18 were granted medical treatment furlough. During this same time period, 54 people were denied release: 3 were denied

### Approval Rates by Type of Medical Release

- Of the 36 people who were considered for compassionate release, 89% were approved and 8% were denied.
- Of the 56 people who were considered for medical parole, 39% were approved and 48% were denied.
- Of the 46 people who were considered for medical treatment furlough, 39% were approved and 52% were denied.

*\*The findings reflected here exclude individuals who died, were released, or have applications that were canceled or are still pending.*

	DCI	DWCC	EHCC	LCIW	LSP	RCC	RLCC	Tangi PH/WR	
<b>Compassionate Release</b>	<b>5</b>	<b>2</b>	<b>12</b>		<b>2</b>	<b>8</b>	<b>2</b>	<b>4</b>	<b>1</b>
Individuals Approved	5	2	11		2	5	2	4	1
Individuals Denied			1			2			
<b>Medical Parole</b>	<b>3</b>	<b>1</b>	<b>19</b>		<b>4</b>	<b>22</b>	<b>5</b>	<b>2</b>	
Individuals Approved	3	1	8		4	6			
Individuals Denied			8			14	3	2	
<b>Medical Treatment Furlough</b>	<b>5</b>		<b>8</b>		<b>2</b>	<b>30</b>	<b>1</b>		
Individuals Approved	1		2		1	14			
Individuals Denied	3		5		1	15			
<b>Total Number of Individuals Considered</b>	<b>13</b>	<b>3</b>	<b>39</b>		<b>8</b>	<b>60</b>	<b>8</b>	<b>6</b>	<b>1</b>
Total Number of Individuals Approved	9	3	21		7	25	2	4	1

**Figure 4: Approvals and Denials by DPS&C Facility**

compassionate release, 27 were denied

medical parole, and 24 were denied medical treatment furlough. An additional 12 people were considered by DPS&C for medical release but were neither approved nor denied because their applications were canceled, they were released, they died, or their application is still pending. Based on these numbers, the overall approval rate for individuals considered for all three types of medical release was 52%.

See Attachment C (2018-2021 Medical

Releases by Type of Release).

### A.3.2 Approval Rates by Facility

*\*Unless specified otherwise, the findings reflected in the remainder of Section IV.A exclude individuals who died, were released, or have applications that were canceled or are still pending.*

Between 2018 and 2021, approval rates varied across DPS&C facilities. Although the total number of individuals considered for any form of medical release were

### Underlying Charges of Those Considered for Medical Release (2018-2021)

*Note: For purposes of this analysis, charges are categorized as violent offenses, property offenses, and drug offenses using DPS&C guidelines. Charges are categorized as sex offenses based on the available data on the underlying charges. In addition, for people with multiple charges, the most serious charge is determined using statutory sentencing ranges.*

- Of the 107 people who were considered for any type of medical release and whose most serious offense was a violent offense (including 13 people charged with first degree murder), 50% were approved and 44% were denied.
- Of the 10 people who were considered for any type of medical release and whose most serious offense was a drug offense, 50% were approved and 20% were denied.
- Of the 6 people who were considered for any type of medical release and whose most serious offense was a property offense, 100% were approved.
- Of the 28 people who were considered for any type of medical release and were charged with a sex offense, 29% were approved and 64% were denied.
- Of the 16 denials of medical parole for people charged with a sex offense, Wardens were responsible for 50% of the denials, followed by Facility Medical Directors (12.5%) and the Parole Board (12.5%).

See Attachment D (2018-2021 Medical Releases by Charge).

highest at Elayn Hunt Correctional Center (EHCC) and LSP, which aligns with the understanding of the Task Force that these facilities have sicker populations and are the only providers of Level I care, EHCC and LSP’s overall approval rates for all three forms of medical release were 54% and 42%, respectively.

Furthermore, 27% of the 22 individuals who were considered for medical parole at LSP were approved, while 42% of the 19 individuals who were considered for medical parole at EHCC were approved. Of the 8 individuals in total considered for medical parole at Dixon Correctional Institute (DCI), David Wade Correctional Center (DWCC), and Louisiana Correctional Institute for Women (LCIW), 100% were approved.

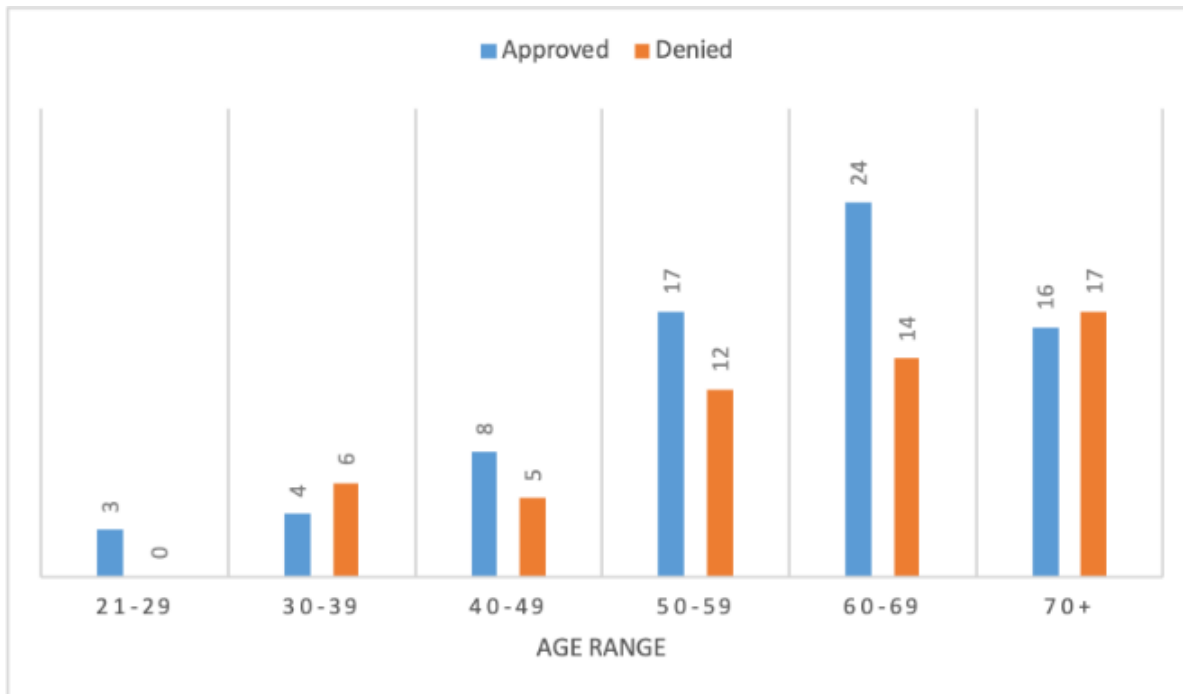
*A.4 Demographic Data on Medical Releases*

The 2018-2021 medical release data included information on age, gender, and race. For context, in 2018, the average age of people in DPS&C custody was 37.4

years. The average age increased to 40 years in 2019. In 2020 and 2021, 9.5% of people in DPS&C custody (representing an average of 2,552 people each year) were 60 years of age or older.

**“She did not have health problems when she entered LCIW, but developed nasal cancer, lymphoma. The cancer started in her sinuses, moved through two lymph nodes, and it had already spread to her entire body. It took her ten to eleven months before they actually did something. It takes them a very long time for them to do anything. I feel like this could have gotten caught way earlier. She was writing to the medical bay for months and nothing came about it.**

*James Stevens, brother of previously incarcerated person*



**Figure 5: Approvals and Denials of Medical Release by Age of Individual**

Additionally, between 2018 and 2021, on average, 67% of people in DPS&C custody were Black, 33% of people in DPS&C custody were white, 95% of people in DPS&C custody identified as male, and 5% of people in DPS&C custody identified as female.<sup>125</sup>

#### A.4.1 Age

Between 2018 and 2021, elderly incarcerated people were not granted release at higher rates than younger individuals. Of the 78 people aged 60 or older who were considered for any type of medical release, 51% were approved and 40% were denied.

Within this subset, of the 34 people aged 70 or older who were considered for any type of medical release, 47% were approved and 50% were denied. Of the 11

people aged 70 or older who were considered for medical parole specifically, 27% were approved and 73% were denied.

Also within this subset, 87% of the 78 people aged 60 or older who were considered for any type of medical release were convicted of a violent offense and 60% were serving a life sentence.

Compassionate Release: Of the 2 people aged 60 or older and convicted of **first degree murder**, both were granted compassionate release. Of the 2 people aged 60 or older and convicted of **second degree murder**, one was granted compassionate release and one was denied compassionate release.

Medical Treatment Furlough: Of the 7 people aged 60 or older and convicted of **first degree murder**, 3 were approved

### Stages of Medical Denial

Between 2018 and 2021, 56 denials of compassionate release, medical parole, and medical treatment furlough—including two separate denials for the two individuals who were denied medical treatment furlough twice during this time period—were issued at different stages of the medical release consideration process. As discussed earlier in this report, the decision-making process begins with the Facility Medical Director, followed by the Interdisciplinary Team (IDT), the Warden, the Statewide Medical Director, the Secretary, and the Parole Board.

The data reveals that correctional personnel (including IDT members and wardens) and Parole Board members, rather than medical personnel, are most frequently responsible for a denial of medical release. As shown in the table below, DPS&C wardens were responsible for the greatest percentage of denials across all forms of medical release (34%), followed by the Parole Board (23%) and the Statewide Medical Director (14%). These figures varied by type of release, with DPS&C wardens responsible for 44% of the 27 denials of medical parole and the Parole Board responsible for 38% of the 26 denials of medical treatment furlough. This data suggests that correctional personnel and Parole Board members, rather than medical personnel, are most frequently responsible for a denial of a referral for medical release.

At which stage of the medical release process a denial was issued also varied by facility. All 5 denials issued by the Facility Medical Director were at LSP, and of the 7 denials issued by the IDT, 6 were at LSP.

Stage at which Denial Occurred	Compassionate Release	Medical Parole	Medical Treatment Furlough	Total Number of Denials
Warden	1 (5%)	12 (60%)	7 (35%)	20
Parole Board	0 (0%)	3 (23%)	10 (76%)	13
Statewide Medical Director	0 (0%)	3 (37%)	5 (62%)	8
IDT	1 (14%)	5 (71%)	1 (14%)	7
Facility Medical Director	1 (20%)	2 (40%)	2 (40%)	5
Secretary	0 (0%)	2 (66%)	1 (33%)	3
<b>Grand Total</b>	<b>3 (5%)</b>	<b>27 (48%)</b>	<b>26 (46%)</b>	<b>56</b>

**Figure 6: Denials of Medical Release by stage**

and 2 were denied prior to the statutory changes making people convicted of first degree murder ineligible for medical treatment furlough. The remaining 2 individuals died prior to a decision being rendered. Of the 25 people aged 60 or older and convicted of **second degree murder** who were considered for medical

treatment furlough, 52% were approved and 44% were denied.<sup>126</sup>

Of the 60 people under 60 years old who were considered for any type of medical release, 53% were approved and 38% were denied.

#### A.4.2 Gender

As of June 30, 2021, there were 1,233 women in DPS&C custody.<sup>127</sup> Between 2018 and 2021, a total of 8 women—representing roughly 0.65% of the female

prison population and 6% of all people considered for medical release during that period—were considered for any form of medical release. Of these, 2 women were granted compassionate release, 4 women

were granted medical parole, and 1 woman was granted medical treatment furlough. The remaining 1 woman was denied medical treatment furlough. See *Attachment E (2018-2021 Medical Releases by Gender)*.

#### A.4.3 Race

Between 2018 and 2021, nearly twice as many Black individuals were considered for medical release as were white individuals. Controlling for these discrepancies, the overall rate of medical release approval across all three forms of release between 2018 and 2021 was similar for Black and white individuals. Of the 91 Black individuals who were considered for any form of medical release, 53% were approved and 40% were denied. Of the 46 white individuals who were considered for any form of medical release, 52% were approved and 37% were denied. See *Attachment F (2018-2021 Medical Releases by Race)*.

#### A.5 Time Between Decision and Death

Of the 72 people approved for any form of medical release between 2018 and 2021, death occurred the soonest, on average, for those approved for compassionate release (65 days after approval) followed by those approved for medical parole (153 days after approval) and medical treatment furlough (460 days after approval). Similarly, of the 54 people denied medical release between 2018 and 2021, death occurred the soonest, on average, for those denied compassionate release (71 days after denial) followed by medical parole (260 days after denial) and medical



## Death and Illness in Custody

In 2018 and 2019, 42 people were released on some form of medical release. During this same time period, 213 people died from medical causes in DPS&C custody. DPS&C indicated that 38% of decedents had pre-existing conditions diagnosed prior to their admission to the prison. Of the 213 people who died, 83% were 50 years of age or older and 52% were 60 years of age or older. Fifty-seven percent of them were Black males.

### *Medical Conditions of Those Considered for Medical Release*

Of the 138 people considered for any type of medical release between 2018 and 2021, 38 (or 28%) were diagnosed with cancer, 29 (or 21%) were diagnosed with COPD/Pulmonary Disease, 22 (or 16%) were diagnosed with Coronary Artery Disease/Peripheral Artery Disease/Peripheral Vascular Disease (CAD/PAD/PVD), and 21 (or 15%) were diagnosed with dementia.<sup>128</sup>

- Of the 38 individuals diagnosed with cancer, 18 were granted compassionate release and 7 were approved for medical parole. Two individuals diagnosed with cancer died prior to a decision being rendered, and 2 were released.
- Of the 29 individuals diagnosed with COPD/Pulmonary Disease, 6 were approved for medical parole, 5 were granted compassionate release, and 3 were approved for medical treatment furlough.
- Of the 22 individuals diagnosed with CAD/PAD/PVD, 6 were approved for medical parole, 3 were granted compassionate release, and 3 were approved for medical treatment furlough.
- Of the 21 individuals diagnosed with dementia, 7 were approved for medical treatment furlough, 4 were approved for medical parole, and 2 were granted compassionate release.

Among the 13 people denied medical parole or medical treatment furlough by the Parole Board, 4 were diagnosed with cancer and 4 were diagnosed with COPD/Pulmonary Disease.

treatment furlough (479 days after denial). Thus, individuals who were denied compassionate release died on average 6 days later than those who were approved, individuals who were denied medical parole died on average 107 days later than those who were approved, and individuals who were denied medical treatment furlough died on average 20 days later than those who were approved. See *Attachment G (2018-2021 Days Between Decision and Death)*.

The denials included the following individuals, both of whom died while in

DPS&C care. One individual was diagnosed with Acute Leukemia, Thrombophlebitis, and Thrombocytopenia. He died one week after being denied compassionate release. Additionally, a 79 year-old woman who was diagnosed with COPD and used a wheelchair died less than four months after she was denied medical treatment furlough.

### *A.6 Revocations of Release*

Of the 32 people who were granted compassionate release between 2018 and 2021, 25% had their compassionate release

rescinded.

In addition, DPS&C revoked medical parole for one individual less than three months after it was granted. This individual was diagnosed with Reynaud's Phenomenon and Hepatitis C, and both his leg and toe had been amputated. No persons had their medical treatment furlough revoked during this time period.

## **B. Testimonials and Surveys**

In order to present a comprehensive, qualitative account of medical release in Louisiana, the Task Force gathered testimonials from a broad range of stakeholders to provide additional insight into the eligibility, recommendation, and approval processes for these medical release programs. Representatives of DPS&C, crime victims, community doctors who treat incarcerated patients, attorneys and individuals involved in medical release efforts, family members of currently or formerly incarcerated persons, and formerly incarcerated individuals provided statements describing their experiences with medical parole, medical treatment furlough, and compassionate release. See Attachment H for full testimonials.

Additionally, in a survey of 20 community doctors in Louisiana,<sup>129</sup> 95% of physicians indicated that they have provided care to an incarcerated person from a jail or prison. Seventy-five percent of respondents indicated that they had identified an incarcerated patient that they thought would benefit from some form of medical release. 40% of physicians surveyed indicated that they were well aware of the compassionate release, medical parole, and medical treatment furlough processes.

The community doctors who initiated the process of medical release did so in a variety of ways, including through contacting prison medical staff, staff at DPS&C headquarters, palliative care programs, and by contacting advocacy groups and family members. For future referrals, 100% of the community doctors who have provided care to incarcerated patients indicated that the ability to initiate the compassionate release, medical parole, and medical furlough processes via the Emergency Physicians Integrated Care system (EPIC) would improve their ability to initiate such a request. Task Force representatives from DPS&C indicated that they would "welcome more open communication with the treating practitioners" at outside hospitals.

# V. National Comparison

The Task Force also conducted a review of trends and best practices across the United States. At least 21 states have adopted a singular medical release process.<sup>130</sup> Because the terminology pertaining to medical release varies by state, and because several states' guidelines do not provide for three distinct medical release processes (i.e. compassionate release, medical parole, and medical treatment furlough), the language used in this section of the report may vary.

## A. National Comparison on Eligibility for Medical Release

### A.1 Eligibility Criteria Based on Medical Condition

Several states have established clear and objective eligibility criteria for compassionate release enabling medical practitioners, incarcerated persons, family members and corrections staff to easily identify eligible individuals. Throughout the 50 states and D.C., compassionate release guidelines include severe medical conditions, terminal illness, and advanced age as eligibility criteria.

For example, Hawaii's eligibility criteria define a terminal condition as "a progressive and incurable medical condition that is expected to result in death" and "a terminal illness with a

At least 21 states have adopted a singular medical release process

'predictably poor prognosis.'"<sup>131</sup> Unlike Louisiana, Hawaii's eligibility criteria does not include a specific time frame for which death is considered to be terminally ill.<sup>132</sup> Hawaii's guidelines specify that identification of a terminal illness must be made by "competent medical authorities."<sup>133</sup> Hawaii also includes seriously debilitating conditions in their eligibility criteria. Seriously debilitating conditions are defined as irreversible, as well as persistent and/or progressive mental or physical conditions that compromise quality of life and impair functional abilities to the extent that he or she would be more appropriately treated in a community setting. These criteria can include various conditions, both mental and physical.<sup>134</sup>

Ohio also provides detailed medical criteria by defining medically incapacitated as:

"the person has a diagnosable medical condition and a severe, permanent medical or cognitive disability that (1) prevents completion of activities of daily living (including feeding, bathing, dressing, and grooming) without significant assistance; (2) incapacitates the person to the extent that institutional confinement offers no additional restrictions; (3) is likely to continue through the entire period of parole; and (4) is unlikely to noticeably improve."<sup>135</sup>

Rhode Island has similar eligibility criteria but adds that one may be eligible for compassionate release if "the person needs help with most of the activities that are necessary for independence."<sup>136</sup>

Some states list specific medical diagnoses

that would be considered for compassionate release to ensure the criteria are easily understood.<sup>137</sup> North Dakota, for example, provides the following as examples of serious medical conditions: “strokes, heart attacks, and aggressive or advanced stage forms of cancer.”<sup>138</sup> Similarly, Mississippi provides examples of conditions that are incapacitating, disabling or terminal: “a cancer diagnosis appropriate for hospice care, end-stage lung disease, end-stage heart failure, a severe stroke with disabling neurologic manifestations, end-stage liver disease, end-stage AIDS, advanced Alzheimer’s disease, and a severe, progressive neurological disease, including paraplegia and quadriplegia.”<sup>139</sup> In addition to the diagnoses themselves, Mississippi also takes into account the severity of the individual’s condition: Individuals with a medical condition or disease that is “chronic but stable and being addressed by ongoing medical intervention or therapy” are not eligible for medical release.<sup>140</sup>

In addition, multiple states specify that patients with medical conditions impeding the rehabilitative purposes of incarceration can also be eligible for compassionate release. For example, Hawaii qualifies individuals who are “too ill or cognitively impaired to participate in rehabilitation and/or to be aware of punishment” as eligible for its medical release program.<sup>141</sup>

Furthermore, at least six states have incorporated eligibility criteria related to cost saving by indicating that if an individual’s cost of healthcare and treatment are excessive, they may be eligible for compassionate release.<sup>142</sup> For example, one of South Dakota’s eligibility criteria is “having medical care needs that are at least double the average annual medical cost for incarcerated individuals.”<sup>143</sup>

**At least 19 states and D.C. have no exclusions for some, if not all, of their compassionate release processes.**

At least 23 states and D.C. include eligibility criteria based on advanced age and/or medical conditions related to aging.<sup>144</sup> Of those, at least 15 states rely on age as the main factor in eligibility rather than medical conditions related to aging.<sup>145</sup> For example, California’s compassionate release eligibility criteria allow patients 50 years and older to be eligible for elderly parole.<sup>146</sup> Alabama, Georgia, Texas, Utah and Washington consider age as a discrete determinant for eligibility regardless of the amount of time served by an incarcerated individual.<sup>147</sup>

Further, some states specifically mention dementia, Alzheimer’s Disease, and other cognitive disabilities related to aging in their eligibility criteria for compassionate release.<sup>148</sup> Currently, at least 9 states make explicit reference to at least one of the above in their guidelines.<sup>149</sup> Michigan states that “a permanent or terminal disabling mental disorder, including dementia, Alzheimer’s disease, or a similar degenerative brain disorder, which results in a significantly impaired ability to perform two or more activities of daily living and the need for nursing home care” renders an incarcerated individual eligible for medical parole.<sup>150</sup>

### A.3 Non-Medical Eligibility Exclusions

Many states do not have categorical, non-medical exclusions from eligibility for

medical release. At least 19 states and D.C. have no exclusions (for example, for a first-degree murder conviction or a capital sentence) for some, if not all, of their compassionate release processes.<sup>151</sup> Out of those, at least 12 states have no exclusions for all of their compassionate release processes.<sup>152</sup>

## **B. Initiation and Application**

Several states have expanded the ability for incarcerated individuals, treating physicians, attorneys, family members, and other patient advocates to initiate the application processes for medical release. At least 4 states allow for all of the above individuals to initiate the process.<sup>153</sup> At least 9 states allow for incarcerated individuals, treating physicians, attorneys and family members to initiate the process.<sup>154</sup> In addition, Oregon's guidelines permit anyone to initiate the process through telephone or email and the contact information is provided on the Oregon Department of Corrections' website.<sup>155</sup>

## **C. Review and Decision-Making Process**

Several states have adopted streamlined review processes for medical release.<sup>156</sup> For example, in Massachusetts, the Superintendent of the correctional facility reviews each application for Medical Parole.<sup>157</sup> Within 21 days, he or she must forward the application to the Commissioner of the Department of Corrections, including a recommendation, the petition, a Medical Parole Plan, a physician's diagnosis, and a risk assessment.<sup>158</sup> The Medical Parole Plan consists of:

“(1) the proposed course of treatment, (2) the proposed location for treatment and post-treatment care, (3) documentation that qualified medical

providers are prepared to provide such services, and (4) the financial resources in place to cover the cost of the plan for the duration of the individual's Medical Parole (e.g., Medicare, Medicaid, or commercial insurance).”<sup>159</sup>

The Commissioner of the Massachusetts Department of Corrections then makes the final decision regarding whether an applicant will be granted Medical Parole.<sup>160</sup>

Some states have incorporated explicit policies regarding the notification of and communication with victims and their families during the review and decision-making process. In Minnesota, after an application for medical release is approved by the Deputy Commissioner of Facility Services, it is then forwarded to a multidisciplinary team consisting of the Health Services Administrator, Caseworker, Conditional Medical Release Monitor, Medical Release Planner, Victim Assistance Director, Victim Assistance Manager (or designee), Supervising Agent, and the Associate Warden of Operations.<sup>161</sup> If they decide to recommend the application, the Victim Assistance and Restorative Justice Program (VARJP) notifies the victim(s) and coordinates any further communication throughout the duration of the medical release process.<sup>162</sup>

### *C.1 Timeframes for the Review Process*

Many states specify time frames for document-gathering, assessments, review and making decisions pertaining to medical release. At least 19 states mention some type of timeline in their compassionate release guidelines:<sup>163</sup>

- Ohio requires that a hearing on the application be held within 30-60 days after the application is received and that the decision must be made within

10 days of the hearing.<sup>164</sup>

- Rhode Island’s guidelines similarly provide in-depth timelines on the document-gathering, assessment, review and decision-making processes.<sup>165</sup> Specifically, applications must be referred to the Health Services Unit within 72 hours of receiving the application.<sup>166</sup> The Health Services Unit has 10 days to complete the medical report and the medical discharge plan, which is then sent to the Parole Board.<sup>167</sup> Within 7 days, the Parole Board must make a decision on whether parole is warranted.<sup>168</sup> If it is, the hearing must be set within 30 days.<sup>169</sup> The Parole Board has 7 days after the hearing to issue a written notice of their decision.<sup>170</sup>
- North Carolina also outlines timelines for the medical release application review and decision-making processes. Within 45 days of receiving the application, conviction review, medical assessment, psychosocial/ risk review, committee review, release plan and facility/ residence investigation must be completed.<sup>171</sup> The Parole Commission then has 15 days to make a decision for terminally ill applicants and 20 days for all others.<sup>172</sup>

Furthermore, at least eight states explicitly state that the review process can be expedited based on the circumstances of the applicant.<sup>173</sup>

#### **D. Appeals of Denials and Reconsideration for Medical Release**

Several states allow for individuals who are denied to either appeal the decision or re-apply. At least six states permit individuals to directly appeal if they are denied medical release.<sup>174</sup> For example, Alaska

provides denied individuals the opportunity to appeal within 30 days of receiving the denial.<sup>175</sup> Even where direct appeals are not allowed, at least 16 states allow for individuals to re-apply in the future.<sup>176</sup> The ability to reapply provides applicants with opportunities to submit additional information about their condition, especially in cases with significant developments or changes in medical condition. For example, Rhode Island explicitly allows an individual to re-apply after 60 days if there is a material change in their condition.<sup>177</sup>

#### **E. Tracking & Reporting Outcomes**

A number of states require tracking and reporting of outcomes of their medical release processes, such as annual data of applications, approvals, denials, and revocations, as well as the reasons for denials and revocations. At least 16 states are required to report outcomes on an annual, quarterly or monthly basis.<sup>178</sup> Colorado’s Department of Corrections and Arkansas Parole Board are required to report on a monthly basis<sup>179</sup>. Alaska’s Department of Corrections is required to report every quarter.<sup>180</sup>

Massachusetts includes the following information in their annual reports on compassionate release:

- the number of individuals who applied
- the race and ethnicity of each applicant
- the number of individuals granted medical parole
- the race and ethnicity of those who were granted
- the nature of the illness of each applicant
- the county to which those granted have been released
- the number of individuals denied



- the reasons for denying
- the race and ethnicity of those denied
- the number of people who have petitioned more than once
- the number of people released who have been returned to custody
- the reason for the return of those who have returned to custody
- the number of appeal petitions.<sup>181</sup>

# VI. Summary of Recommendations

As informed by the data analysis, testimonials, and practices nationwide, the Task Force recommends statutory and policy changes in five overarching areas: eligibility, initiation of consideration, review and decision-making, post-release planning

and transition, and data & reporting outcomes.

Below is a chart summarizing the problems identified by the task force and specific recommendations for each relevant implementing entity.

<b>A. LIMITED ELIGIBILITY</b>	
<p><b>PROBLEM:</b> Under the current statutory and policy eligibility criteria, a narrow category of people are considered for medical release.</p> <p><b>FINDINGS:</b></p> <p>A.1 Medical definitions are inconsistent across medical parole, medical treatment furlough, and compassionate release.</p> <p>A.2 18 people have been released through medical treatment furlough since the program’s inception in 2017.<sup>182</sup> Between 2018 and 2019, 82 people died from medical conditions that preexisted their admission to prison.<sup>183</sup></p> <p>A.3 Predicting life expectancy of 60 days or 1 year is difficult for treating physicians and may exclude from eligibility patients who are bedridden, irreversibly ill, or permanently incapacitated, but who may live for an indeterminate amount of time.</p> <p>A.4 Fewer people of advanced age are being granted medical release than would be expected.</p> <p>A.5 A significant percentage of Louisiana’s elderly and sick prison population is ineligible</p>	<p><b>SOLUTION:</b> The Task Force recommends that clear, objective, and reasonable eligibility criteria be promulgated with input from medical professionals.</p> <p><b>RECOMMENDATIONS FOR THE LEGISLATURE:</b></p> <ul style="list-style-type: none"> <li>• Bring medical definitions into compliance with standards used in community hospitals, including inability to perform activities of daily living (ADLs) (A.1).</li> <li>• Specify eligible medical conditions that may constitute “terminally ill” to include significant cardio-pulmonary diseases, cancer, heart failure, liver disease, stroke, and coronary artery disease, among other conditions, to trigger evaluation under the full list of eligibility criteria (A.1).</li> <li>• Statutorily combine medical parole and medical treatment furlough (A.2).</li> <li>• Adjust the definitions and criteria accordingly to encompass both targeted populations, primarily patients in need of costly and prolonged medical treatment or assistance in one or more ADLs who may be considered for eligibility (A.2).</li> <li>• Focus statutory definitions and criteria for eligibility on limited mobility and quality of life to determine eligibility for medical release, rather than life expectancy (A.3).</li> <li>• Remove 1-year life expectancy from medical parole eligibility criteria (A.3).</li> <li>• Incorporate ADLs, the ECOG performance status, and/or PPS and other assessments based on mobility and quality of life into eligibility criteria for medical parole/furlough (A.3).</li> <li>• Eliminate exclusion of people convicted of armed robbery, a crime of violence, or a sex offense from being</li> </ul>

<p>for medical parole or medical treatment furlough, due to the statutory requirement that medical parole and medical treatment furlough are not available to individuals serving a sentence for a conviction of first degree murder, or to individuals serving a capital sentence. Individuals serving a sentence for second degree murder are also not eligible for medical parole.</p> <p>A.6 DPS&amp;C’s intake process does not include a screening for initiation of consideration of medical release.</p>	<p>eligible on the basis of advanced age as prescribed by La. R.S. §15:574.4 (A.4).</p> <ul style="list-style-type: none"> <li>• Expand medical release eligibility to people diagnosed with Alzheimer’s and other types of dementia (A.4).</li> <li>• Create a specific set of criteria and guidance for the Board of Pardons and Parole to consider when assessing eligibility based on advanced age that is specific to this population (A.4).</li> <li>• Eliminate categorical exclusions, including the exclusion of first and second degree murder conviction from eligibility for medical parole. This will bring medical release eligibility in line with the standards for general parole eligibility (A.5).</li> <li>• Allow eligible patients serving capital sentences to be considered for compassionate release (A.5).*</li> </ul> <p><b>RECOMMENDATIONS FOR DPS&amp;C:</b></p> <ul style="list-style-type: none"> <li>• Remove 60 days life expectancy from compassionate release eligibility criteria (A.3).</li> <li>• Incorporate activities of daily living (ADLs), the Eastern Cooperative Oncology Group (ECOG) performance status, and/or Palliative Performance Scale (PPS) and other assessments based on mobility and quality of life into eligibility criteria for compassionate release.</li> <li>• Incorporate screening for medical release eligibility into the annual physicals for all individuals &gt;50 years of age (A.4).</li> <li>• Build a screening form or a similar tool into the intake process for both admission into the DPS&amp;C system and transfer admissions between DPS&amp;C facilities (A.6).</li> </ul>
<p><b>B. INITIATING THE CONSIDERATION PROCESS FOR MEDICAL RELEASE</b></p>	
<p><b>PROBLEM:</b> Few people who are incarcerated, their family members, or community medical providers know that medical release exists, how to initiate the process, or what information is needed to do so.</p> <p><b>FINDINGS:</b></p> <p>B.1 The Task Force found that despite Louisiana’s aging and medically vulnerable prison population, the medical parole, medical treatment furlough, and compassionate release programs resulted in the release of less than 0.6%</p>	<p><b>SOLUTION:</b> The Task Force recommends instituting a consideration process that provides informational materials and allows initiation by a broader group of stakeholders, including incarcerated patients themselves, their family members, attorneys, and community medical providers, and will allow a larger number of people to be considered for medical release.</p> <p><b>RECOMMENDATIONS FOR THE LEGISLATURE:</b></p> <ul style="list-style-type: none"> <li>• Add statutory authority for incarcerated patients, attorneys, family members, and other patient advocates to initiate the consideration process for all types of medical release (B.2).</li> <li>• Create a mechanism for the Board of Pardons and Parole to initiate the consideration process for people who they find do not meet regular parole requirements</li> </ul>

\* DPS&C was an active participant in this Task Force and contributed to the creation of this report. DPS&C does not endorse any specific recommendation put forth by the Task Force that has an \* indicated.

<p>of people housed in DPS&amp;C facilities between 2018 and 2021.<sup>184</sup></p> <p>B.2 Information on eligibility criteria and initiation process is not widely known and is largely inaccessible to incarcerated patients and their families and advocates.</p> <p>B.3 The Louisiana Board of Pardons and Parole has no clear mechanism to formally recommend people for medical parole.<sup>185</sup></p> <p>B.4 There is currently no clear mechanism to formally refer people to medical parole and medical treatment furlough if they are denied compassionate release.</p>	<p>or whose parole is denied, but who they believe may be eligible for medical release (B.3).</p> <p><b>RECOMMENDATIONS FOR DPS&amp;C:</b></p> <ul style="list-style-type: none"> <li>• Institute a centralized and visible screening and referral process that can be initiated by community healthcare providers by incorporating it into an Electronic Health Record system (e.g. EPIC) and with assistance from the Louisiana Department of Health and Medicaid to develop trainings for outside hospital staff on eligibility and initiation procedure for medical release (B.1).</li> <li>• Automatically initiate eligibility consideration of medical release for anyone who costs the state over \$120,000 in healthcare costs in a single fiscal year (B.1).*</li> <li>• Establish a visible and standardized way for non-medical professionals, including incarcerated patients and their family members, to request and recommend medical release (B.2).</li> <li>• Create a widely-available resource in simple and straightforward language that includes information about the processes of medical release, eligibility criteria, and how to initiate the consideration process (B.2).</li> <li>• Require that information and initiation materials be provided to all correctional medical care providers and made available to incarcerated patients when they enter medical care units, hospice care, or assisted living dormitories (B.2).</li> <li>• Develop an electronic submission form for incarcerated patients, attorneys, family members, and other patient advocates to initiate the consideration process for all types of medical release and integrate submission form with workflow software (B.2)</li> <li>• Establish mechanism for compassionate release eligibility consideration to begin immediately when a patient enters hospice care across all facilities (B.2).</li> <li>• Provide training materials and courses for all DPS&amp;C staff and parole board members involved in any stage of the review and decision-making processes (B.2).</li> <li>• Establish a process for a person to be automatically considered for medical parole or medical treatment furlough if they are deemed not eligible for compassionate release (B.4).</li> </ul>
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## C. REVIEW AND DECISION-MAKING

<p><b>PROBLEM:</b> The review process currently in place can be lengthy and complex, and incarcerated patients can grow increasingly sick and in several cases die while waiting for a decision.</p> <p><b>FINDINGS:</b></p>	<p><b>SOLUTION:</b> The Task Force recommends streamlining the review process with well-defined, reasonable, and consistent timelines to allow family members to spend more quality time with their sick and elderly loved ones, and also create significant cost-savings for the state in cutting back on the provision of prison healthcare, particularly end-of-life care.</p>
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- C.1 While compassionate release can take as little as 24 hours to 2 weeks to process, the medical parole and medical treatment furlough processes can be lengthy and uncertain. There is currently no formal timeline in place for internal review.
- C.2 Correctional personnel, rather than medical personnel, are most frequently responsible for a denial of a referral for medical release.
- C.3 23% of denials of medical parole and treatment furlough are denied by the Louisiana Board of Pardons and Parole.
- C.4 Louisiana does not have a designated staff member or individual responsible for coordinating victim outreach to ensure that the medical release review process moves forward in a timely and transparent manner. Under the current Louisiana Pardon and Parole Board policy or practice, there must be at least a 60 day period between when victims are notified and the hearing takes place.<sup>186</sup>
- C.5 Outcomes of medical release decision-making vary widely from facility to facility, and do not align with known information about where the patients with the most significant medical conditions and need for assistance and treatment are located.
- C.6 While statutory policy does allow individuals denied medical release to appeal the denial, there is currently no formal appeals process or procedure in place.

**RECOMMENDATIONS FOR THE LEGISLATURE:**

- Statutorily require that the wardens, security and classifications members of the interdisciplinary team, Secretary, and BOP&P consider factors beyond the charge, conviction, security status, and disciplinary history when making determinations about medical release. Other factors that should be weighted more heavily in the consideration process include age, mobility and quality of life, rehabilitation, prison healthcare costs, and progression of illness (C.2).
- Create a special panel of community physicians with experience treating Medicaid-eligible populations appointed by the governor to consider medical parole and to supplement the Louisiana Board of Pardons and Parole (C.3).\*
- Set specific grounds for reconsideration that include a provision allowing an individual to appeal their denial if they can demonstrate a material change in circumstances after a certain amount of time (C.6).\*
- Establish a reasonable timeline for the Louisiana Board of Pardons and Parole to rule on the appeal, and waive the normal waiting period of 90 days or more for medical parole and medical treatment furlough (C.6).

**RECOMMENDATIONS FOR DPS&C:**

- Establish reasonable time frames and processes for each level of decision-making. Include deadlines and clear steps for document-gathering, assessments, review, and decision-making, while being sensitive to the need for expedited review in the case of terminal illness (C.1).
- Adopt an electronic system that automatically notifies the initial reviewer, including a mechanism by which if the assigned reviewer doesn't take action within a set amount of time, a different reviewer is automatically assigned (C.1).
- Promulgate policy requiring that the wardens, security and classifications members of the interdisciplinary team, and Secretary consider factors beyond the charge, conviction, security status, and disciplinary history when making determinations about medical release. Other factors that should be weighted more heavily include age, mobility and quality of life, rehabilitation, prison healthcare costs, and progression of illness (C.2).
- Require training to ensure standardized consideration of the factors above (C.2).
- Limit consideration of an individual's disciplinary history for medical release in include only disciplinary actions that took place following the medical diagnosis and/or within the past three years (C.2).\*

- Amend the review process such that interdisciplinary team members' decisions are documented by their area of expertise (C.2).
- Re-evaluate the victim outreach system to meet the unique needs of medical release while allowing for fairness and transparency (C.4).
- Designate a staff person at a state agency or non-profit to coordinate victim outreach. Coordinator should have trauma-informed training and be authorized to access and discuss patients' medical information with the patient's permission (C.4).
- Tighten timeline for victim notification for medical parole and medical treatment furlough to allow for an expedited hearing when time is of the essence (C.4).
- Establish alternative mechanisms by which victims, their families, and other stakeholders are able to participate even in the expedited hearings, such as video or written testimony (C.4).
- Build upon DPS&C's existing Victim-Offender Dialogue program to allow for family members of the patient and family members of the victim to engage in optional restorative justice dialogue, if they wish to seek one (C.4).
- Bolster mechanisms to ensure that survivors and victims' loved ones are notified earlier in the criminal legal process of programs such as the Victim Offender Dialogue and the Accountability Letter Bank, so that if medical release comes up later in their incarceration, it is possible there has already been communication or healing in the case (C.4).
- Standardize the documentation and assessment process and establish consistent criteria and deadlines across statewide facilities (C.5).
- Provide a written decision to the incarcerated patient for any DPS&C denial at any level (C.5).

#### **RECOMMENDATIONS FOR BOP&P:**

- Prioritize medical parole and medical treatment furlough hearings by designating a specific day per month for those to occur or prioritizing in scheduling process (C.1).
- Narrow the scope of the public safety risk assessment to include only the disciplinary history following the medical diagnosis and/or within the past three years (C.3).
- Provide a written decision to incarcerated patients denied medical parole or medical treatment furlough (C.5).

## **D. POST-RELEASE PLANNING & TRANSITION**



<p><b>PROBLEM:</b> There are strict guidelines regarding where people are allowed to go once they are released and navigating those and the public benefits system can be complex and sometimes lead to revocation.</p> <p><b>FINDINGS:</b></p> <p>D.1 During the consideration process, there are no formal mechanisms to trigger communication between DPS&amp;C, Medicaid, and other community partners when a patient is being considered for medical release.</p> <p>D.2 Louisiana does not provide people whose medical release was revoked a means to appeal the decision.</p>	<p><b>SOLUTION:</b> The Task Force recommends that once an application for medical release is under consideration, there should be mechanisms in place through the Medicaid Pre-Release Enrollment Program to assist incarcerated patients and their families in navigating public benefits and transitioning into a community hospital, assisted living or nursing facility, or community-based care. If medical release is revoked for any reason, there must be a process in place to allow people to appeal or reapply, with reasonable time frames and requirements.</p> <p><b>RECOMMENDATIONS FOR THE LEGISLATURE:</b></p> <ul style="list-style-type: none"> <li>• Remove requirement that patients granted medical treatment furlough must be transferred to LTAC facility or hospital (D.1).</li> <li>• Create a clear process to allow patients whose medical release is revoked to reapply or appeal the decision (D.2).*</li> <li>• Establish reasonable criteria for consideration of reapplication, such as change in material circumstances (D.2).</li> </ul> <p><b>RECOMMENDATIONS FOR DPS&amp;C:</b></p> <ul style="list-style-type: none"> <li>• Designate a point-person or coordinator to liaison between DPS&amp;C, Medicaid, the incarcerated patient and their family, the Division of Probation and Parole, and community partners (D.1).</li> <li>• Upon initiation of consideration, trigger notification to the Medicaid pre-release enrollment program to identify eligibility, housing if necessary, and streamline transition and provision of healthcare services (D.1).</li> <li>• Establish a formal partnership with Formerly Incarcerated Transitions (FIT) Clinic in New Orleans to provide care and services for people upon their release, including expansion of FIT clinics to other areas of the state (D.1).</li> <li>• Create a clear process to allow patients whose medical release is revoked to reapply or appeal the decision (D.2).*</li> <li>• When possible based on conditions of release, confer with Medicaid Pre-Release Enrollment on alternatives, including home care, before revoking for any housing or proximity to victim/victim’s family considerations (D.2).</li> </ul>
<p><b>E. TRACKING AND REPORTING OUTCOMES</b></p>	
<p><b>PROBLEM:</b> Currently there is limited public data available on medical release or the DPS&amp;C population that may be eligible for consideration to fully assess the cost-saving opportunities and the amount of those</p>	<p><b>SOLUTION:</b> The Task Force recommends having more public data available on medical release to allow key stakeholders and lawmakers the ability to better understand and assess the current processes, and identify areas of both success and room for improvement, as well as quantify the costs saved on prison healthcare expenditures.</p>

cost-saving opportunities.

**FINDINGS:**

- E.1 Compilation of this report revealed a lack of consistent and available data on how medical release is utilized in Louisiana, who is eligible, and the processes and procedures involved.
- E.2 Compilation of this report revealed a lack of available information on how much of DPS&C’s healthcare budget is spent on specific medical conditions and treatments.
- E.3 Additional data collection would be helpful in determining the efficacy of these recommendations and what, if any, further recommendations are necessary.

**RECOMMENDATIONS FOR THE LEGISLATURE:**

- Require that DPS&C compile relevant data for the Louisiana Department of Health and Medicaid who will, with assistance from this Task Force where appropriate, issue a report on how these recommendations have been implemented and the related cost-savings by March 1, 2023 (E.3).\*

**RECOMMENDATIONS FOR DPS&C:**

- Improve and publicly report bi-annually data tracking at all steps of the medical release process, including date of initiation of consideration, reason for release or denial, and demographic characteristics (age, race, sex, offense) in the DPS&C Briefing Book (E.1).
- Identify and track people in DPS&C custody whose medical conditions and ADLs may allow them to be considered for eligibility for medical release. Standardize data tracking and reporting mechanisms across all facilities and include in the DPS&C’s briefing book and interactive demographic dashboard (E.1).
- Require sheriffs to report the same data for people in state custody held in local facilities. Track the medical release considerations and approvals/denials for everyone moved from a local facility to a DPS&C facility for medical purposes. Include in the DPS&C Briefing Book (E.1).
- Track referrals and approvals/denials from community medical facilities through an automatic screening form and mechanism built into Electronic Health Record software systems. Include in the DPS&C Briefing Book (E.1).
- Develop and implement an “electronic flag” for medical release conditions as electronic health records come online for all DPS&C facilities (E.1).
- Provide additional details and information to Louisiana Commission on Law Enforcement (LCLE) and LDH on deaths in custody in DPS&C facilities, including release of datasets, in order to track causes of death by disease, trends by age, race, gender, offense, and admission and death dates. LCLE and LDH to make public the aforementioned data collected from jails and prisons statewide (E.1).
- Identify and track treatment costs for people in DPS&C custody whose medical conditions are considered seriously symptomatic (e.g. three or more hospitalizations within the same year for the same condition) (E.2).

# VII. Detailed Findings and Recommendations

For each overarching area below, the problem and solution have been broken out into specific sub-problems with targeted recommendations by the Task Force.

## A. Limited Eligibility

*Summary of Problem:* Under the current statutory and policy eligibility criteria, a narrow category of people are considered for medical release.

*Summary of Solution:* The Task Force recommends that clear, objective, and reasonable eligibility criteria be promulgated with input from medical professionals. This can be done by a) broadening the pool of who qualifies for consideration of medical release; and b) removing potential barriers to eligibility for patients whose medical conditions are serious or chronic and who do not pose a risk to society.

*Sub-problems and Recommendations:*

A.1 : Medical definitions are inconsistent across medical parole, medical treatment furlough, and compassionate release. For example, Louisiana defines “terminally ill” and “limited mobility offender” differently across different types of medical release.<sup>187</sup>

- **Recommendations for the Legislature:**

- Bring medical definitions into compliance with standards used in community hospitals, including inability to perform activities of daily living (ADLs).
- Utilize standard performance status scales such as the Eastern Cooperative Oncology Group (ECOG) or Palliative Performance Scale (PPS) to determine limited mobility with a clear cutoff for recommending medical release.
- Specify eligible medical conditions that may constitute “terminally ill” to include significant cardio-pulmonary diseases, cancer, heart failure, liver disease, stroke, and coronary artery disease, among other conditions, to trigger evaluation under the full list of eligibility criteria.

A.2 : 18 people have been released through medical treatment furlough since the program’s inception in 2017.<sup>188</sup> Between 2018 and 2019, 82 people died from medical conditions that preexisted their admission to prison.<sup>189</sup>

- **Recommendations for the Legislature:**

- Statutorily combine medical parole and medical treatment furlough.
- Adjust the definitions and criteria accordingly to encompass both targeted

populations, primarily patients in need of costly and prolonged medical treatment or assistance in one or more ADLs who may be considered for eligibility.

A.3 : Predicting life expectancy of 60 days or 1 year is difficult for treating physicians and may exclude from eligibility patients who are bedridden, irreversibly ill, or permanently incapacitated, but who may live for an indeterminate amount of time.

- **Recommendations for the Legislature:**

- Focus statutory definitions and criteria for eligibility on limited mobility and quality of life to determine eligibility for medical release, rather than life expectancy.
- Remove 60 days life expectancy from compassionate release eligibility criteria and remove 1-year life expectancy from medical parole eligibility criteria.
- Incorporate activities of daily living (ADLs), the Eastern Cooperative Oncology Group (ECOG) performance status, and/or Palliative Performance Scale (PPS) and other assessments based on mobility and quality of life into eligibility criteria for compassionate release and medical parole/furlough.

- **Recommendation for DPS&C:**

- Remove 60 days life expectancy from compassionate release eligibility criteria.

A.4 : Fewer people of advanced age are being granted medical release than would be expected. Focusing on the elderly could lead to significant cost-savings in prison healthcare.

- **Recommendations for the Legislature:**

- Expand eligibility criteria for both geriatric and medical parole.
- Eliminate exclusion of people convicted of armed robbery, a crime of violence, or a sex offense from being eligible on the basis of advanced age as prescribed by La. R.S. §15:574.4.
- Expand medical release eligibility to people diagnosed with Alzheimer's and other types of dementia.
- Create a specific set of criteria and guidance for the Board of Pardons and Parole to consider when assessing eligibility based on advanced age that is specific to this population.

- **Recommendation for DPS&C:**

- Incorporate screening for medical release eligibility into the annual physicals for individuals >50 years of age.

A.5 : A significant percentage of Louisiana’s elderly and sick prison population is ineligible for medical parole or medical treatment furlough, due to the statutory requirement that medical parole and medical treatment furlough are not available to individuals serving a sentence for a conviction of first degree murder, or to individuals serving a capital sentence. Individuals serving a sentence for second degree murder are also not eligible for medical parole.

- **Recommendations for the Legislature:**

- Eliminate categorical exclusions, including the exclusion of first and second degree murder conviction from eligibility for medical parole. This will bring medical release eligibility in line with the standards for general parole eligibility.
- Allow eligible patients serving capital sentences to be considered for compassionate release.\*

A.6 : DPS&C’s intake process does not include a screening for initiation of consideration of medical release, even when a patient is being transferred from a local facility to a DPS&C facility due to acuteness of medical needs.

- **Recommendations for DPS&C:**

- Build a screening form or a similar tool into the intake process for both admission into the DPS&C system and transfer admissions between DPS&C facilities.

## **B. Initiating the Consideration Process for Medical Release**

*Summary of Problem:* Few people who are incarcerated, their family members, or community medical providers know that medical release exists, how to initiate the process, or what information is needed to do so.

*Summary of Solution:* The Task Force recommends establishing a consideration process that allows initiation by a broader group of stakeholders, including incarcerated patients themselves, their family members, attorneys, and community medical providers, and will allow for a larger number of people being considered for medical release. In addition, providing straightforward and widely

**“Most families don’t know about this [medical parole]. They don’t know how to call anyone or find an advocate. As soon as a family member’s health starts to fail, and if they have comorbidities or something that could potentially cause death, the families need to be mailed this information from the prison system that these options are available to that particular inmate. Not everyone has someone there to speak for them or an attorney. I think the prison system needs to take some initiative to make sure they get everything they’re deserving. If this is something they can do to go home, they need to make that available to them and their families.”**

*Mary Smith-Moore, Task Force Member and sister of formerly incarcerated patient*

available resources on the eligibility and processes for medical release will ensure that stakeholders beyond DPS&C staff understand and are able to navigate the process.

*Sub-problems and Recommendations:*

B.1 : The Task Force found that despite Louisiana’s aging and medically vulnerable prison population, the medical parole, medical treatment furlough, and compassionate release programs resulted in the release of less than 0.6% of people housed in DPS&C facilities between 2018 and 2021.<sup>190</sup> Additional methods of initiation would allow for consideration and potential approval for a larger group of patients, at significant cost-savings to the state in the provision of prison healthcare.

- **Recommendations for DPS&C:**

- Institute a centralized and visible screening and referral process that can be initiated by community healthcare providers by incorporating it into an Electronic Health Record system (e.g. EPIC) and with assistance from the Louisiana Department of Health and Medicaid to develop trainings for outside hospital staff on eligibility and application procedure for medical release.
- Automatically initiate eligibility consideration of medical release for anyone who costs the state over \$120,000 in healthcare costs in a single fiscal year.\*

B.2 : Information on eligibility criteria and initiation process is not widely known and is largely inaccessible to incarcerated patients and their families and advocates.

- **Recommendation for the Legislature:**

- Add statutory authority for incarcerated patients, attorneys, family members, and other patient advocates to initiate the consideration process for all types of medical release under the above recommended criteria.

- **Recommendations for DPS&C:**

- Establish a visible and standardized way for non-medical professionals, including incarcerated patients and their family members, to request and recommend medical release.
- Create a widely-available resource in simple and straightforward language that includes information about the processes of medical release, eligibility criteria, and how to initiate the consideration process. Make this resource readily available and include on Louisiana DPS&C website, law libraries, and handbooks.
- Require that information and initiation materials be provided to all correctional medical care providers and made available to incarcerated patients when they enter medical care units, hospice care, or assisted living dormitories.
- Develop an electronic submission form for incarcerated patients, attorneys,



family members, and other patient advocates to initiate the consideration process for all types of medical release and integrate submission form with workflow software.

- Establish mechanism for compassionate release eligibility consideration to begin immediately when a patient enters hospice care across all facilities.
- Provide training materials and courses for all DPS&C staff and parole board members involved in any stage of the review and decision-making processes.

B.3 : The Louisiana Board of Pardons and Parole has no clear mechanism to formally recommend people for medical parole.<sup>191</sup>

- **Recommendation for the Legislature:**

- Create a mechanism for the Board of Pardons and Parole to initiate the consideration process for people who they find do not meet regular parole requirements or whose parole is denied, but who they believe may be eligible for medical release.

B.4 : There is currently no clear mechanism to formally refer people to medical parole and medical treatment furlough if they are denied compassionate release.

- **Recommendation for DPS&C:**

- Establish a process for a person to be automatically considered for medical parole or medical treatment furlough if they are deemed not eligible for compassionate release.

## **C. Review and Decision-Making**

*Summary of Problem:* The review process currently in place can be lengthy and complex, and incarcerated patients can grow increasingly sick and in several cases die while waiting for a decision.

*Summary of Solution:* The Task Force recommends streamlining the review process with well-defined, reasonable, and consistent timelines to allow family members to spend more quality time with their sick and elderly loved ones, and also create significant cost-savings for the state in cutting back on the provision of prison healthcare, particularly end-of-life care.

*Sub-problems and Recommendations:*

C.1 : While compassionate release can take as little as 24 hours to 2 weeks to process, the medical parole and medical treatment furlough processes can be lengthy and uncertain. There is currently no formal timeline in place for internal review.

- **Recommendation for Board of Pardons & Parole:**

- Prioritize medical parole/medical treatment furlough hearings by designating a specific day per month for those to occur or prioritizing in scheduling process.

- **Recommendation for DPS&C:**

- Establish reasonable time frames and processes for each level of decision-making. Include deadlines and clear steps for document-gathering, assessments, review, and decision-making, while being sensitive to the need for expedited review in the case of terminal illness.
- Adopt an electronic system that automatically notifies the initial reviewer, including a mechanism by which if the assigned reviewer doesn't take action within a set amount of time, a different reviewer is automatically assigned.

C.2 : Correctional personnel, rather than medical personnel, are most frequently responsible for a denial of a referral for medical release. Of the 56 denials that took place between 2018 and 2021, DPS&C wardens were responsible for the most denials across all types of medical release (34%), followed by Louisiana Board of Pardons and Parole (23%), the Statewide Medical Director (14%), and the IDT (13%). These figures varied across types of medical release, with wardens being responsible for 44% of the 27 denials of medical parole, and the Board of Pardons and Parole being responsible for 38% of the 26 denials of medical treatment furlough.<sup>192</sup>

- **Recommendation for the Legislature:**

- Statutorily require that the wardens, security and classifications members of the interdisciplinary team, Secretary, and BOPP consider factors beyond the charge, conviction, security status, and disciplinary history when making determinations about medical release. Other factors that should be weighted more heavily in the consideration process include age, mobility and quality of life, rehabilitation, prison healthcare costs, and progression of illness.

- **Recommendations for DPS&C:**

- Promulgate policy requiring that the wardens, security and classifications members of the interdisciplinary team, and Secretary consider factors beyond the charge, conviction, security status, and disciplinary history when making determinations about medical release. Other factors that should be weighted more heavily include age, mobility and quality of life, rehabilitation, prison healthcare costs, and progression of illness
- Require training to ensure standardized consideration of the factors above.
- Limit consideration of an individual's disciplinary history for medical release to include only disciplinary actions that took place following the medical diagnosis and/or within the past three years.\*
- Amend the review process such that interdisciplinary team members' decisions are documented by their area of expertise.

C.3 : 23% of denials of medical parole and treatment furlough are denied by the Louisiana Board of Pardons and Parole.<sup>193</sup> Members of the Board of Pardons and Parole are not required to have the medical expertise to make informed decisions about quality of

life and severity of illness. In addition, the same form is used to consider eligibility for medical parole and medical treatment furlough as is used for regular parole.<sup>194</sup>

- **Recommendation for the Legislature:**
  - Create a special panel of community physicians with experience treating Medicaid-eligible populations appointed by the governor to consider medical parole and to supplement the Louisiana Board of Pardons and Parole.\*
- **Recommendation for DPS&C:**
  - Create a separate form and criteria for medical parole and medical treatment furlough that has the relevant considerations to appropriately assess medical condition and eligibility for medical parole and medical treatment furlough.
- **Recommendation for Board of Pardons & Parole:**
  - Narrow the scope of the public safety risk assessment to include only the disciplinary history following the medical diagnosis and/or within the past three years.

C.4 : Unlike other states, Louisiana does not have a designated staff member or individual responsible for coordinating victim outreach to ensure that the medical release review process moves forward in a timely and transparent manner.<sup>195</sup> In Minnesota, for example, cases for medical release are reviewed by a multidisciplinary team that includes a Victim Assistance Director and Victim Assistance Manager. If they decide to recommend the application, the Victim Assistance and Restorative Justice Program notifies the victim(s) and manages any further communication with them throughout the remainder of the medical release process. In addition, under the current Louisiana Board of Pardons and Parole policy or practice, there must be at least a 60 day period between when victims are notified by writing and the hearing takes place.<sup>196</sup>

- **Recommendations for DPS&C:**

**“It is helpful to know that such releases are rigorously examined and involve strict criteria, and is only for inmates who are typically in the final phase of their life, or have a serious debilitating illness. This means that many factors are carefully considered, such as the inmate's record, how much time they have served, what parole supervision will be in place, where they will be located - and of course notification to crime survivors, plus safeguards that prevent the inmate contacting the crime survivors (unless a program such as Restorative Justice is being utilized, which can be of great assistance to survivors).to go home, they need to make that available to them and their families.”**

*Rose Preston, appointee from Louisiana Survivors for Reform*

- Re-evaluate the victim outreach system to meet the unique needs of medical release while allowing for fairness and transparency.
- Designate a staff person at a state agency or non-profit to coordinate victim outreach. Coordinator should have trauma-informed training and be authorized to access and discuss patients' medical information with the patient's permission.
- Tighten timeline for victim notification for medical parole and medical treatment furlough to allow for an expedited hearing when time is of the essence.
- Establish alternative mechanisms by which victims, their families, and other stakeholders are able to participate even in expedited hearings in the case of terminal illness, such as video or written testimony.
- Build upon DPS&C's existing Victim-Offender Dialogue program to allow for family members of the patient and family members of the victim to engage in optional restorative justice dialogue, if they wish to seek one.
- Bolster mechanisms to ensure that survivors and victims' loved ones are notified earlier in the criminal legal process of programs such as the Victim Offender Dialogue and the Accountability Letter Bank, so that if medical release comes up later in their incarceration, it is possible there has already been communication or healing in the case.

C.5 : Outcomes of medical release decision-making vary widely from facility to facility, and do not align with known information about where the patients with the most significant medical conditions and need for assistance and treatment are located. For example, Louisiana State Penitentiary (LSP) and Elayn Hunt Correctional Center (EHCC) are the only providers of Level I care, but have comparatively low rates of approval for medical release.<sup>197</sup>

- **Recommendation for Board of Pardons & Parole:**

- Provide a written decision to incarcerated patients denied medical parole or medical treatment furlough.

- **Recommendations for DPS&C:**

- Standardize the documentation and assessment process and establish consistent criteria and deadlines across statewide facilities.
- Provide a written decision to the incarcerated patient for any DPS&C denial at any level.

C.6 : While statutory policy does allow individuals denied medical release to appeal the denial, there is currently no formal appeals process or procedure in place. Many people may not have a chance to repeat the whole process over again -- Individuals denied medical parole and medical treatment furlough live an average of 260 and 479 days past their denial, respectively. The average length of time between denial and

death for compassionate release is even shorter at 71 days.<sup>198</sup> Given what is known about the lengthy and complex nature of medical release, it is possible that individuals may die before their case for medical release could be reconsidered.

- **Recommendations for the Legislature:**
  - Set specific grounds for reconsideration that include a provision allowing an individual to appeal their denial if they can demonstrate a material change in circumstances after a certain amount of time.\*
  - Establish a reasonable timeline for the Louisiana Board of Pardons and Parole to rule on the appeal, and waive the normal waiting period of 90 days or more for medical parole and medical treatment furlough.

## **D. Post-Release Planning & Transition**

*Summary of Problem:* There are strict statutory and policy guidelines regarding where people are allowed to go once they are released and navigating those and the public benefits system can be complex and lead to revocation.

*Summary of Solution:* The Task Force recommends that once an application for medical release is under consideration, there should be mechanisms in place through the Medicaid Pre-Release Enrollment Program to assist incarcerated patients and their families in navigating public benefits and transitioning into a community hospital, assisted living or nursing facility, or community-based care. It is important that these processes begin before release is approved. If medical release is revoked for any reason, there must be a process in place to allow people to appeal or reapply, with reasonable time frames and requirements.

*Sub-problems and Recommendations:*

- D.1 : During the consideration process, there are no mechanisms to trigger communication between DPS&C, Medicaid, and other community partners when a patient is being considered for medical release.

- **Recommendation for the Legislature:**
  - Remove requirement that patients granted medical treatment furlough must be transferred to LTAC facility or hospital.
- **Recommendations for DPS&C:**
  - Designate a point-person or coordinator to liaison between DPS&C, Medicaid, the incarcerated patient and their family, the Division of Probation and Parole, and community partners.
  - Upon initiation of consideration, trigger notification to the Medicaid pre-release enrollment program to identify eligibility, housing if necessary, and streamline transition and provision of healthcare services.
  - Establish a formal partnership with Formerly Incarcerated Transitions (FIT) Clinic in New Orleans to provide care and services for people upon their

release, including expansion of FIT clinics to other areas of the state.

D.2 : Louisiana does not provide people whose medical release was revoked a means to appeal the decision. Of the 33 people who were granted compassionate release between 2018 and 2021, nearly 25% of their release decisions were later revoked, and they were returned to incarceration.<sup>199</sup>

- **Recommendations for the Legislature:**

- Create a clear process to allow patients whose medical release is revoked to reapply or appeal the decision.\*
- Establish reasonable criteria for consideration of reapplication, such as change in material circumstance.

- **Recommendations for DPS&C:**

- Create a clear process to allow patients whose medical release is revoked to reapply or appeal the decision.\*
- When possible based on conditions of release, confer with Medicaid Pre-Release Enrollment on alternatives, including home care, before revoking for any housing or proximity to victim/victim's family considerations.

## **E. Tracking & Reporting Outcomes**

*Summary of Problem:* Currently there is limited public data available on medical release or the DPS&C population that may be eligible for consideration to fully assess the cost-saving opportunities.

*Summary of Solution:* The Task Force recommends having more public data available on medical release to allow key stakeholders and lawmakers the ability to better understand and assess the current processes, and identify areas of both success and room for improvement, as well as quantify the costs saved on prison healthcare expenditures.

*Sub-problems and Recommendations:*

E.1 : Even with DPS&C's and LDH's full effort cooperation, compilation of this report revealed a lack of consistent and available data on how medical release is utilized in Louisiana, who is eligible, and the processes and procedures involved.

- **Recommendations for DPS&C:**

- Improve and publicly report bi-annually data tracking at all steps of the medical release process, including date of initiation of consideration, reason for release or denial, and demographic characteristics (age, race, sex, offense) in the DPS&C Briefing Book.
- Identify and track people in DPS&C custody whose medical conditions and ADLs may allow them to be considered for eligibility for medical release (i.e. How many people require orderly assistance, surgical history, durable



medical equipment (DME) requirements, etc.) Standardize data tracking and reporting mechanisms across all facilities and include in the DPS&C's briefing book and interactive demographic dashboard.

- Require sheriffs to report the same data for people in state custody held in local facilities. Track the medical release considerations and approvals/denials for everyone moved from a local facility to a DPS&C facility for medical purposes.
- Track referrals and approvals/denials from community medical facilities through an automatic screening form and mechanism built into Electronic Health Record software systems, or a similar type of system. Include in the DPS&C Briefing Book.
- Develop and implement an “electronic flag” for medical release conditions as electronic health records come online for all DPS&C facilities.
- Provide additional details and information to Louisiana Commission on Law Enforcement (LCLE) and LDH on deaths in custody in DPS&C facilities, including release of datasets, in order to track causes of death by disease, trends by age, race, gender, & offense, and admission and death dates. LCLE and LDH to make public the aforementioned data collected from jails and prisons statewide.

E.2 : Compilation of this report revealed a lack of available information on how much of DPS&C's healthcare budget is spent on specific medical conditions and treatments.

- **Recommendation for DPS&C:**

- Identify and track treatment costs for people in DPS&C custody whose medical conditions and treatment costs are considered seriously symptomatic (e.g. three or more hospitalizations within the same year for the same condition).

E.3 : Additional data collection would be helpful in determining the efficacy of these recommendations and what, if any, further recommendations are necessary.

- **Recommendation for the Legislature:**

- Require that DPS&C compile relevant data for the Louisiana Department of Health and Medicaid who will, with assistance from this Task Force where appropriate, issue a report on how these recommendations have been implemented and the related cost-savings by March 1, 2023.\*

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- <sup>1</sup> House Resolution No. 51, 2021 Regular Session (Enrolled), available at <http://www.legis.la.gov/legis/ViewDocument.aspx?d=1230189>.
- <sup>2</sup> *Id.*
- <sup>3</sup> Loyola University New Orleans College of Law, LSU Health New Orleans, & VOTE Nola, “Study Brief, Adequacy of Healthcare Provided in Louisiana State Prisons,” May 2021, at 3, available at [https://www.loyno.edu/sites/default/files/2021-05/DPSC\\_Healthcare\\_Brief.pdf](https://www.loyno.edu/sites/default/files/2021-05/DPSC_Healthcare_Brief.pdf).
- <sup>4</sup> *Id.*
- <sup>5</sup> Louisiana Dept. of Corrections, “Demographic Dashboard,” LA DPS&C, June 30, 2021, available at <https://doc.louisiana.gov/demographic-dashboard/>.
- <sup>6</sup> *Id.*
- <sup>7</sup> John Simerman, “‘The Only Way Out is a Pine Box’: Costly, Enfeebled Lifers Clog Louisiana Prisons,” *Nola.com*, Dec. 17, 2021, available at [https://www.nola.com/news/courts/article\\_a1895208-5d16-11ec-a569-1f234e8e0b1e.html](https://www.nola.com/news/courts/article_a1895208-5d16-11ec-a569-1f234e8e0b1e.html).
- <sup>8</sup> Loyola University New Orleans College of Law, “Louisiana Deaths Behind Bars 2015-2019,” June 2021, at 10, available at <https://www.incarcerationtransparency.org/wp-content/uploads/2021/06/LA-Death-Behind-Bars-Report-Final-June-2021.pdf> [hereinafter, “Deaths Behind Bars”]. See also La. DPS&C, Briefing Book at 32 (Jan. 2015); La. DPS&C, Briefing Book at 19 (Jan. 2020).
- <sup>9</sup> DPS&C Briefing Book at 18-19 (Jan. 2020).
- <sup>10</sup> Deaths Behind Bars at 10. For comparison, people 55 years of age or older constituted 85.8% of all deaths in Louisiana of people ages 15-99 years old in 2019. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Feb 23, 2022 3:19:17 PM.
- <sup>11</sup> Federal Bureau of Prisons, “Inmate Age,” January 2022, available at [https://www.bop.gov/about/statistics/statistics\\_inmate\\_age.jsp](https://www.bop.gov/about/statistics/statistics_inmate_age.jsp).
- <sup>12</sup> Lea Skene, “Louisiana’s Life Without Parole Sentencing the Nation’s Highest – And Some Say That Should Change,” *The Advocate*, Dec. 7, 2019, available at [https://www.theadvocate.com/baton\\_rouge/news/article\\_f6309822-17ac-11ea-8750-f7d212aa28f8.html](https://www.theadvocate.com/baton_rouge/news/article_f6309822-17ac-11ea-8750-f7d212aa28f8.html).
- <sup>13</sup> Louisiana Dept. of Corrections, “Demographic Dashboard,” LA DPS&C, June 30, 2021, available at <https://doc.louisiana.gov/demographic-dashboard/>.
- <sup>14</sup> *Id.*
- <sup>15</sup> *Id.*
- <sup>16</sup> Loyola University New Orleans College of Law, LSU Health New Orleans, & VOTE Nola, “Study Brief, Adequacy of Healthcare Provided in Louisiana State Prisons,” May 2021, available at [https://www.loyno.edu/sites/default/files/2021-05/DPSC\\_Healthcare\\_Brief.pdf](https://www.loyno.edu/sites/default/files/2021-05/DPSC_Healthcare_Brief.pdf).
- <sup>17</sup> *Id.* at 2. These figures do not reflect unique counts as one individual may have been diagnosed with multiple medical conditions. Other conditions included serious mental illness, end stage renal disease (requiring dialysis), and pregnancy/childbirth. In FY 2020, the proportion of people on medication at any given facility ranged from 58% at David Wade to 95% at the Louisiana Correctional Institute for Women (LCIW). *Id.*
- <sup>18</sup> Department of Medical and Mental Health, “Medical and Mental Health Quarterly Report”, DPS&C, July 2020-June 2021, at 4, available at <https://s32082.pcdn.co/wp-content/uploads/2021/10/Medical-C05-Quarter-4.-NEW.-RE.pdf>.
- <sup>19</sup> E. Ann Carson, “Mortality in State and Federal Prisons, 2001-2018- Statistical Tables,” *U.S. Department of Justice: Bureau of Justice Statistics*, Apr. 2021, at 13-16, available at <https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf>.
- <sup>20</sup> Deaths Behind Bars at 13.
- <sup>21</sup> *Id.* at 21.
- <sup>22</sup> *Id.* at 26. For medically-related deaths occurring exclusively in DPS&C facilities (528), 254 (48.1%) were due to a condition pre-existing their admission to the prison. Incarceration Transparency, “Louisiana Death Behind Bars: 2015-2019,” dataset available at [https://www.incarcerationtransparency.org/?page\\_id=3837](https://www.incarcerationtransparency.org/?page_id=3837).
- <sup>23</sup> E. Ann Carson, “Prisoners in 2020 - Statistical Tables,” *U.S. Department of Justice: Bureau of Justice Statistics*, Dec. 2021, at 19, available at <https://bjs.ojp.gov/content/pub/pdf/p20st.pdf>.
- <sup>24</sup> See e.g., *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Brown v. Plata*, 563 U.S. 493, 510–11, 545 (2011); see also *Edmo v. Corizon, Inc.*, 935 F.3d 757, 786 (9th Cir. 2019), *cert. denied sub nom. Idaho Dep’t of Corr. v. Edmo*, 141 S. Ct. 610 (2020) (“Accepted standards of care and practice within the medical community are highly relevant in determining what care is medically acceptable and unacceptable.”).
- <sup>25</sup> Loyola University New Orleans College of Law, LSU Health New Orleans, & VOTE Nola, “Study Brief, Adequacy of Healthcare Provided in Louisiana State Prisons,” May 2021, at 3, available at [https://www.loyno.edu/sites/default/files/2021-05/DPSC\\_Healthcare\\_Brief.pdf](https://www.loyno.edu/sites/default/files/2021-05/DPSC_Healthcare_Brief.pdf).
- <sup>26</sup> DPS&C Briefing Book, page 69, available at <https://s32082.pcdn.co/wp-content/uploads/2021/10/0m-Full-Briefing-Book.pdf>.
- <sup>27</sup> *Id.*
- <sup>28</sup> WBRZ Staff, “Another \$34M Sought to Fill Gaps in Louisiana Prisons Budget,” WBRZ, Feb. 21, 2020, available at <https://www.wbrz.com/news/another-34m-sought-to-fill-gaps-in-louisiana-prisons-budget/>.
- <sup>29</sup> “How and When Medicaid Covers People Under Correctional Supervision,” PEW, Aug. 2, 2016, available at <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision>.
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<sup>30</sup> *Id.*

<sup>31</sup> Duplicates removed.

<sup>32</sup> Medicaid information was provided by Task Force member Karissa Page, Program Manager of the Justice-Involved Initiatives for the Louisiana Department of Health, Bureau of Health Services Financing. Additional Medicaid information can be found at Attachment A.

<sup>33</sup> “Louisiana Justice Reinvestment Task Force Report and Recommendations”, March 16, 2017, at 42, available at [https://www.lasc.org/documents/LA\\_Task\\_Force\\_Report\\_2017\\_FINAL.pdf](https://www.lasc.org/documents/LA_Task_Force_Report_2017_FINAL.pdf).

<sup>34</sup> *Id.*

<sup>35</sup> DPS&C Health Care Policy No. HCP41.

<sup>36</sup> DPS&C Health Care Policy No. HCP42.

<sup>37</sup> DPS&C Health Care Policy No. HCP46.

<sup>38</sup> DPS&C HCP41 at §§ 5.A, 7.J.

<sup>39</sup> Notably, La. R.S. 15:833.2 uses the phrase “condition that totally prevents mobility.”

<sup>40</sup> DPS&C HCP41 at § 5.G.

<sup>41</sup> *Id.* at § 5.E.

<sup>42</sup> *Id.* at § 6.B.1.c.

<sup>43</sup> *Id.* at § 6.A.

<sup>44</sup> *Id.* at §§ 7.B, 7.C.

<sup>45</sup> For consistency, throughout this report, “Facility Medical Director” is used to refer to the Unit Medical Director.

<sup>46</sup> DPS&C HCP41 at § 7.B.

<sup>47</sup> *Id.* at § 7.D.1.

<sup>48</sup> *Id.* at § 7.D.2.

<sup>49</sup> *Id.* at § 7.E.

<sup>50</sup> *Id.* at § 7.A.

<sup>51</sup> *Id.* at § 5.F.

<sup>52</sup> *Id.* at §§ 7.E.2, 7.E.3

<sup>53</sup> *Id.* at § 7.E.3.

<sup>54</sup> *Id.* at § 7.F.

<sup>55</sup> *Id.* at § 7.G.

<sup>56</sup> *Id.* at § 7.I.1.a.

<sup>57</sup> *Id.* at § 7.I.1.b.

<sup>58</sup> *Id.* at § 7.K.

<sup>59</sup> *Id.* at § 7.K.2.

<sup>60</sup> *Id.* at §§ 5.A, 7.J.

<sup>61</sup> *Id.* at § 7.I.3.b. If a person considered a sex offender is approved for Compassionate Release, the Unit Warden follows the notification requirements in Department Regulation No. IS-E-1, Sex Offender Notification, Registration Requirements and Residence Plan. *Id.* at 3.c.

<sup>62</sup> *Id.* at § 7.K.

<sup>63</sup> DPS&C HCP 42 (2019) at § 6.B.

<sup>64</sup> *Id.* at § 5.F.

<sup>65</sup> *Id.* at § 5.E.

<sup>66</sup> *Id.* at § 6.A; see also Senate Bill 139 (2017), available at <https://www.legis.la.gov/legis/ViewDocument.aspx?d=1051859>.

<sup>67</sup> DPS&C HCP42 at § 6.B.2.

<sup>68</sup> *Id.* at § 7.M.

<sup>69</sup> *Id.* at §§ 7.B, 7.C.

<sup>70</sup> *Id.* at § 7.B.

<sup>71</sup> *Id.* at § 7.D.1.

<sup>72</sup> *Id.* at § 7.D.2.

<sup>73</sup> *Id.* at § 7.E.

<sup>74</sup> *Id.* at §§ 7.E.2, 7.E.3.

<sup>75</sup> *Id.* at § 7.E.3.

<sup>76</sup> *Id.* at § 7.F.

<sup>77</sup> *Id.* at § 7.G.

<sup>78</sup> *Id.* at § 7.H.6.

<sup>79</sup> *Id.* at § 7.G.2.b.

<sup>80</sup> *Id.* at § 7.H.

<sup>81</sup> *Id.* at § 7.H.3.

<sup>82</sup> *Id.* at § 7.I.2.

<sup>83</sup> LA DPS&C, “Louisiana Board of Pardons and Committee on Parole,” available at <https://doc.louisiana.gov/imprisoned-person-programs-resources/pardons-parole/>.

<sup>84</sup> DPS&C HCP42 at § 7.J.1.

<sup>85</sup> *Id.* at § 7.K.

<sup>86</sup> *Id.* at § 7.L.

<sup>87</sup> *Id.*

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- <sup>88</sup> DPS&C HCP46 (2018) at §§ K., L.
- <sup>89</sup> *Id.* at § 7.J.1.
- <sup>90</sup> “Louisiana Justice Reinvestment Task Force Report and Recommendations”, March 16, 2017, available at [https://www.lasc.org/documents/LA\\_Task\\_Force\\_Report\\_2017\\_FINAL.pdf](https://www.lasc.org/documents/LA_Task_Force_Report_2017_FINAL.pdf).
- <sup>91</sup> 2018 Regular Session Act No. 473, Enrolled, <http://www.legis.la.gov/legis/ViewDocument.aspx?d=1102934>.
- <sup>92</sup> *Id.*
- <sup>93</sup> La. R.S. 15:574.20 (2018).
- <sup>94</sup> DPS&C HCP46 (2018) at § 5.D.
- <sup>95</sup> *Id.* at § 6.B.1.a.
- <sup>96</sup> *Id.* at § 6.A.
- <sup>97</sup> *Id.* at § 6.B.1.c.
- <sup>98</sup> *Id.* at § 7.M.
- <sup>99</sup> *Id.* at §§ 7.B, 7.C.
- <sup>100</sup> *Id.* at § 7.B.
- <sup>101</sup> *Id.* at § 7.D.1.
- <sup>102</sup> *Id.* at § 7.D.2.
- <sup>103</sup> *Id.* at § 7.E.
- <sup>104</sup> *Id.* at § 7.A.
- <sup>105</sup> *Id.* at § 5.F.
- <sup>106</sup> *Id.* at §§ 7.E.2, 7.E.3
- <sup>107</sup> *Id.* at § 7.E.3.
- <sup>108</sup> *Id.* at § 7.F.
- <sup>109</sup> *Id.* at § 7.G.
- <sup>110</sup> *Id.* at § 7.H.6.
- <sup>111</sup> *Id.* at § 7.G.2.b.
- <sup>112</sup> *Id.* at § 7.H.
- <sup>113</sup> *Id.*
- <sup>114</sup> *Id.*
- <sup>115</sup> *Id.* at § 7.J.1.
- <sup>116</sup> *Id.* at § K.
- <sup>117</sup> *Id.* at § L.
- <sup>118</sup> *Id.*
- <sup>119</sup> Datasets available upon request.
- <sup>120</sup> DPS&C HCP41 at §§ 5.G.
- <sup>121</sup> DPS&C HCP42 (2019) at § 5.F.
- <sup>122</sup> DPS&C HCP46 (2018) at § 5.D.
- <sup>123</sup> DPS&C HCP41 at §§ 5.E.
- <sup>124</sup> These figures were calculated by combining the data in the 2006-2017 and 2018-2021 datasets. Any data from 2018 appearing in the 2006-2017 dataset was disregarded for purposes of this analysis.
- <sup>125</sup> DPS&C Briefing Books provided by DPS&C. 2021 data available at <https://doc.louisiana.gov/about-the-dpsc/annual-statistics/>.
- <sup>126</sup> Medical parole is not considered here because people convicted of first or second degree murder are ineligible for medical parole.
- <sup>127</sup> DPS&C Briefing Book, page 20, available at <https://s32082.pcdn.co/wp-content/uploads/2021/10/0m-Full-Briefing-Book.pdf>.
- <sup>128</sup> These figures do not represent unique counts as one individual may have been diagnosed with multiple conditions.
- <sup>129</sup> Ninety percent of the community doctors surveyed worked at the University Medical Center New Orleans.
- <sup>130</sup> Colo. Rev. Stat. §§ 17-22.5-403.5, 17-1-102, and 17-2-201; Hawaii Administrative Rules (HAR) §§ 23-700-26 (c) and 23-700-29 (b); Hawaii Department of Public Safety, Corrections Division Policy and Procedures (COR Policy), Policy 10.1G.11-Medical Releases; Idaho Code § 20-223 (8); Idaho Admin. Code § 50.01.01.250-05; Idaho Department of Correction Standard Operating Procedure (DOC Procedure) 324.02.01.002, Parole of Offenders with a Terminal Disease of Permanent Incapacitation; 730 Illinois Compiled Statutes (ILCS) 5/3-3-1 and 5/3-3-14 (HB 3665/Public Act 102-0494); Ky. Rev. Stat. Ann. § 439.3405; Kentucky Parole Board Policies and Procedures, KYPB 10-01, Parole Release Hearings; Kentucky Corrections Policies and Procedures (DOC Policy), Policy 13.2, § II (O); Maine Rev. Stat. Ann. Tit.34-A, § 3036-A (10); Maine Department of Corrections, Chapter 27: Release Preparation, Policy 27.2-Supervised Community Confinement (2017) (DOC Policy 27.2), § VI-Procedures: Procedure I-Supervised Community Confinement for a Terminally Ill or Severely Incapacitated Prisoner; Mass. Gen. Laws ch. 127, § 119A; Minn. Stat. § 244.05, Subd. 8; Minnesota Department of Corrections Policy (DOC Policy) 203.200; Mont. Code Ann. § 46-23-210; Mont. Admin. R. 20.25.307; Montana Department of Corrections Policy Directive (DOC Policy) 4.6.7; Neb. Rev. Stat. §§ 83-1, 110.02 and 83-1, 110.03; Nebraska Board of Parole Rules, §§ 4-601 and 4-602; N.H. Rev. Stat. Ann. § 651-A; 10-a; N.H. Code Admin. R. Par. 303; N.J. Rev. Stat. § 30:4-123.51e; New Jersey Administrative Office of the Courts (AOC), Directive 04-21, Procedures for Compassionate Release; N.M. Stat. § 31-21-25.1; New Mexico Corrections Department Policy (Department Policy) CD-050400, Parole of Geriatric, Permanently Incapacitated, or Terminally Ill Inmates; New Mexico Corrections Department Policy CD-050401 Application Procedures for Probation/parole of Geriatric, Permanently Incapacitated, or Terminally Ill Inmates; N.Y. Exec. Law § 259-r; New York Department of Corrections and Community Supervision, Directive 4309, Medical Parole; N.Y. Exec. Law § 259-s, Directive 4304, Medical Parole; N.D. Cent. Code § 12-59-08; North Dakota Department of Corrections and Rehabilitation Policy (Department Policy) 1A-13, §§ 3 and 5

(E) (4); Or. Rev. Stat. §§ 144.122 and 144.126; Or. Admin. R. 255-040-0028; 42 Pa. Cons. Stat. § 9777; R.I. Gen. Laws §§ 13-8.1-1 through 13.8.1-4; Rhode Island Department of Corrections Policy and Procedure (DOC Policy) 20.08-3; S.C. Code Ann. § 24-21-715; South Carolina Board of Pardons and Paroles, Policy and Procedure Manual (Nov. 2019), Part II-Parole Process, § D (4), Parole for Terminally Ill, Geriatric or Permanently Disabled Inmates; South Carolina Department of Corrections, Operations Policy Manual, Policy/Procedure (SCDC Policy) OP-21.04: Inmate Classification Plan (Oct. 22, 2020), § 30.2-Medical Parole; Utah Admin. Code r. 671-314-1; Wy. Stat. Ann. § 7-13-424; Wyoming Board of Parole, Policy and Procedure Manual, Parole: Medical Parole.

<sup>131</sup> Hawaii Department of Public Safety, Corrections Division Policy and Procedures COR Policy 10.IG.11, § 2.2 (a) and § 3.  
<sup>132</sup> *Id.*

<sup>133</sup> HAR §§ 23-700-26 (c) and 23-700-29 (b), see also COR Policy 10.IG.11 at § 4.4.

<sup>134</sup> HAR §§ 23-700-26 (c) and 23-700-29 (b), COR Policy 10.IG at §§ 2.2, 3.

<sup>135</sup> DRC Rule 66-ILL-01, § IV, Definitions; see also Ohio Rev. Code § 2967.05 (A) (2) (a); Ohio Admin. Code 5120:1-1-40 (A) (2); DRC Rule 66-ILL-01, § IV, Definitions. Note that this does not include conditions related solely to mental illness unless accompanied by injury, disease, or “organic defect.” See Ohio Rev. Code § 2967.05 (A) (2) (b); Ohio Admin. Code 5120:1-1-40 (A) (2); DRC Rule 66-ILL-01, § IV, Definitions.

<sup>136</sup> R.I. Gen. Laws § 13-8.1-3 (a).

<sup>137</sup> See, e.g., Mississippi Department of Corrections, Department Policy 1A-13, § 3 (R).

<sup>138</sup> North Dakota Department of Corrections and Rehabilitation Policy 1A-13, § 3 (R).

<sup>139</sup> *Id.*

<sup>140</sup> Mississippi Department of Corrections, Medical Division webpage, available at <https://www.mdcc.ms.gov/Divisions/Pages/Medical-Division.aspx>.

<sup>141</sup> Hawaii Department of Public Safety, Corrections Division Policy and Procedures (COR Policy) 10.IG.11 at §3.

<sup>142</sup> Ala. Code § 15-22-43 (a) (2); Ala. Admin. Code §§ 640-X-3-.05 (3) (a) and (b); Alabama Board of Pardon and Pardons Rules Regulations, and Procedures (Board Rules), Article 1, §§ 14 (a) and (b); Alaska Stat. § 33.16.085 (a) (4); Colo. Rev. Stat. § 17-1-102 (7.5) (a) (III); N.H. Rev. Stat. Ann. § 651-A:10-a (I) (b); S.D. Codified Laws § 24-15A-55; South Dakota Department of Corrections Policy (DOC Policy) 1.5.G.12, § IV (2) (A); South Dakota Board of Pardons and Paroles Policy (Board Policy) 8.1.A.16 (IV) (A); Wash. Rev. Code § 9.94A.728 (1) (c) (i) (A); State of Washington Department of Corrections Policy (DOC Policy) 350.270, Directive, §§ I (C) (1) and II (A) (3); Wash. Rev. Code § 9.94A.728 (c) (i) (C); State of Washington Department of Corrections Policy (DOC Policy) 350.270, Directive, § I (C) (2).

<sup>143</sup> S.D. Codified Laws § 24-15A-55; South Dakota Department of Corrections Policy (DOC Policy) 1.5.G.12, § IV. (2) (A); South Dakota Board of Pardons and Paroles Policy (Board Policy) 8.1.A.16 (IV) (A).

Note: Medical cost is one of the many criteria that triggers the eligibility consideration phase. If an individual is deemed eligible based on medical cost (or any other eligibility criteria), the individual may be granted release only if a determination is made by the secretary and the board that the release is unlikely to pose a detriment to the offender, victim, or community.

<sup>144</sup> Ala. Code §§ 15-22-43 (2); Alaska Stat. § 33.16.090 (a) (2); Cal. Penal Code § 3055; Colo. Rev. Stat. § 17-1-102 (7.5) (a) (III); Conn. Gen. Stat. § 54-131k (a); D.C. Code § 24-403.04 (a) (3) (B) (i) through (B) (iii), and at (a) (2); Ga. Const. art. IV, § II, par. II (e); Ga. Code Ann. § 42-9-42 (c); Md. Code Ann., Crim. Law § 14-101 (f); Miss. Code Ann. § 47-7-3; Mo. Rev. Stat. § 217.250; Parole board Procedures, § 29 (A) (2); Nev. Rev. Stat. § 213.12155; N.M. Stat. § 31-21-25.1 (F) (1); Department Policy CD-050400, Definitions, § (A); N.C. Gen. Stat. § 15A-1369 (3); Prison Policy, Chapter Q, § .0302 (c); Health Policy CC-12, Definitions; Corrections Policy, Chapter E, §§ .0902 and .0904; Okla. Stat. § 57-332.21; Oklahoma Department of Corrections, policies and Procedures, Section 06: Classification and Case Management, Parole Process Procedure OP-060205 (DOC OP-060205); Oklahoma Pardon and Parole Board, Aging Prisoners Application and Instructions; Oklahoma Pardon and Parole Board, Frequently Asked Questions About Aging Prisoner Parole; Or. Rev. Stat. §§ 144.122 (1) (c) and 144.126 (1) (b); Or. Admin. R. 255-040-0028 (1); S.C. Code Ann. § 24-21-715 (A) (2); SCDC Policy OP-21.04, § 30.2; S.D. Codified Laws §§ 24-15A-55 through 24-15A-68; South Dakota Department of Corrections Policy (DOC Policy) 1.5.G.12; South Dakota Board of Pardons and Paroles Policy (Board Policy) 8.1.A.16; Tenn. Code Ann. § 41-21-227; Tex. Gov’t Code Ann. § 508.146 (a) (1) (A); Department Guideline PGP-0.1.04, Attachment A; Department Health Policy A-08.6, Definitions, referencing the Texas Health and Safety Code, § 571.003; Utah Admin. Code r. 671-314-1 (4) (a); Va. Code Ann. § 53.1-40.01; Virginia Parole Board Policy Manual, § II (B); Virginia Parole Board Administrative Procedure (Parole Board Procedure) 1.226-Conditional Release of Geriatric Inmates; DOC-OP 820.2, § XI (A) (1); Wash. Rev. Code § 9.94A.728 (1) (c) (i) (B); DOC Policy 350.270, Directive, §§ I (C) (3) and (D) (3); Wis. Stat. § 302.113 (9g) (a) (1) and (b); DOC Policy 302.00.13, Definitions; Wy. Stat. Ann. § 7-13-424 (A) (ii); Board Manual, Parole: Medical Parole, § II (A) (2).

<sup>145</sup> See above: Alabama, Alaska, California, Colorado, Georgia, Maryland, Mississippi, Missouri, Nevada, Oklahoma, South Dakota, Texas, Utah, Virginia, Wisconsin.

<sup>146</sup> Cal. Penal Code § 3055 (a).

<sup>147</sup> Ala. Code §§ 15-22-43 (2); Ga. Const. art. IV, § II, par. II (e); Ga. Code Ann. § 42-9-42 (c); Tex. Gov’t Code Ann. § 508.146 (a) (1) (A); Department Guideline PGP-0.1.04, Attachment A; Department Health Policy A-08.6, Definitions, referencing the Texas Health and Safety Code, § 571.003; Utah Admin. Code r. 671-314-1 (4) (a).

Note: Louisiana has a specific geriatric parole process that is separate from medical release.

<sup>148</sup> See, e.g., Alaska Stat. § 33.16.085 (a) (1); Colo. Rev. Stat. § 17-1-102 (7.5) (a) (IV); COR Policy 10.IG.11, § 2.2 (b) and § 3; Kan. Admin. Regs. § 45-700-1 (b); DOC IMPPP 11-110, Definitions; Mich. Comp. Laws § 791.235 (22) (c) (ii); Mississippi Department of Corrections, Medical Division webpage; Miss. Code Ann. § 47-7-4; DRC Rule 66-ILL-01, § IV, Definitions; Okla. Stat. § 57-332.18 (F) (3); DOC-OP 060205, § I (C) (1) (c); R.I. Gen. Laws § 13-8.1-3 (a); Wisconsin Department of Correction, *Affidavit of Extraordinary Health Condition* (Form DOC 3612).



<sup>149</sup> *Id.*

<sup>150</sup> Mich. Comp. Laws § 791.235 (22) (c) (ii).

<sup>151</sup> Ariz. Rev. Stat. §§ 31-403 (D) and 31-442; DOC Order 1002, §§ 1.11.3.1.3, 1.11.3.1.4 and 1.12; Parole board Manual § 4.5; Del. Code Ann. Tit. 11, § 4217 (f); D.C. Code, § 24-4403.04; Fla. Admin. Code § 33-601.603 (7) (b); Ga. Const. art. IV, § II, par. II €; Ga. Code Ann. § 42-9-43 (b); Ga. Const. art. IV, § II, par. II (e); Ga. Code Ann. § 42-9-42 (c); Hawaii Administrative Rules (HAR), §§ 23-700-26 (c) and 23-700-29 (b); Hawaii Department of Public Safety, Corrections Division Policy and Procedures (COR Policy), Policy 10.1G.11-Medical Releases; HB 3665; 220 Ind. Admin. Code § 1.1-4-1.5 (a); DOC Policy 01-04-105, § VIII (D); Ky. Rev. Stat. Ann § 439.3405; Kentucky Parole Board Policies and Procedures, KYPB 10-01, Parole Release Hearings; Kentucky Corrections Policies and Procedures (DOC Policy), Policy 13.2, § II (O); Mass. Gen. Laws ch. 127, § 119A; Minn. Stat. § 244.05, Subd. 8; Minnesota Department of Corrections Policy (DOC Policy) 203.200; N.J. Rev. Stat. § 30:4-123.51e; New Jersey Administrative Office of the Courts (AOC), Directive 04-21, Procedures for Compassionate Release; N.D. Cent. Code § 12-59-08; Or. Admin. R. 225-040-0028 (1) (d); 42 Pa. Cons. Stat. § 9777; Utah Admin. Code r. 671-314-1; Vt. Stat. Ann. Tit. 28, § 502a (d); Vt. Stat. Ann. Tit. 28, § 808 (e); W. Va. Const. art. 7, § 11; W. Va. Code § 5-1-16; West Virginia Division of Corrections Policy Directive 410.12, §§ IV and V (E) (1); DOC Directive 31, §§ V and VI (A).

<sup>152</sup> See *above*: Delaware, Georgia, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, New Jersey, North Dakota, Pennsylvania, Utah, Vermont, and West Virginia.

<sup>153</sup> N.C. Gen. Stat. § 15A-1369.3 (a); Prison Policy, Chapter Q, § .0304 (b) (2); Health Policy CC-12, § I (A) (2); Prison Policy, Chapter Q, § .0402 (b) (1); Oregon Department of Corrections, Frequently Asked Questions: Early Medical Release; R.I. Gen. Laws § 13-8.1-4 (b); DOC Policy 20.08-3, § III (B) (1); Department Guideline PGP-01.04, § I (A).

<sup>154</sup> Ala. Code § 14-14-5 (c) and (a); Cal. Penal code § 3550 (d); Cal. Code Regs. Tit. 15, §§ 3359.1 (b) (2) through (b) (4); Conn. Gen. Stat. § 54-131e; 730 ILCS 5/3-3-14 (c) (1); DOC Policy 01-04-105, § VIII (E); Mass. Gen. Laws ch. 125, § 119A (c) (1); Nev. Rev. Stat. § 209.3925.2 (a) (1) through (a) (5); N.M. Stat. § 31-21-25.1 (A) (1); Directive 4304, § III (A).

<sup>155</sup> Oregon Department of Corrections, “Frequently Asked Questions: Early Medical Release”, [Oregon.gov](https://www.oregon.gov/doc/covid19/Pages/faq.aspx), available at <https://www.oregon.gov/doc/covid19/Pages/faq.aspx>.

<sup>156</sup> See, e.g., COR Policy 10.1G.11; DOC Procedure 324.02.01.002; Idaho Code § 20-223 (4); Ky. Rev. Stat. Ann § 439.3405; Mass. Gen. Laws ch. 127, § 119A; DOC Policy 203.200; Mont. Code Ann. § 46-23-210 (3) and (4); Mont. Admin. R. 20.25.307 (2) and (3); DOC Policy 4.6.7; Or. Admin. R. 225-040-0028 (1) (a) through (1) (c); R.I. Gen. Laws § 13-8.1-4 (b), (c), and (e); DOC Policy 20.08-3, § III (B) (3) and (4); SCDC Policy OP-21.04, §§ 30.2.1, 30.2.2, and 30.2.3.

<sup>157</sup> Mass. Gen. Laws ch. 127 § 119A (c) (1).

<sup>158</sup> *Id.*

<sup>159</sup> *Id.* at § (a).

<sup>160</sup> *Id.* at § (e)

<sup>161</sup> Minn. DOC Policy 203.200 (C) (5) and (D).

<sup>162</sup> *Id.* at (E).

<sup>163</sup> Ala. Code § 14-14-5 (d); DOC Order 1002, §§ 1.11.3.2 and 1.11.3.2.2; Ark. Code Ann. § 16-93-207 (b); Cal. Penal Code § 3550; Cal. Code regs. Tit 15, § 3359.2; Color. Rev. Stat. §§ 17-22.5-403.5 (3) (c) (1), (3) (c) (II) and (4) (d); 28 C.F.R. § 2.77 (e); 28 C.F.R. § 2.78 (d); DOC Procedure 324.02.01.002, § 2, Step 6; Mass. Gen. Laws ch. 127, § 119A; Mich. Comp. Laws § 791.244 (2); Minn. DOC Policy 203.200 (C), (D), and (E); Nev. Rev. Stat. § 209.3925.3; DOC Regulation 523.04, §§ 4 (C) and 4 (D); Nev. Stat § 213.12155 (3), (5) and (8); N.J. Rev. Stat. § 30:4-123.51e-1 (e) (3), (e) (5) and (g); N.C. Gen. Stat. § 15A-1369.3 (c); Prison Policy, Chapter Q, § .0304 (1); N.C. Gen. Stat. § 15A-1369.3 (d); Ohio Rev. Code § 2929.20 (D); R.I. Gen. Laws § 13-8.1-4 (b); DOC Policy 20.08-3, § III (B) (2); R.I. Gen. Laws § 13-8.1-4 (h) and DOC Policy 20.08-3 § III (C) (1); R.I. Gen. Laws § 13-8.1-4 (i) and DOC Policy 20.08-3 § III (C) (2); R.I. Gen. Laws § 13-8.1-4 (j) and DOC Policy 20.08-3 § III (C) (3); S.D. Codified Laws § 24-15A-56; DOC Policy 1.5.G.12, § IV (1) (e); Board Policy 8.1.A.16 (IV), Board Consideration, Subparagraph A; Department Policy 511.01.1, § VI (C) (3) and (C) (6); Department Health Policy A-08.6, Procedures, § I (A); Texas Board of Pardons and Paroles, Board Policy 145.204, Procedure, § V; West Virginia Division of Corrections Policy Directive 410.12, § V (B) (2), (B) (3), and (C) (2).

<sup>164</sup> Ohio Rev. Code § 2929.20 (D).

<sup>165</sup> R.I. Gen. Laws § 13-8.1-4 (b) and DOC Policy 20.08-3, § III (B) (2).

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.* at § (h) and *Id.* at § (C) (1).

<sup>169</sup> *Id.* at § (i) and *Id.* at § (2).

<sup>170</sup> *Id.* at § (j) and *Id.* at § (3).

<sup>171</sup> N.C. Gen. Stat. § 15A-1369.3 (c), and Prison Policy, Chapter Q, § .0304 (1).

<sup>172</sup> *Id.* at (d).

<sup>173</sup> Board Rules, Article 16, § 1; Alaska Admin. Code tit. 22, § 20.610 (e); Board Policy #114, § 114.3, Subsection 3.2.3; Conn. Gen. Stat. § 54-131f; D.C. Code § 24-468 (b) (2); DOC Policy 01-04-105, § VIII (D); Mich. Comp. Laws § 791.244 (2); N.Y. Exec. Law § 259-r (10).

<sup>174</sup> Board Rules, Article 3, § 6; Alaska Admin. Code tit. 22, § 20.630 (b); 200 Ind. Admin. Code § 1.1-4-1.5 (c); DOC Policy 01-04-105, § VII (D); Mass. Gen. Laws ch. 127, § 119A (g); N.Y. Exec. Law §§ 259-r (8) and 259-s (8); *Commonwealth v. Folk* 40 A.3d 169 (Pa. Super. 2012).

<sup>175</sup> Alaska Admin. Code tit. 22, § 20.630 (b).

<sup>176</sup> Ariz. Rev. Stat. §§ 31-403 (A) through (C); Board Policy #114, § 114.7, Subsection 7.7.2; Clemency Board, Frequently Asked Questions; Ark. Code Ann. §§ 16-93-207 (b), (c), (d) and (3) (A); California Department of Corrections and Rehabilitation,



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Board of Parole Hearings, Medical Parole hearings webpage, “What to Expect at an Expanded Parole Hearing”; Del. Code Ann. Tit. 11, § 4217 (d) (3) and (e); Michigan Department of Corrections, Executive Clemency Process, Summary; Department Policy CD-050401, § (C) (2) (b); N.C. Gen. Stat. § 15A-1369.3 (f); Oklahoma Pardon and Parole Board FAQ, Question 29; R.I. Gen. Laws § 13-8.1-4 (h); S.D. Codified Laws § 24-15A-59; DOC Policy 1.5.G.12, § IV (3) (B); Board Policy 8.I.A.16 (IV), Board Consideration, Subparagraph (B) (1); Department Guideline PGP-01.04, § VI (F); DOC-OP 820.2, §XI (A) (1) (c) (iv); DOC Policy 350.270, Directive, § III (E); West Virginia Division of Corrections Policy Directive 410.12, § V (E) (2); Wis. Stat. § 302.113 (9g) (i); DOC Policy 302.00.13, Procedure, § VII (B).

<sup>177</sup> R.I. Gen. Laws § 13-8.1-4 (h).

<sup>178</sup> Ala. Code § 15-22-43 (g); Ala. Code § 14-14-4 (h); Alaska Admin. Code tit. 22, §§ 20.655 through 20.660; Alaska Stat. § 44.19.645 (g) (5); Parole Board Manual § 5.14; California Board of Parole Hearings, *2019 Report of Significant Events* (Feb. 18, 2020); California Board of Parole Hearings, *2020 Report of Significant Events* (April, 19 2021); Colo. Rev. Stat. § 17-22.8-403.5 (4) (e); Connecticut Board of Pardons and Paroles, Parole Historical Statistics; Georgia Board of Pardons and Paroles, Annual report FY 2019, 25; Georgia Board of Pardons and Paroles, Annual report FY 2020, 25; Idaho Code § 20-223 (9); Maryland Parole Commission, Fiscal year 2018 Annual Report (Nov. 5, 2018); Mass. Gen. Laws ch. 127, § 119A (i); N.M. Stat. § 31-21-25.1 (A) (3); N. Y. Exec. Law §§ 259-r (9) and 259-s (9); N.C. Gen. Stat. § 143B-707.2 (b); R.I. Gen. Laws § 13-8.1-4 (l); DOC Policy 20.08-3, § III (D); South Carolina Department of Probation, Parole and Pardon Services, Report to the Sentencing Reform Oversight Committee (2020), 19; Wash. Rev. Code § 72.09.620.

<sup>179</sup> Colo. Rev. Stat. § 17-22.8-403.5 (4) (e), and Parole Board Manual § 5.14.

<sup>180</sup> Alaska Admin. Code tit. 22, §§ 20.655 through 20.660, and Alaska Stat. § 44.19.645 (g) (5).

<sup>181</sup> Mass. Gen. Laws ch. 127, § 119A (i).

<sup>182</sup> See Figure 3.

<sup>183</sup> 2018-2019 data on medically-related deaths in DPS&C facilities.

<sup>184</sup> See *supra* section IV.A.3.

<sup>185</sup> DPS&C Board Policy, 01-103-A-DIR, “Committee on Parole Administration,” October 26, 2020, available at <https://s32082.pcdn.co/wp-content/uploads/2020/12/01-103-A-DIR-COMMITTEE-ON-PAROLE-ADMINISTRATION.pdf>.

<sup>186</sup> DPS&C HCP41 at § 7.1.3.b.

<sup>187</sup> DPS&C HCP41 at §§ 5.G, 5.E., DPS&C HCP 42 (2019) at § 5.F., and DPS&C HCP46 (2018) at § 5.D.

<sup>188</sup> See Figure 3.

<sup>189</sup> 2018-2019 data on medically-related deaths in DPS&C facilities.

<sup>190</sup> See *supra* section IV.A.3.

<sup>191</sup> DPS&C Board Policy, 01-103-A-DIR, “Committee on Parole Administration,” October 26, 2020, available at <https://s32082.pcdn.co/wp-content/uploads/2020/12/01-103-A-DIR-COMMITTEE-ON-PAROLE-ADMINISTRATION.pdf>.

<sup>192</sup> See Figure 6.

<sup>193</sup> See Figure 6.

<sup>194</sup> Attachment B.

<sup>195</sup> DPS&C HCP41 at § 7.1.3.b.

<sup>196</sup> [LA Rev Stat § 46:1844 \(2020\)](#) at § O., see also DPS&C Board Policy, 05-509-POL, “Victim Notification and Participation in Hearings,” August 20, 2019, available at <https://doc.louisiana.gov/wp-content/uploads/2019/10/05-509-POL-VICTIM-NOTICE-AND-PARTICIPATION.pdf>.

<sup>197</sup> See Figure 4.

<sup>198</sup> See Attachment G.

<sup>199</sup> See *supra* section IV.A.6.

# Attachment A: Mortality Analysis among Formerly Incarcerated Louisiana Medicaid Members

**Date of report:** 1/13/22

**Date of analysis:** 1/3/22

## Methodology

The number of deaths among justice-involved Louisiana Medicaid members was analyzed by querying the MARS data warehouse (MDW) for members who had Medicaid eligibility at the time of release from incarceration and who had a date of death.

The ELDOC table in MDW was queried for records with a release date between 1/1/17 and 12/31/2050 (12/31/2050 is a fake date used to signify that someone is presently incarcerated); 130,927 records were returned. Records where the lock-in code was a 5 (indicating incarcerated youth), X or Y (indicating invalid historical segments) were removed, thus leaving records of incarcerated and formerly incarcerated adults (lock-in code = 6); 114,287 records were returned. These records were then sorted by Medicaid eligibility ID and incarceration start date and the most recent incarceration segment was retained; 77,037 records returned. Records where the release date was between 1/1/17 and 6/30/21, inclusive, were retained; 49,584 released members returned. If the incarceration segment contained a location code for a DOC facility that participates in the Pre-Release Enrollment Program or contained a '9999,'

which indicates that the member has released from the Pre-Release Enrollment Program, the member was considered to have been part of the Pre-Release Enrollment Program. To further be eligible, members must have had eligibility at the time of release from incarceration (e.g., where their ELB\_time\_key = month of release); 38,664 records retained.

## Findings

Between 1/1/17 and 6/30/21, 49,584 justice-involved Medicaid members were released from incarceration, of which nearly 17% were part of the Pre-Release Enrollment Program (Table 1). However, only 38,664 (78.0%) were found to have eligibility at the time of their release (Table 2). Pre-release Enrollment Program members were more likely to have eligibility at time of release (99.4%) than non-Program members (73.7%). Released members were predominantly male (79.3%), Black/African American (49.5%) (Tables 3a, 3b). When race was restricted to black and white only, the majority of released females were white, but the majority of males were black (Table 3c), which is to be expected based on incarceration data from the Louisiana Department of Public Safety &

Corrections. This difference was found to be statistically significant. The majority of released members were never married or partnered (60.8%) (Table 3d). The majority of released members were enrolled into Medicaid Expansion (type case = 550) at time of release (data not shown).

Of released members, 2,653 (6.9%) were found to have a date of death in the MDW (Table 4). The rate of death per release year decreases with time from 10.8% among 2017's releases to 3.2% among 2021's releases. The difference of death rates per release year was found to be statistically significant, however, with time, this difference may be minimized. Mortality rate by participation in the Pre-release Enrollment Program was analyzed (Table 5). Of deceased members, 18% were Pre-release Enrollment Program participants, representing 5.8% of all released Program participants. The difference in mortality rate between members enrolled through Pre-release and members who did not participate in the Program was found to be statistically significant. Among deceased members, 86.2% were male, representing 7.5% of released males, and 13.8% were female, representing 4.6% of released females (Table 6). The difference in mortality rate across genders was found to be statistically significant. Among deceased members, 51.8% were Black/African American, representing 6.3% of released Black/African Americans, and 48.2% were white, representing 6.7% of released whites (Table 6). This difference was not statistically significant.

The average time from release to death was 413 days (13.8 months), but half of deceased members died within 270 days (9

months) after release (Figure 1, Table 8), including 14.1% whose death corresponds to their release date from prison/jail. The time between release and death by gender (Figure 2, Table 9) is strikingly different: on average, females died more than 100 days later than men (mean 509.5 days vs. 398.3), 50% of men died within 9 months of release, but 50% of females died after at least 1 year of release. These differences were statistically significant. The time between release and death was analyzed by race (restricted to "black" and "white");

differences between races was not statistically significant (Figure 3, Table 10).

The age at time of death is presented by year of release in Figure 4 and Table 11. The average age at time of death is 47.8 years old and the median is between 46 and 50 years old. However, the median age has decreased from 46-50 years old to 41-45 years old starting with 2019's releases. The age at time of death varies between females and males (Figure 5, Table 12); on average, females were almost 5 years younger at time of death than males. The median age of females at time of death was similarly less than males: 50% of female deaths occurred in the population 41-45 years old or younger, compared to 46-50 years old or younger in the male population. This difference was statistically significant. The age at time of death by race (restricted to "black" and "white") was analyzed (Figure 6, Table 13). On average, Black/African American members were over 3.5 years younger than White members at time of death (46.3 years old vs. 49.9 years old), but the median age at death was the same for both races (46-50 years old).

**Table 1: Justice-involved Medicaid Members by Year of Release**

Year of Release	Not Pre-Release Member		Pre-Release Member		TOTAL	
	#	%	#	%	#	%
2017	10,426	93.6%	708	6.4%	11,134	22.5%
2018	12,234	88.4%	1,605	11.6%	13,839	27.9%
2019	8,109	76.2%	2,527	23.8%	10,636	21.5%
2020	6,766	74.9%	2,270	25.1%	9,036	18.2%
2021 (Jan 1 - Jun 30)	3,720	75.3%	1,219	24.7%	4,939	10.0%
<b>TOTAL</b>	<b>41,255</b>	<b>83.2%</b>	<b>8,329</b>	<b>16.8%</b>	<b>49,584</b>	<b>100.0%</b>

**Table 2: Justice-involved Medicaid Members with Eligibility at Time of Release**

Year of Release	Not Pre-Release Member		Pre-Release Member		TOTAL	
	#	%	#	%	#	%
2017	5,725	88.5%	746	11.5%	6,471	16.7%
2018	7,106	81.8%	1,584	18.2%	8,690	22.5%
2019	7,500	74.8%	2,526	25.2%	10,026	25.9%
2020	6,436	74.1%	2,247	25.9%	8,683	22.5%
2021 (Jan 1 - Jun 30)	3,616	75.4%	1,178	24.6%	4,794	12.4%
<b>TOTAL</b>	<b>30,383</b>	<b>78.6%</b>	<b>8,281</b>	<b>21.4%</b>	<b>38,664</b>	<b>100.0%</b>
<b>% of Released</b>	<b>73.7%</b>		<b>99.4%</b>		<b>78.0%</b>	

**Table 3a: Justice-involved Medicaid Members with Eligibility at Time of Release by Gender**

Year of Release	Female		Male		TOTAL
	#	%	#	%	#
2017	1,612	24.9%	4,859	75.1%	6,471
2018	2,078	23.9%	6,612	76.1%	8,690
2019	2,016	20.1%	8,010	79.9%	10,026
2020	1,534	17.7%	7,149	82.3%	8,683
2021 (Jan 1 - Jun 30)	775	16.2%	4,019	83.8%	4,794
<b>TOTAL</b>	<b>8,015</b>	<b>20.7%</b>	<b>30,649</b>	<b>79.3%</b>	<b>38,664</b>

**Table 3b: Justice-involved Medicaid Members with Eligibility at Time of Release by Race**

Race	2017		2018		2019		2020		2021		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
American Indian/Alaskan Native	49	0.8%	49	0.6%	54	0.5%	65	0.7%	24	0.5%	241	0.6%
Asian	11	0.2%	24	0.3%	13	0.1%	11	0.1%	6	0.1%	65	0.2%
Black/African American	3,319	51.3%	4,366	50.2%	4,994	49.8%	4,111	47.3%	2,349	49.0%	19,139	49.5%
Hispanic or Latino, and 1 or more other races	12	0.2%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	13	0.0%
Hispanic or Latino, no other race info	4	0.1%	3	0.0%	0	0.0%	0	0.0%	0	0.0%	7	0.0%
More than 1 race indicated, not Hispanic or Latino	14	0.2%	3	0.0%	0	0.0%	0	0.0%	0	0.0%	17	0.0%
Native Hawaiian or Other Pacific Islander	4	0.1%	0	0.0%	2	0.0%	1	0.0%	0	0.0%	7	0.0%
Not declared	2	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.0%
White	2,746	42.4%	3,869	44.5%	4,382	43.7%	3,829	44.1%	2,017	42.1%	16,843	43.6%
Unknown	310	4.8%	375	4.3%	581	5.8%	666	7.7%	398	8.3%	2,330	6.0%
<b>TOTAL</b>	<b>6,471</b>	<b>100.0%</b>	<b>8,690</b>	<b>100.0%</b>	<b>10,026</b>	<b>100.0%</b>	<b>8,683</b>	<b>100.0%</b>	<b>4,794</b>	<b>100.0%</b>	<b>38,664</b>	<b>100.0%</b>



**Table 3c: Justice-involved Medicaid Members with Eligibility at Time of Release by Race<sup>1</sup> & Gender**

	Female		Male		TOTAL	
	#	%	#	%	#	%
<b>Black/African American</b>	2,477	32.2%	166,62	58.9%	19,139	53.2%
<b>White</b>	5,220	67.8%	11,623	41.1%	16,843	46.8%
<b>TOTAL</b>	<b>7,697</b>	<b>100.0%</b>	<b>28,285</b>	<b>100.0%</b>	<b>35,982</b>	<b>100.0%</b>

Chi square  $P < 0.0001$

**Table 3d: Justice-involved Medicaid Members with Eligibility at Time of Release by Marital Status**

	Divorced	Legally married	Never married or partnered	Other	Separated	Unknown	Widow/widower	TOTAL
<b>2017</b>	19	105	3,799	1	8	2,538	1	<b>6,471</b>
<b>2018</b>	28	206	5,164	0	15	3,275	2	<b>8,690</b>
<b>2019</b>	24	276	5,927	0	9	3,788	2	<b>10,026</b>
<b>2020</b>	1	251	5,561	0	0	2,870	0	<b>8,683</b>
<b>2021</b>	1	132	3,052	0	0	1,609	0	<b>4,794</b>
<b>TOTAL</b>	<b>73</b>	<b>970</b>	<b>23,503</b>	<b>1</b>	<b>32</b>	<b>14,080</b>	<b>5</b>	<b>38,664</b>
<b>%</b>	<b>0.2%</b>	<b>2.5%</b>	<b>60.8%</b>	<b>0.0%</b>	<b>0.1%</b>	<b>36.4%</b>	<b>0.0%</b>	<b>100.0%</b>

<sup>1</sup> Race restricted to only Black/African American and White as these 2 options comprise >99% of members with a known race in MDW.

**Table 4: Mortality Rate of Justice-involved Medicaid Members**

Release Year	Dead		Not Dead		Total
	#	% Released	#	% Released	
2017	697	10.8%	5,774	89.2%	6,471
2018	728	8.4%	7,962	91.6%	8,690
2019	651	6.5%	9,375	93.5%	10,026
2020	425	4.9%	8,258	95.1%	8,683
2021	152	3.2%	4,642	96.8%	4,794
<b>TOTAL</b>	<b>2,653</b>	<b>6.9%</b>	<b>36,011</b>	<b>93.1%</b>	<b>38,664</b>

Chi square  $P < 0.0001$

**Table 5: Mortality Rate of Justice-involved Medicaid Members by Participation in Pre-release Enrollment Program**

	Dead			Not Dead			TOTAL	
	#	%	% Released	#	%	% Released	#	%
Not Pre-Release Member	2170	82%	7.1%	28213	78.3%	93%	30,383	78.6%
Pre-Release Member	483	18%	5.8%	7798	21.7%	94%	8,281	21.4%
<b>TOTAL</b>	<b>2,653</b>	<b>100%</b>	<b>6.9%</b>	<b>36011</b>	<b>100.0%</b>	<b>93%</b>	<b>38,664</b>	<b>100.0%</b>

Chi square  $P < 0.0001$

**Table 6: Mortality Rate of Justice-involved Medicaid Members by Gender**

Gender	Dead			Not Dead		TOTAL	
	#	%	% Released	#	% Released	#	%
Male	2,287	86.2%	7.5%	28,362	92.5%	30,649	79.3%
Female	3,66	13.8%	4.6%	7,649	95.4%	8,015	20.7%
<b>TOTAL</b>	<b>2,653</b>	<b>100.0%</b>		<b>36,011</b>		<b>38,664</b>	<b>100.0%</b>

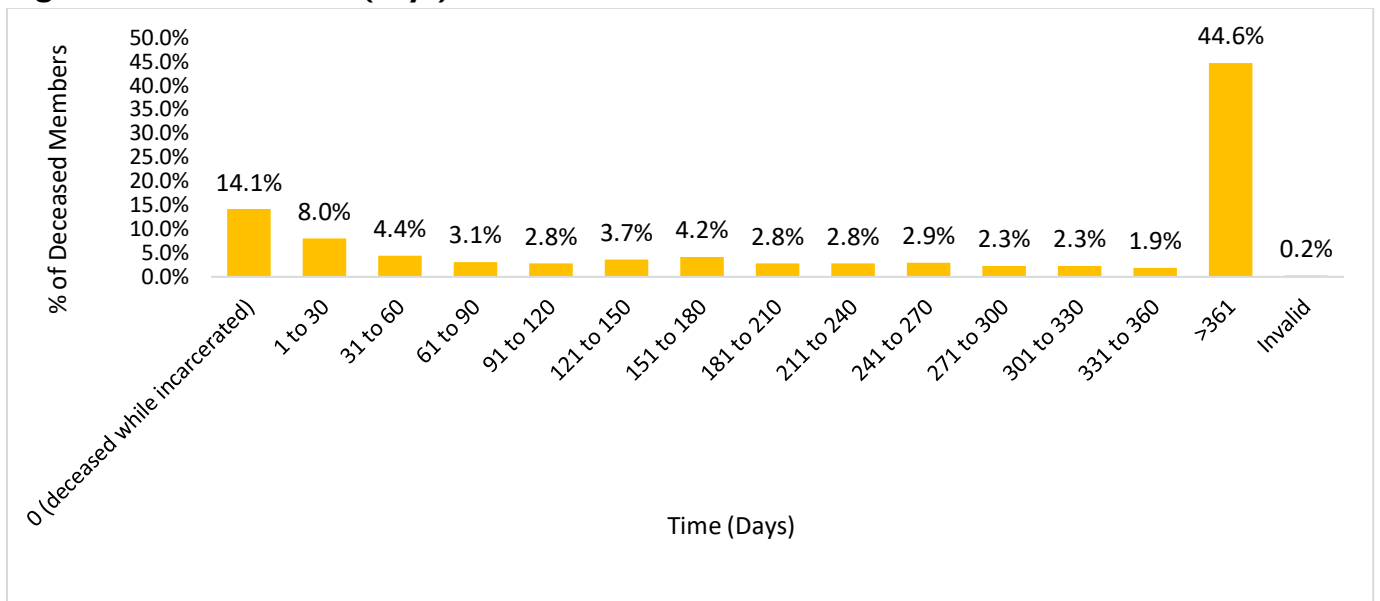
Chi square  $P < 0.0001$

**Table 7: Mortality Rate of Justice-involved Medicaid Members by Race<sup>2</sup>**

Race	Dead			Not Dead		TOTAL	
	#	%	% Released	#	% Released	#	%
Black/African American	1,210	51.8%	6.3%	17,929	93.7%	19,139	53.2%
White	1,127	48.2%	6.7%	15,716	93.3%	16,843	46.8%
<b>TOTAL</b>	<b>2,337</b>	<b>100.0%</b>		<b>33,645</b>		<b>0</b>	<b>100.0%</b>

Chi square  $P = 0.1564$

**Figure 1: Rate of Time (days) between Release date and Date of Death**



<sup>2</sup> Race restricted to only Black/African American and White as these 2 options comprise >99% of members with a known race in MDW.

**Table 8: Count and Rate of Time (days) between Release date and Date of Death**

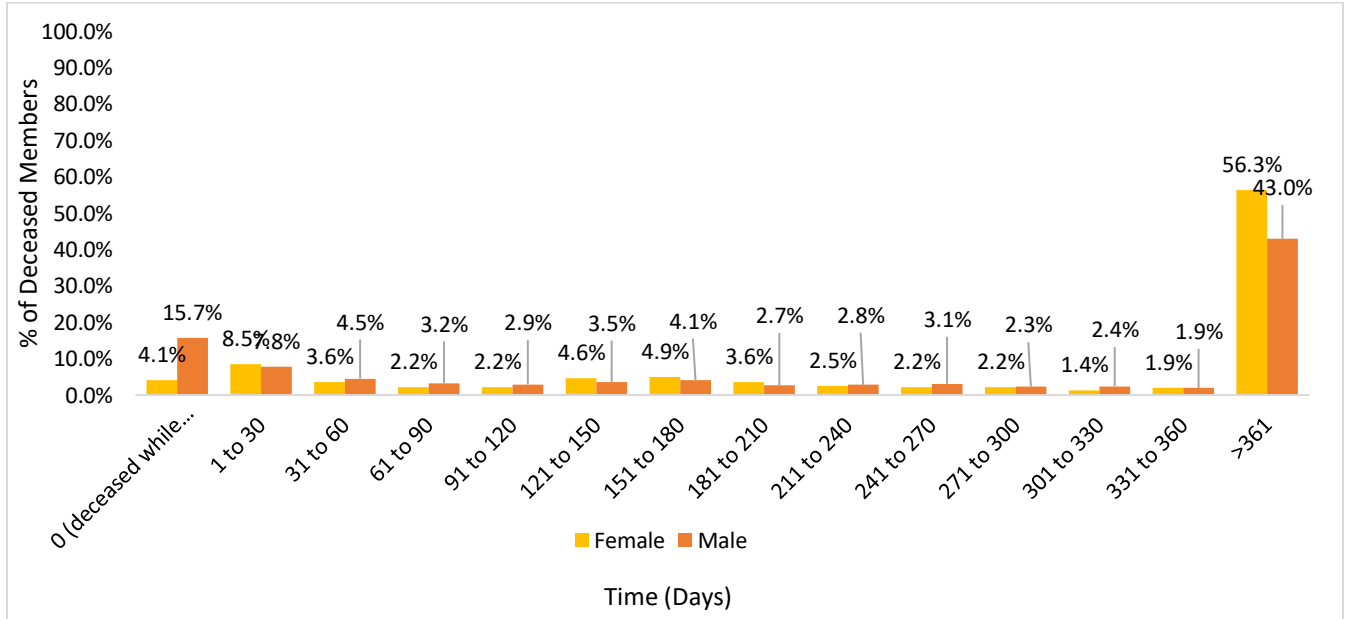
	Count	%	Cum %
0 (deceased while incarcerated)	374	14.1%	
1 to 30	211	8.0%	22.1%
31 to 60	116	4.4%	26.4%
61 to 90	82	3.1%	29.5%
91 to 120	74	2.8%	32.3%
121 to 150	97	3.7%	36.0%
151 to 180	111	4.2%	40.1%
181 to 210	75	2.8%	43.0%
211 to 240	73	2.8%	45.7%
241 to 270	78	2.9%	48.7%
271 to 300	61	2.3%	51.0%
301 to 330	60	2.3%	53.2%
331 to 360	51	1.9%	55.1%
>361	1184	44.6%	99.8%
Invalid (DOD before release date)	6	0.2%	100.0%
<b>TOTAL</b>	<b>2653</b>	<b>100.0%</b>	

Mean<sup>3</sup> = 413 days

Minimum = 0 days

Maximum = 1780 days (4.9 years)

**Figure 2: Time between Release and Death by Gender**



<sup>3</sup> Calculated with "Invalid" responses removed.

**Table 9: Count and Rate of Time between Release and Death by Gender**

	Female			Male		
	Count	%	Cum %	Count	%	Cum %
<b>0 (deceased while incarcerated)</b>	15	4.1		359	15.7	
<b>1 to 30</b>	31	8.5	12.6	178	7.8	23.5
<b>31 to 60</b>	13	3.6	16.1	103	4.5	28.1
<b>61 to 90</b>	8	2.2	18.3	74	3.2	31.3
<b>91 to 120</b>	8	2.2	20.5	66	2.9	34.2
<b>121 to 150</b>	17	4.6	25.1	80	3.5	37.7
<b>151 to 180</b>	18	4.9	30.1	93	4.1	41.8
<b>181 to 210</b>	13	3.6	33.6	62	2.7	44.5
<b>211 to 240</b>	9	2.5	36.1	64	2.8	47.3
<b>241 to 270</b>	8	2.2	38.3	70	3.1	50.4
<b>271 to 300</b>	8	2.2	40.4	53	2.3	52.7
<b>301 to 330</b>	5	1.4	41.8	55	2.4	55.1
<b>331 to 360</b>	7	1.9	43.7	44	1.9	57.0
<b>&gt;361</b>	206	56.3	100.0	980	43.0	100.0

Chi square P = <0.0001

Female mean = 509.5 days

Female minimum = 0 days

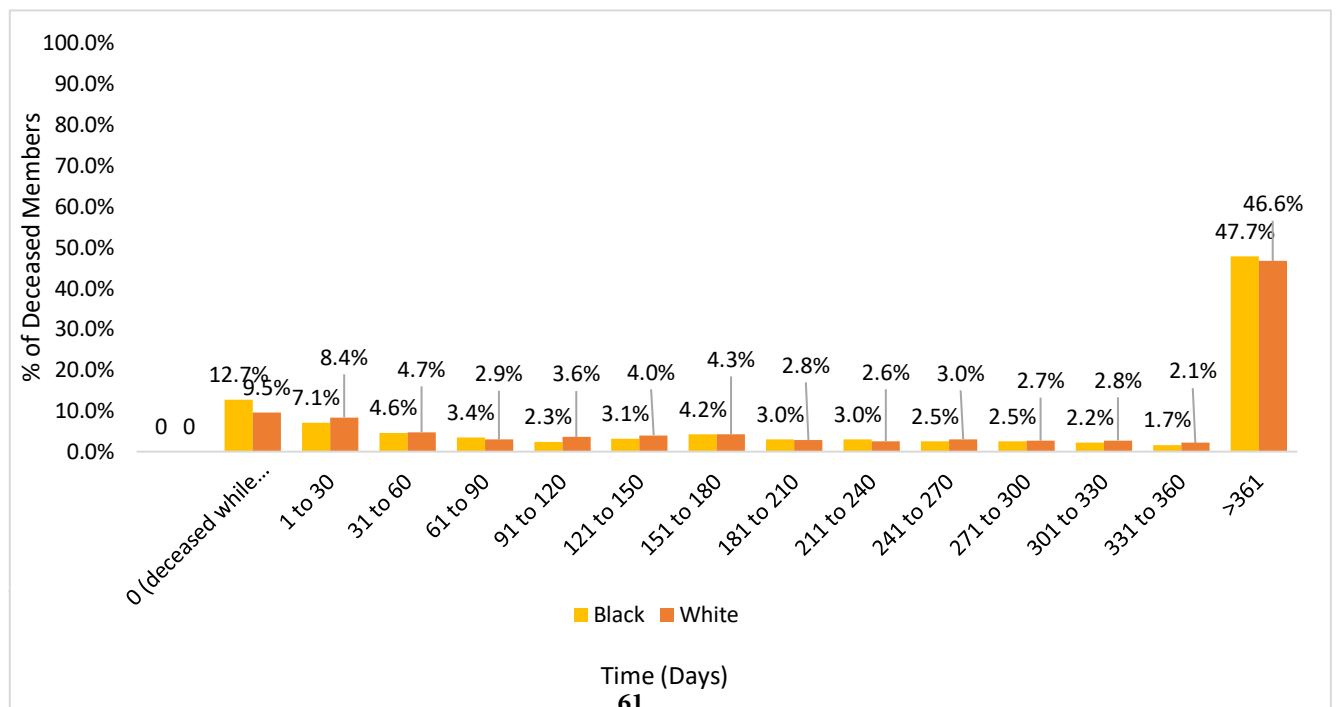
Female maximum = 1683 days

Male mean = 398.3 days

Male minimum = 0 days

Male maximum = 1780 days

**Figure 3: Time between Release and Death by Race**



**Table 10: Count and Rate of Time between Release and Death by Race<sup>4</sup>**

Days	Black/African American			White		
	Count	%	Cum %	Count	%	Cum %
<b>0 (deceased while incarcerated)</b>	154	12.7		107	9.4	
<b>1 to 30</b>	86	7.1	19.9	94	8.4	17.9
<b>31 to 60</b>	56	4.6	24.5	53	4.7	22.6
<b>61 to 90</b>	41	3.4	27.9	33	2.9	25.5
<b>91 to 120</b>	28	2.3	30.2	40	3.6	29.1
<b>121 to 150</b>	38	3.1	33.4	45	4.0	33.1
<b>151 to 180</b>	51	4.2	37.6	48	4.3	37.4
<b>181 to 210</b>	36	3.0	40.6	32	2.8	40.2
<b>211 to 240</b>	36	3.0	43.5	29	2.6	42.8
<b>241 to 270</b>	30	2.5	46.0	34	3.0	45.8
<b>271 to 300</b>	30	2.5	48.5	30	2.7	48.5
<b>301 to 330</b>	26	2.2	50.7	31	2.8	51.2
<b>331 to 360</b>	20	1.7	52.3	24	2.1	53.4
<b>&gt;361</b>	576	47.7	100.0	524	46.6	100.0

Chi square  $P = 0.1344$

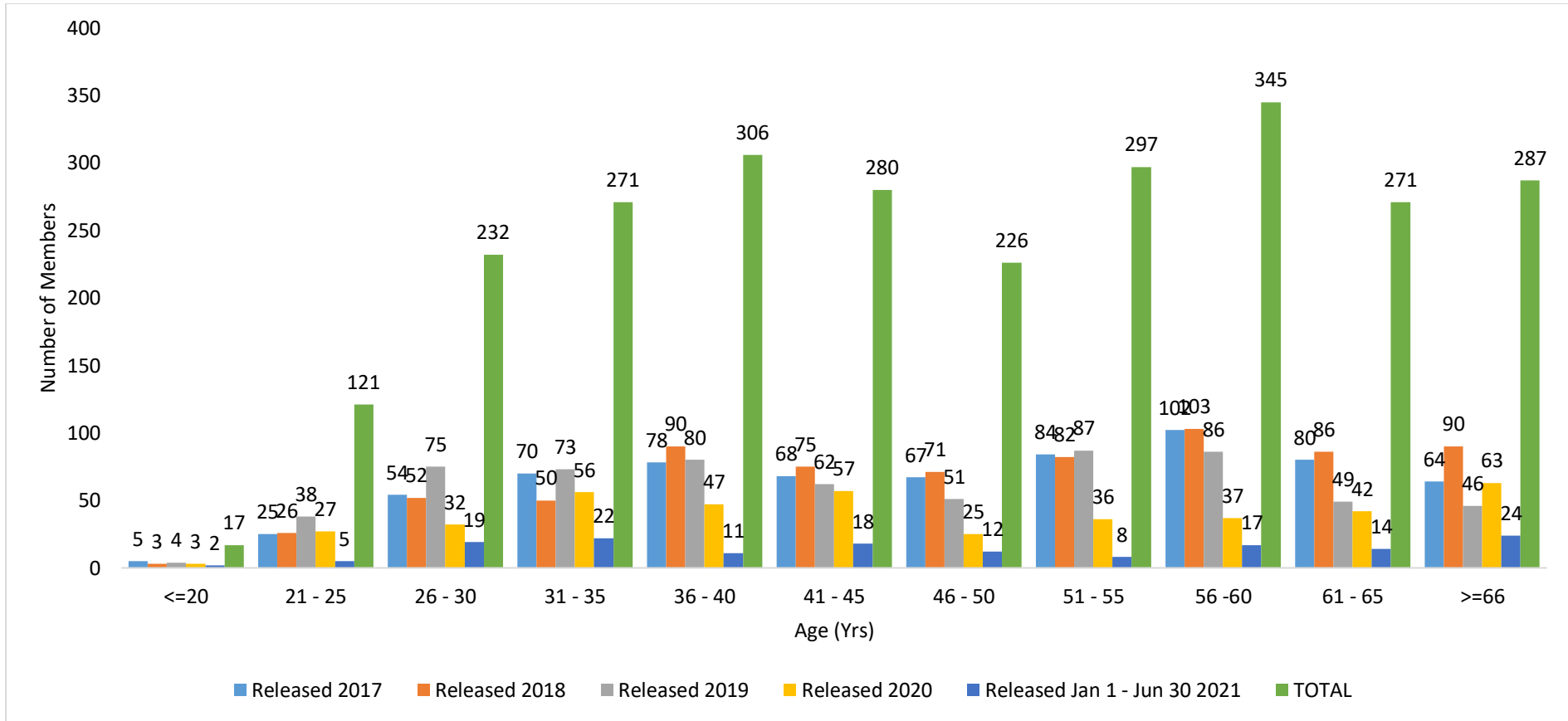
Black/African American mean = 433.1 days  
 Black/African American minimum = 0 days  
 Black/African American maximum = 1718

White mean = 436.1 days  
 White minimum = 0 days  
 White maximum = 1652 days

<sup>4</sup> Race restricted to only Black/African American and White as these 2 options comprise >99% of members with a known race in MDW.



**Figure 4: Age (years) at Time of Death, by year of release from incarceration**

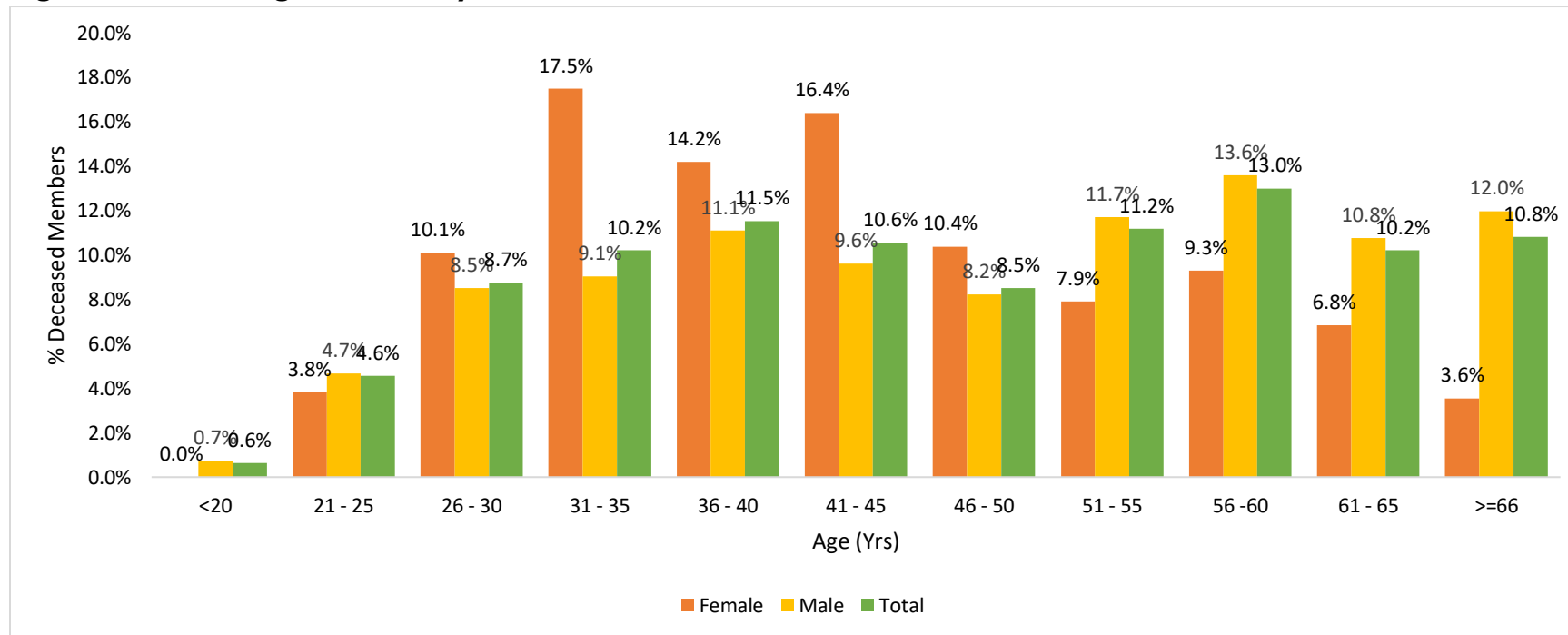


**Table II: Age (years) at time of death, by year of release from custody**

Age (Yrs)	2017			2018			2019			2020			Jan – Jun 2021			TOTAL		
	#	%	Cum %	#	%	Cum %	#	%	Cum %	#	%	Cum %	#	%	Cum %	#	%	Cum %
<=20	5	0.7%		3	0.4%		4	0.6%		3	0.7%		2	1.3%		17	0.6%	
21 - 25	25	3.6%	4.3%	26	3.6%	4.0%	38	5.8%	6.5%	27	6.4%	7.1%	5	3.3%	4.6%	121	4.6%	5.2%
26 - 30	54	7.7%	12.1%	52	7.1%	11.1%	75	11.5%	18.0%	32	7.5%	14.6%	19	12.5%	17.1%	232	8.7%	13.9%
31 - 35	70	10.0%	22.1%	50	6.9%	18.0%	73	11.2%	29.2%	56	13.2%	27.8%	22	14.5%	31.6%	271	10.2%	24.2%
36 - 40	78	11.2%	33.3%	90	12.4%	30.4%	80	12.3%	41.5%	47	11.1%	38.8%	11	7.2%	38.8%	306	11.5%	35.7%
41 - 45	68	9.8%	43.0%	75	10.3%	40.7%	62	9.5%	51.0%	57	13.4%	52.2%	18	11.8%	50.7%	280	10.6%	46.2%
46 - 50	67	9.6%	52.7%	71	9.8%	50.4%	51	7.8%	58.8%	25	5.9%	58.1%	12	7.9%	58.6%	226	8.5%	54.8%
51 - 55	84	12.1%	64.7%	82	11.3%	61.7%	87	13.4%	72.2%	36	8.5%	66.6%	8	5.3%	63.8%	297	11.2%	66.0%
56 -60	102	14.6%	79.3%	103	14.1%	75.8%	86	13.2%	85.4%	37	8.7%	75.3%	17	11.2%	75.0%	345	13.0%	79.0%
61 - 65	80	11.5%	90.8%	86	11.8%	87.6%	49	7.5%	92.9%	42	9.9%	85.2%	14	9.2%	84.2%	271	10.2%	89.2%
>=66	64	9.2%	100.0%	90	12.4%	100.0%	46	7.1%	100.0%	63	14.8%	100.0%	24	15.8%	100.0%	287	10.8%	100.0%
<b>TOTAL</b>	<b>697</b>	<b>100%</b>		<b>728</b>	<b>100.0%</b>		<b>651</b>	<b>100.0%</b>		<b>425</b>	<b>100.0%</b>		<b>152</b>	<b>100.0%</b>		<b>2653</b>	<b>100.0%</b>	

Mean = 47.8 y.o.  
 Minimum = 18 y.o.  
 Maximum = 92 y.o.

**Figure 5: Rate of Age at Death by Gender**



**Table 12: Count and Rate of Deceased Members per Age Group by Gender**

	Female			Male			TOTAL	
	#	%	Cum %	#	%	Cum %	#	%
≤ 20	0	0.0%		17	0.7%		17	0.6%
21 - 25	14	3.8%	3.8%	107	4.7%	5.4%	121	4.6%
26 - 30	37	10.1%	13.9%	195	8.5%	13.9%	232	8.7%
31 - 35	64	17.5%	31.4%	207	9.1%	23.0%	271	10.2%
36 - 40	52	14.2%	45.6%	254	11.1%	34.1%	306	11.5%
41 - 45	60	16.4%	62.0%	220	9.6%	43.7%	280	10.6%
46 - 50	38	10.4%	72.4%	188	8.2%	51.9%	226	8.5%
51 - 55	29	7.9%	80.3%	268	11.7%	63.7%	297	11.2%
56 -60	34	9.3%	89.6%	311	13.6%	77.3%	345	13.0%
61 - 65	25	6.8%	96.4%	246	10.8%	88.0%	271	10.2%
≥ 66	13	3.6%	100.0%	274	12.0%	100.0%	287	10.8%
<b>TOTAL</b>	<b>366</b>	<b>100.0%</b>		<b>2287</b>	<b>100.0%</b>		<b>2653</b>	

Chi square P = 0.0015

*Female mean = 43.6 y.o.*

*Male mean = 48.5 y.o.*

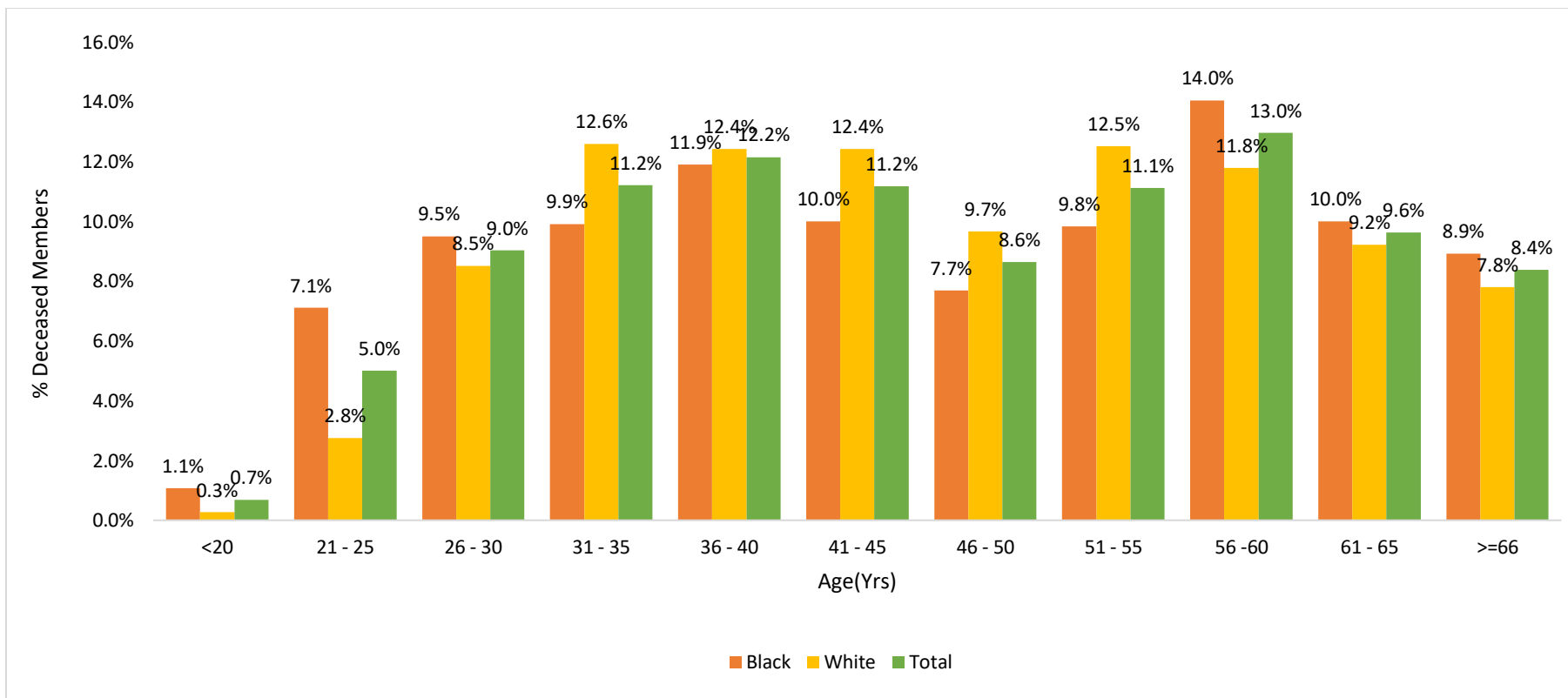
*Female minimum = 21 y.o.*

*Male minimum = 18 y.o.*

*Female maximum = 83 y.o.*

*Male maximum = 92 y.o.*

**Figure 6: Rate of Age at Death by Race<sup>5</sup>**



<sup>5</sup> Race restricted to only Black/African American and White as these 2 options comprise >99% of members with a known race in MDW.

**Table 13: Count and Rate of Deceased Members per Age Group by Race<sup>3</sup>**

	Black/African American			White			TOTAL	
	#	%	Cum %	#	%	Cum %	#	%
≤ 20	13	1.1		3	0.3		16	0.7
21 - 25	86	7.1	8.2	31	2.8	3.0	117	5.0
26 - 30	115	9.5	17.7	96	8.5	11.5	211	9.0
31 - 35	120	9.9	27.6	142	12.6	24.1	262	11.2
36 - 40	144	11.9	39.5	140	12.4	36.6	284	12.2
41 - 45	121	10.0	49.5	140	12.4	49.0	261	11.2
46 - 50	93	7.7	57.2	109	9.7	58.7	202	8.6
51 - 55	119	9.8	67.0	141	12.5	71.2	260	11.1
56 - 60	170	14.0	81.1	133	11.8	83.0	303	13.0
61 - 65	121	10.0	91.1	104	9.2	92.2	225	9.6
≥ 66	108	8.9	100.0	88	7.8	100.0	196	8.4
<b>TOTAL</b>	<b>1210</b>	<b>100.0</b>		<b>1127</b>	<b>100.0</b>		<b>2337</b>	<b>100.0</b>

Chi square P = 0.0030

*Black/African American mean = 46.3 y.o. White mean = 49.9 y.o.*

*Black/African American minimum = 18 y.o. White minimum = 19 y.o.*

*Black/African American maximum = 91 y.o. White maximum = 87 y.o.*



# Attachment B

STATE OF LOUISIANA  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS  
CORRECTIONS SERVICES

Health Care Policy  
No. HCP41



12 June 2018

**INSTITUTIONAL SERVICES / HEALTH CARE POLICIES**  
**Health Care Policy – Medical Release Procedures**  
**Compassionate Release**

1. **OBJECTIVE:** To identify DPS&C offenders who represent a low public safety risk due to their significant health conditions and consider these offenders for compassionate release.
2. **REFERENCES:** ACA Standards 4-4347 and 4-4357 (Adult Correctional Institutions); La. R.S. 15:574.4.2 and 15:833.2; Department Regulation Nos. [IS-E-1](#) "Sex Offender Notification, Registration Requirements and Residence Plan," [HCP15](#) "Continuity of Care," [HCP21](#) "Communicable and Infectious Diseases Infection Control Program," [HCP24](#) "Human Immunodeficiency Virus (HIV)," [HCP7](#) "Pharmaceuticals," [IS-F-1](#) "Release Procedures," [PS-C-1](#) "Louisiana Prisoner Reentry," [OP-C-12](#) "DNA Protocols," [PS-H-1](#) "Crime Victims Services Bureau," [JO-1](#) "Basic Jail Guidelines," and P&P-1 "Probation and Parole Officer's Manual."
3. **POLICY:** It is the Secretary's policy that the Department shall have procedures to efficiently identify limited mobility offenders or terminally ill offenders who, due to a medical condition, represent a low public safety risk and consider these offenders for compassionate release. Compassionate release shall be approved by the Secretary, pursuant to the provisions of this policy.
4. **APPLICABILITY:** Deputy Secretary, Chief of Operations, Department's Medical/Mental Health Director, Department's Chief Nursing Officer, Director of Probation and Parole, Regional Wardens, Wardens and Sheriffs or Administrators of local jail facilities where state offenders are housed. Each Unit Head shall be responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this policy.
5. **DEFINITIONS:**
  - A. **Compassionate Release:** A temporary leave of absence from secure custody for limited (medical) purposes for offenders who, because of a medical condition, are determined by the Department to be a limited mobility offender or terminally ill offender.

- B. **Health Care Facility:** For the purpose of this regulation, an acute care hospital, nursing home or other licensed medical facility which complies with all state and federal laws and regulations that is appropriate to meet the offender.
- C. **Health Care Personnel:** Individuals whose primary duty is to provide health services to offenders in keeping with their respective levels of health care training or experience.
- D. **Health Care Practitioner:** Clinicians trained to diagnose and treat patients, such as physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners, and physician assistants.
- E. **Limited Mobility Offender:** For the purpose of this regulation, any offender who, due to an underlying medical condition, is unable to perform activities of daily living without significant assistance or is confined to a bed or chair, including but not limited to prolonged coma and mechanical ventilation. Limited mobility offenders shall only be discharged to a health care facility.

NOTE: This definition of limited mobility offender is specific to compassionate release. (See Department Regulation No. [HCP46](#) "Medical Treatment Furlough" for the definition of limited mobility offender specific to medical treatment furlough.)

- F. **Multidisciplinary Team:** For the purpose of this regulation, a team that includes at a minimum, representatives from the following areas: Warden or designee, Medical Department, Mental Health Department, Classifications, and Security.
- G. **Terminally Ill Offender:** For the purpose of this regulation, any offender who is diagnosed with a terminal illness and death is expected within sixty days. Terminally ill offenders shall only be discharged to a health care facility or a home-setting which is able to meet the needs of the offender.

NOTE: This definition of terminally ill offender is specific to compassionate release. (See Department Regulation No. [HCP42](#) "Medical Parole" for the definition of terminally ill offender specific to medical parole.)

**6. COMPASSIONATE RELEASE ELIGIBILITY:**

- A. Non-Medical Criterion

Any offender sentenced to the custody of DPS&C may be considered for compassionate release by the Secretary, except an offender sentenced to death.

**B. Medical Criteria**

- 1) Any limited mobility offender or terminally ill offender may be considered for compassionate release.
  - a. Limited mobility offenders shall require rehabilitative and/or ongoing skilled nursing care to complete activities of daily living, such as bathing, dressing, transferring, toileting, and eating.
    - i. Limited mobility offenders shall be discharged to a health care facility and shall meet the individual admission requirements for the health care facility.
  - b. Terminally ill offenders shall require end of life care.
    - i. If being discharged to a health care facility, the terminally ill offender shall meet the individual admission requirements for the health care facility. .
    - ii. If being discharged to a home-setting, the terminally ill offender shall meet the admission requirements to be admitted to Hospice or a home health program.
  - c. Generally, compassionate release consideration shall not be given to an offender when the offender's medical condition was present at the time of sentencing, unless the offender's overall condition has significantly deteriorated since that time.

NOTE: Medical criteria is only one of the many factors in determining the suitability of an offender for a compassionate release. A multidisciplinary team conducts a thorough assessment, including a public safety risk assessment.

**7. COMPASSIONATE RELEASE PROCEDURES:**

- A. The Warden at each institution shall appoint a multidisciplinary team to evaluate every compassionate release request. The staff appointed to this team shall be permanently assigned unless the team member's position changes.

- B. Any treating health care practitioner with knowledge of an offender's terminal illness or limited mobility may initiate the process by completing a Medical Criteria Screening Form (Form [HCP41-a](#)) and submitting it to the Unit Medical Director for consideration.
- C. In addition, any staff, including, but not limited to, health care personnel, Wardens, and Headquarters' Medical staff with knowledge of an offender's terminal illness or limited mobility may request the Unit Medical Director to review the offender for compassionate release consideration.
- D. The Unit Medical Director or designee shall:
  - 1) Evaluate every Medical Criteria Screening Form (Form [HCP41-a](#)) received and, based solely on the offender's medical information, advise that the offender:
    - a. Meets the medical criteria for compassionate release consideration; or
    - b. Does not meet the medical criteria for compassionate release consideration.

NOTE: The Unit Medical Director's evaluation shall be objective and fact-based regarding the only the offender's medical condition meeting or not meeting the medical criteria.

- 2) If the Unit Medical Director advises that the offender meets the medical criteria and recommends the offender for compassionate release:
  - a. Complete the Unit Medical Director's portion of the Recommendation for Compassionate Release (Form [HCP41-b](#)) by evaluating and providing information on the offender's medical condition and submit to the Unit Warden for review.
- 3) If the Unit Medical Director declines to recommend the offender for compassionate release consideration:
  - a. Send notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking; and

- b. File the Medical Criteria Screening Form (Form [HCP41-a](#)) in the offender's medical record.

E. The Unit Warden or designee shall:

- 1) Ensure that multidisciplinary team members provide pertinent information relative to their discipline to aid in determining an offender's suitability for compassionate release and document this information on such form;
- 2) Evaluate every Recommendation for Compassionate Release (Form [HCP41-b](#)) received; and
- 3) Complete the Unit Warden's portion of the Recommendation for Compassionate Release (Form [HCP41-b](#)) by evaluating and providing information on the offender's offense(s)/conviction(s) and available information regarding his time incarcerated and:
  - a. Recommending the offender for compassionate release consideration and submitting the Recommendation for Compassionate Release (Form [HCP41-b](#)) to the Department's Chief Nursing Officer for processing; or
  - b. Declining recommending the offender for compassionate release consideration, sending notice of declination to the Department's Chief Nursing Officer for data collection and tracking, and filing the Recommendation for Compassionate Release (Form [HCP41-b](#)) in the offender's medical record.

F. The Department's Medical/Mental Health Director shall:

- 1) Evaluate every Recommendation for Compassionate Release (Form [HCP41-b](#)) received for compliance with applicable law and policy, and
- 2) Complete the Department's Medical/Mental Health Director's portion of the recommendation by:
  - a. Recommending the offender for compassionate release consideration and submitting it to the Department's Secretary for review, or
  - b. Declining to recommend the offender for compassionate release consideration and sending notification of declination

to the Warden and the Department's Chief Nursing Officer for data collection and tracking.

G. The Department's Secretary shall:

- 1) Evaluate every Recommendation for Compassionate Release (Form [HCP41-b](#)) received, and
- 2) Complete the Department's Secretary's portion of recommendation by:
  - a. Granting the offender compassionate release;
  - b. Seeking additional information prior to rendering a decision regarding compassionate release; or
  - c. Declining to grant the offender compassionate release and sending notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking.

H. Declination of Compassionate Release Request

In the event that a compassionate release request is declined at any point, reconsideration may be granted upon re-initiation of the process at the unit level.

I. Compassionate Release Discharge Planning

- 1) Residence Plan Based on Medical Condition
  - a. Terminally ill offenders shall be discharged to either a health care facility or a home-setting which is able to meet the needs of the offender.
  - b. Limited mobility offenders shall only be discharged to a health care facility.
- 2) The Unit Health Authority or designee shall:
  - a. Ensure that each offender's discharge planning begins prior to the offender's approval of compassionate release and is completed immediately upon approval of compassionate release, in accordance with the provisions of this regulation, Department Regulation Nos. [HCP15](#) "Continuity of Care," [IS-](#)



- [F-1](#) "Release Procedures," [PS-C-1](#) "Louisiana Prisoner Reentry," and each unit's discharge policy;
- b. Ensure that the offender is enrolled in Medicaid or a health insurance plan prior to discharge;
  - c. Ensure that the appropriate residence plan based on the offender's medical condition is secured, in accordance with Section 7.I.1) of this regulation, and that a Residence Agreement (Form [HCP41-d](#)) is completed for terminally ill offenders being discharged to a home-setting;
  - d. Ensure that copies of the offender's pertinent medical records accompany the offender upon discharge and that a verbal report has been given to the receiving health care facility or home-setting;
  - e. Ensure that the offender is offered "opt-out" HIV testing, unless the offender is known to be HIV positive or had a documented HIV test within the previous 12 months prior to discharge, pursuant to La. R.S. 15:574.4.2 and Health Care Policy No. [HCP24](#) "Human Immunodeficiency Virus (HIV);" and
  - f. Ensure that an adequate supply of medication is accompanying the offender upon discharge if the offender is being discharged to a home-setting, pursuant to Health Care Policy No. [HCP7](#) "Pharmaceuticals."
- 3) The Unit Warden or designee shall:
- a. Ensure that prior to an offender's discharge on compassionate release, the offender's DNA sample has been obtained and transmitted to the state DNA database maintained and administered by the Office of State Police, pursuant to Department Regulation No. [OP-C-12](#) "DNA Protocols;"
  - b. Determine whether there is a Victim Notice and Registration (Form [PS-H-1-a](#)) on file and, if applicable, notify the victim(s) or family member(s) by certified mail (with return receipt requested), pursuant to Department Regulation No. [PS-H-1](#) "Crime Victims Services Bureau;" and

c. If a sex offender is granted compassionate release, make all required notifications, pursuant to Department Regulation No. [IS-E-1](#) "Sex Offender Notification, Registration Requirements and Residence Plan."

4) The Department's Chief Nursing Officer shall be responsible for notifying the Division of Probation and Parole of the offender's compassionate release case.

J. Term of Compassionate Release

1) The term of an offender granted compassionate release shall be for the remainder of the offender's sentence, unless otherwise revoked, in accordance with Section 7.K. of this regulation.

2) Offenders granted compassionate release shall earn diminution of sentence while on compassionate release if otherwise eligible to earn diminution of sentence. If an offender on compassionate release earns diminution of sentence so that the offender is eligible for good time parole supervision, the compassionate release shall be converted to good time parole supervision on the date the offender successfully becomes eligible for good time parole supervision.

K. Compassionate Release Supervision and Revocation

1) Supervision of an offender granted compassionate release shall consist of visits by the Division of Probation and Parole, in accordance with Probation and Parole Officer's Manual. (See Department Regulation No. P&P-1 "Probation and Parole Officer's Manual" for more information.)

2) If it is discovered through the supervision of the offender granted compassionate release that his condition has improved such that he would not then be eligible for compassionate release under the provisions of this policy, the Division of Probation and Parole shall report these findings to the Department's Medical/Mental Health Director within five business days.

3) Any offender whose compassionate release is revoked due to an improvement in his condition, and who would otherwise be eligible for parole, may then be considered for traditional parole.

- 4) Any offender whose compassionate release is revoked shall resume serving the balance of his sentence, with credit given for the duration of the compassionate release.
- 5) Any offender granted compassionate release who is discharged from a healthcare facility or who absconds shall have his compassionate release immediately revoked.

**8. MONITORING REQUIREMENTS/REPORTS:**

A. The Unit Health Authority or designee shall identify all offenders who meet the medical criteria for a compassionate release consideration and submit a quarterly report to the Chief Nursing Officer which includes, but is not limited to, the following information on each identified offender:

- 1) Name;
- 2) DOC number;
- 3) Age;
- 4) Medical/mental health diagnosis;
- 5) Current medical treatment;
- 6) Assistance required;
- 7) Housing location;
- 8) Time served;
- 9) GTPS date;
- 10) Full term date; and
- 11) If the offender is currently serving time for a sex offense.

B. The Department's Chief Nursing Officer shall submit a quarterly report to the Secretary which includes, but is not limited to:

- 1) The number of offenders who meet the medical criteria for compassionate release consideration;
- 2) The number of offenders who were granted a compassionate release; and
- 3) The number of offenders who were declined to be recommended for compassionate release consideration at any point during the process outlined in this regulation.

C. The Division of Probation and Parole shall:

- 1) Monitor offenders that have been granted a compassionate release in accordance with Probation and Parole Officer's Manual until the offender's death or the expiration of sentence, and

- 2) Submit a monthly report of all compassionate releases to the Secretary and the Department's Chief Nursing Officer. The report shall include, but is not limited to, the following information on each offender granted a compassionate release:
  - a. Name;
  - b. DOC number;
  - c. Location;
  - d. Date the compassionate release was granted;
  - e. Date the offender left the unit on a compassionate release;
  - f. Latest narrative report from the Probation and Parole officer;
  - g. Date and time of death, if indicated; and
  - h. Any other information deemed appropriate.

**9. DPS&C OFFENDERS HOUSED IN NON-DPS&C FACILITIES:**

- A. A DPS&C offender housed in a non-DPS&C facility shall be considered for a compassionate release in the same manner as a DPS&C offender housed in a DPS&C facility.
- B. Compassionate release eligibility for a DPS&C offender housed in a non-DPS&C facility shall be in accordance with Section 6. of this regulation.
- C. Compassionate Release procedures for a DPS&C offender housed in a non-DPS&C facility shall be as follows:
  - 1) A physician, if available, shall complete the Unit Medical Director's portion of the Recommendation for Compassionate Release (Form HCP41-b) by evaluating and providing information on the offender's medical condition and submitting it to the Warden for review.
  - 2) If a physician is unavailable, the Department's Medical/ Mental Health Director shall coordinate with the non-DPS&C facility to complete the Unit Medical Director's portion of the Recommendation for Compassionate Release (Form [HCP41-b](#))
  - 3) The Warden shall complete the Unit Warden's portion of the Recommendation for Compassionate Release (Form [HCP41-b](#)) and submit to the Department's Chief Nursing Officer.

NOTE: The Unit Medical Director's portion of the Recommendation Compassionate Release (Form [HCP41-b](#)) may be omitted if a physician is unavailable to complete. In such cases, the Warden shall also submit any pertinent medical records.

- 4) The remaining compassionate release procedures shall be in accordance with Sections 7.F. through 7.K. of this regulation.

s/James M. Le Blanc

Secretary

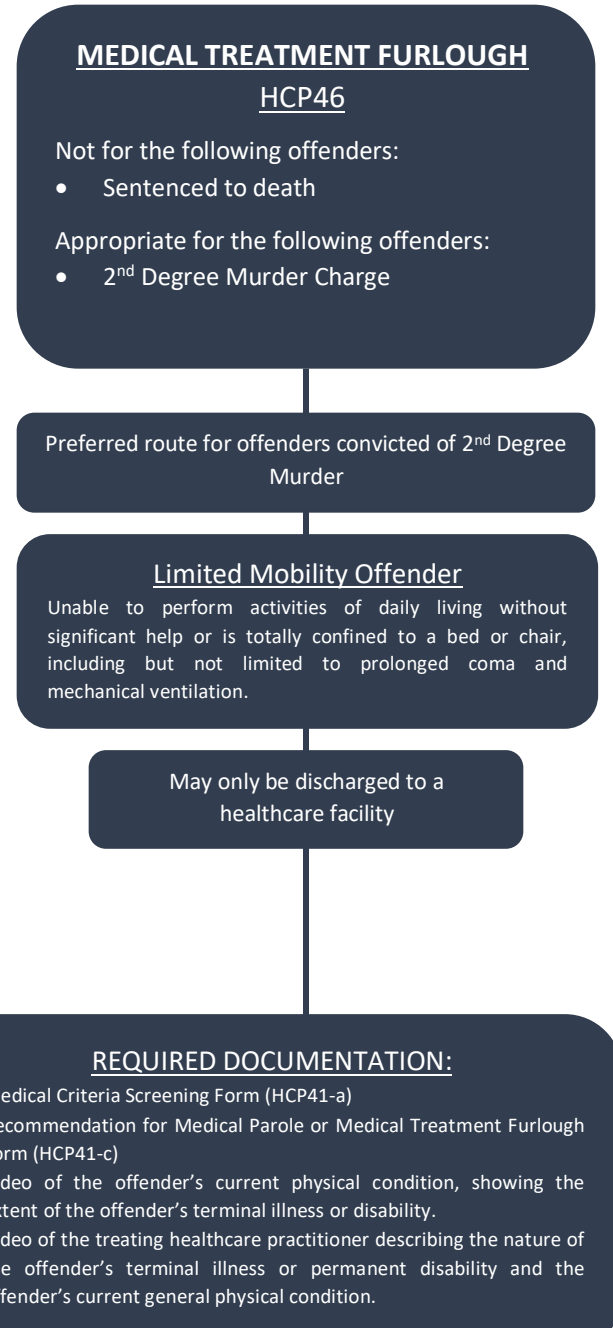
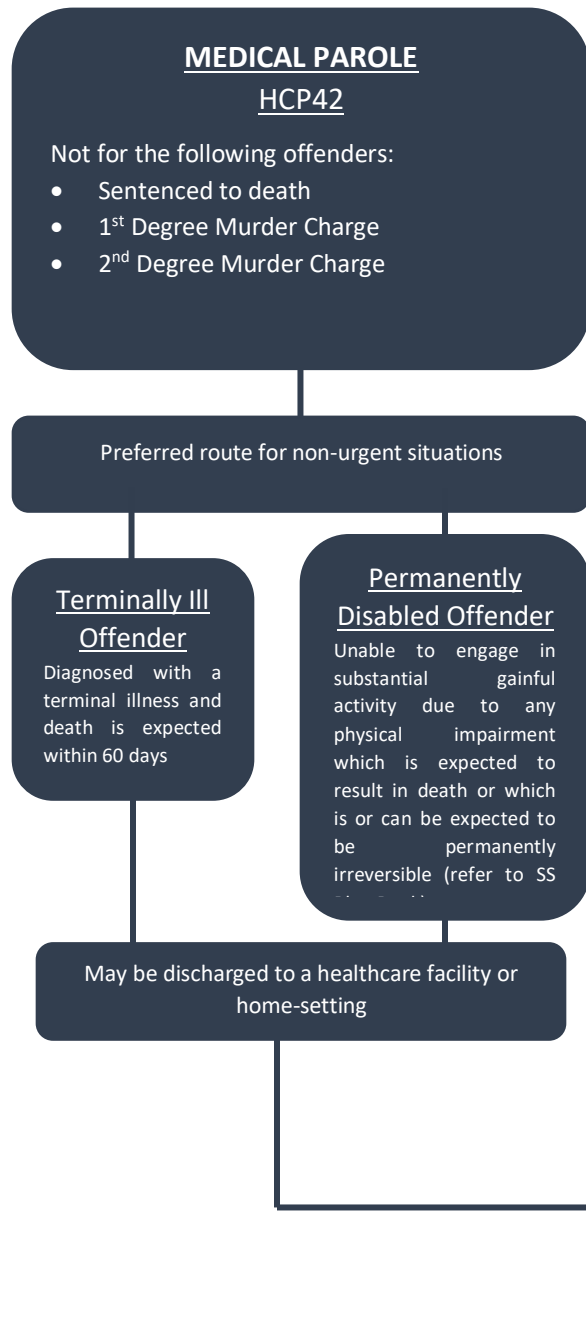
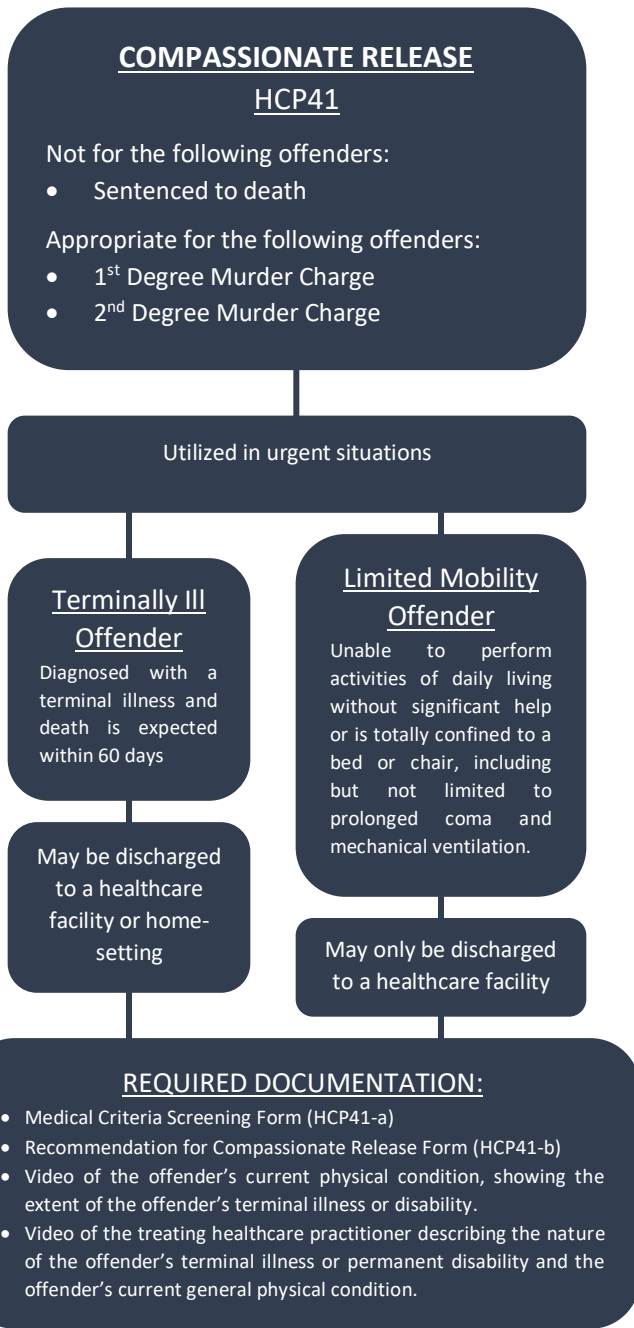
Attachment: [IS-D-2-HCP41 Flow Chart for Compassionate Release, Medical Parole, and Medical Treatment Furlough](#)

Forms: [HCP41-a Medical Criteria Screening Form](#)  
[HCP41-b Recommendation for Compassionate Release](#)  
[HCP41-d Residence Agreement](#)  
[PS-H-1-a Victim Notice and Registration](#)

This policy supersedes Health Care Policy No. HC-06 dated 16 June 2016.

**Reviewed as of: October 1, 2019**

## Medical Release Flowchart 12 June 2018



DATE:

Offender Name:

DOC #:

Age:

Sex:  Male  Female

Current Offense:

**Screening Factors**

Select one or more:

- |   |   |
|---|---|
| <input type="checkbox"/> Physically disabled according to SSA (See SS Blue Book)                              | <input type="checkbox"/> Longterm ventilation           |
| <input type="checkbox"/> Persistent vegetative state  | <input type="checkbox"/> Hospice/end of life care       |
| <input type="checkbox"/> Totally confined to a bed or chair   | <input type="checkbox"/> Dialysis                       |
| <input type="checkbox"/> Life expectancy <input type="checkbox"/> < 1 year <input type="checkbox"/> < 60 days | <input type="checkbox"/> HIV/AIDS patient with CD4 < 50 |
| <input type="checkbox"/> Cancer patient (radiation/ chemotherapy)   | <input type="checkbox"/> Feeding Tube                   |
| <input type="checkbox"/> End stage liver disease with MELD > 22   | <input type="checkbox"/> Complex Wound Care             |
| <input type="checkbox"/> Permanently assigned to infirmary/ skilled nursing unit                              |   |

**Activities of Daily Living**

Select one for each ADL:

- |           |                            |                            |                            |                            |
|-----------|----------------------------|----------------------------|----------------------------|----------------------------|
| Eating    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Dressing  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Mobility  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Bathing   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Toileting | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

- |  |
|--|
| 1. Requires complete assistance<br>2. Requires limited assistance.<br>3. Requires some assistance.<br>4. Requires no assistance. |
|--|

**Diagnoses**

Select one or more:

- |   |  |
|---|--|
| <input type="checkbox"/> Traumatic brain injury   | <input type="checkbox"/> Hemiplegia or Hemiparesis |
| <input type="checkbox"/> Paraplegia   | <input type="checkbox"/> Quadriplegia              |
| <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Alzheimer's disease       |
| <input type="checkbox"/> Respiratory failure  | <input type="checkbox"/> Non-Alzheimer's dementia  |
| <input type="checkbox"/> Coronary artery disease (e.g. angina, myocardial infarction and atherosclerotic heart disease) |  |
| <input type="checkbox"/> Heart failure (e.g. congestive heart failure, pulmonary edema)                                 |  |
| <input type="checkbox"/> Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or Stroke                      |  |
| <input type="checkbox"/> Other:   |  |

**Additional Comments**

\_\_\_\_\_  
Health Care Practitioner Name (Print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Health Care Practitioner Signature

\_\_\_\_\_  
Date

**Unit Medical Director Evaluation**

Based solely on the offender's medical information, the offender:

- Meets the medical criteria for consideration of compassionate release, medical parole, or medical treatment furlough.
- Does not meet the medical criteria for consideration of compassionate release, medical parole, or medical treatment furlough.

\_\_\_\_\_  
Unit Medical Director Name (Print)

\_\_\_\_\_  
Unit Medical Director Signature

\_\_\_\_\_  
81 Date

I. Unit Medical Director Evaluation

Offender Name:

DOC Number:

Age:

Facility Offender is Currently Located:

Medical Diagnosis:

Prognosis:

Medical Condition Present at the Time of Sentencing: Yes  No

Comments:

If Yes, Overall Condition Deteriorated Since Sentencing: Yes  No

Comments:

Nature of Terminal Illness or Limited Mobility (Provide a Medical Summary):

General Physical Condition:

Current Plan of Care (Including Any Treatments Required):

Extent of Help Needed with Activities of Daily Living: (e.g. bathing; continence management; feeding; dressing; getting out of bed; ambulating with wheelchair, walker, cane; etc.):

Proposed Housing Plans If Compassionate Release is Approved:

Health Care Facility (Acute Care Hospital, Nursing Home, or Other Licensed Medical Facility)

Home-Setting (*\*must be admitted to hospice or home-health*)

Address:

**Recommendation:** In my medical opinion, this offender's condition meets the medical criterion for *Compassionate Release* as defined in the Department Regulation No. IS-D-2-HCP41 "Compassionate Release" because:

Offender is unable to perform activities of daily living without significant assistance or is totally confined to a bed or chair.

Offender is diagnosed with a terminal illness and death is expected within 60 days.

\_\_\_\_\_  
Unit Medical Director

\_\_\_\_\_  
Date



**II. Warden Evaluation**

**Date of Offense(s):**

**Current Offense:**

**Parish of Conviction:**

**Offender Class:**

**Sentence Length:**

**Time Served for Current Offense:**

**Full Term Date:**

**GTPS Date:**

**DOC Intake Date:**

**Gang Affiliation:**

**Previous Felony Conviction(s):**

**Convicted of Violent Crime:** Yes  No

**If Yes, Description of Offender's Crime Details** (What Crime, When Crime Occurred, Where Crime Occurred, Under What Conditions Crime Occurred, Weapon(s) Used in Crime, etc.):

**Summary of Disciplinary Violations While Incarcerated** (Date/ Offense):

**Brief Description of Offender's Overall Behavior and Adjustment While Incarcerated:**

**Effect of Offender's Medical Condition upon Conduct with Staff and Other Offenders:**

**Sex Offender:** Yes  No

**Currently Serving Time for a Sex Offense:** Yes  No

**Victim Notice and Registration (Form PS-H-1-a) on File:** Yes  No

**DNA Sample in DNA Database:** Yes  No

**If No, Plans to Obtain DNA Sample:**

**II. Warden Evaluation (Continued)**

**Include the Following Supporting Documentation:**

- Video of the offender's current physical condition, showing the extent of the offender's terminal illness or limit in mobility
- Video of treating health care personnel describing (1) the nature of the offender's terminal illness or condition preventing mobility and (2) the offender's current general physical condition (recorded in private, without the offender being present).  
*\*Please use lay man terms as much as possible.*
- Multidisciplinary team response and any supporting documentation.

**Recommendation:**

- In my opinion, the above-named offender does not pose a high risk to himself or to society and *compassionate release* consideration is appropriate.
- In my opinion, the above-named offender does pose a high risk to himself or to society and *compassionate release* consideration is not appropriate.

Comments:

\_\_\_\_\_  
Unit Warden

\_\_\_\_\_  
Date

**RECOMMENDATION FOR COMPASSIONATE RELEASE**

**III. Department's Medical/Mental Health Director Evaluation**

**Recommendation:**

- In my opinion, based on the evaluations of the Unit Medical Director and Unit Warden, *compassionate release* consideration is appropriate for the above-named offender.
- In my opinion, based on the evaluations of the Unit Medical Director and Unit Warden, *compassionate release* consideration is not appropriate for the above-named offender.

Comments:

\_\_\_\_\_  
DPS&C Medical/Mental Health Director

\_\_\_\_\_  
Date

**IV. Department's Secretary Recommendation**

Regarding *compassionate release*, I, the Secretary of the Department of Public Safety and Corrections:

- Concur with the recommendations of the Unit Medical Director, Unit Warden, and Department's Medical/ Mental Health Director and grant the above-named offender *compassionate release*.
- Seek additional information from medical and/ or administrative staff prior to rendering a decision regarding the granting of *compassionate release* for the above-named offender.  
Comments:
- Decline to grant the above-named offender *compassionate release*.

\_\_\_\_\_  
James M. Le Blanc, DPS&C Secretary

\_\_\_\_\_  
Date

**RECOMMENDATION FOR MEDICAL PAROLE / MEDICAL TREATMENT FURLOUGH:**

**Evaluation by the Unit Medical Director**

**Offender Name:**

**DOC Number:**

**Age:**

**Facility Offender is Currently Located:**

**Medical Diagnosis:**

**Prognosis:**

**Medical Condition Present at the Time of Sentencing:** Yes  No  Comments:

**If Yes, Overall Condition Deteriorated Since Sentencing:** Yes  No  Comments:

**Nature of Terminal Illness or Condition Preventing Mobility**(Please provide a medical summary):

**General Physical Condition:**

**Current Plan of Care:**

**Treatment Given:**

**Patient Currently Requires ER trips, Specialty Care Trips, or Special Medication:** Yes  No   
Comments:

**Care Necessary to Maintain the Patient:**

**Extent of Help Needed with Activities of Daily Living** (e.g. eating, getting out of bed, ambulating with wheelchair/ walker/ cane or bedbound, etc.):

**Proposed Housing Plans for a Medical Release if approved by the Committee on Parole:**

**Address:**

**Recommendation:**

- MEDICAL PAROLE
- MEDICAL TREATMENT FURLOUGH
- NO RECOMMENDATION

In my medical opinion, this offender's condition meets the medical criterion for medical release as defined in the referenced department regulation because this offender:

- Permanently Disability (The offender is unable to engage in substantial gainful activity by reason of any medically determinable physical impairment which can be expected to result in death or which is or can be expected to be permanently irreversible).
- Terminal Illness (The offender because of a medical Condition, is irreversibly terminally ill, having a life expectancy of less than one year due to an underlying medical condition).
- Limited Mobility Offender (The offender, due to an underlying medical condition, is unable to perform activities of daily living without assistance or is bed bound, including but not limited to prolonged coma and mechanical ventilation

\_\_\_\_\_  
Unit Medical Director

\_\_\_\_\_  
Date

**\* Please use layman terms as much as possible.**

**Evaluation by the Multidisciplinary Team**

Date of Offense(s):

Parish of Conviction:

Current Offense:

Offender Class:

DOC Intake Date:

Sentence Length:

Full Term Date:

GTPS Date:

Gang Affiliation:

Sex Offender:  Yes  NO

Currently Serving Time for a Sex Offense:  Yes  NO

Previous Felony Conviction(s):

Convicted of Violent Crime:  Yes  NO

**If Yes, Description of Offender's Crime Details** (What Crime, When Crime Occurred, Where Crime Occurred, Under What Conditions Crime Occurred, Weapon(s) Used in Crime, etc.):

**Summary of Disciplinary Violations While Incarcerated** (Date/ Offense):

**Brief Description of Offender's Overall Behavior While Incarcerated:**

Mental Health LOC:  1  2  3  4  5

Mental Health Summary:

Victim Notice and Registration on File:  Yes  NO  N/A

DNA Sample in DNA Database:  Yes  NO

If No, Plans to Obtain DNA Sample:

**Include the Following Supporting Documentation:**

- Video of the offender's current physical condition, showing the extent of the offender's terminal illness or limit in mobility
- Video of treating health care personnel describing (1) the nature of the offender's terminal illness or condition preventing mobility and (2) the offender's current general physical condition (recorded in private, without the offender being present).  
\* Please use layman terms as much as possible.
- Multidisciplinary Team Response with Supporting Documentation.

On \_\_\_\_\_ at \_\_\_\_\_ the Multidisciplinary Team met. The consensus of the team is as followed:

- The above-named offender meets criteria for consideration of a Medical Parole or Medical Treatment Furlough.
- The above-named offender doesn't meets criteria for consideration of a Medical Parole or Medical Treatment Furlough for the following reasons: \_\_\_\_\_ .

\_\_\_\_\_  
Security

\_\_\_\_\_  
Date

\_\_\_\_\_  
Classification

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mental Health

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other, Title

\_\_\_\_\_  
Date

**Evaluation by the Unit Warden**

- In my opinion, the above-named offender does not pose a high risk to himself or to society.
- In my opinion, the above-named offender does pose a high risk to himself or to society
- Comments:

---

Unit Warden

---

Date



**Evaluation by the Department's Medical/Mental Health Director**

- In my opinion, based on the evaluations of the Unit Medical Director and Unit Warden, a hearing by the Committee on Parole is appropriate for the above-named offender.
  
- In my opinion, based on the evaluations of the Unit Medical Director and Unit Warden, a hearing by the Committee on Parole is not appropriate for the above-named offender.

\_\_\_\_\_  
DPS&C Medical/ Mental Health Director

\_\_\_\_\_  
Date

Evaluation by the Secretary

Regarding a hearing by the Committee on Parole I, the Secretary of the Department of Public Safety and Corrections:

- Concur with the recommendations of the Unit Medical Director, Unit Warden, and Department's Medical/ Mental Health Director and forward the case to the Committee on Parole for review.
- Seek additional information from medical and/ or security staff prior to rendering a decision.  
Comments:
- Decline to forward the case to the Committee on Parole.

\_\_\_\_\_  
James M. Le Blanc, DPS&C Secretary

\_\_\_\_\_  
Date

# LOUISIANA BOARD OF PARDONS, Committee on Parole

## DECISION FORM

Name	DOC Number	Institution
------	------------	-------------

The Louisiana Committee on Parole, after due consideration of all of the facts in your case, has made the decision that:

- You are **GRANTED** parole
  - Effective \_\_\_\_\_ with recommendation for Transitional Work Program (TWP)<sup>1</sup> until parole date
  - Upon completion of High School Equivalency (HSE)
  - Upon completion of DOC approved substance abuse education/treatment program
  - Upon completion of 100 hours pre-release programming
  - Other: \_\_\_\_\_
- Your release is **conditioned** upon:
  - Approval of residence     No disciplinary infractions     Approval of out-of-state plan     Approval of Employment
  - A Low Static99 Score (*applicable to sex offenders only*)     Certification by releasing facility re: compliance with R.S. 15:574.4.2
- Your parole decision has been **DEFERRED** for the following reason: \_\_\_\_\_
- Your parole hearing has been **CONTINUED** due to:
  - Verification of disposition of pending charges
  - The need for additional other information by the Committee on Parole
- You are **DENIED** parole for the following reason(s):
 

<ul style="list-style-type: none"> <li><input type="checkbox"/> Victim Opposition</li> <li><input type="checkbox"/> Prior Criminal History</li> <li><input type="checkbox"/> Probation/Parole Unsatisfactory/Violated</li> <li><input type="checkbox"/> Psychological and/or Psychiatric History</li> <li><input type="checkbox"/> Violation of TWP Agreement</li> <li><input type="checkbox"/> Failed to complete Rehabilitative Programming</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Institutional Disciplinary Reports</li> <li><input type="checkbox"/> History of Drug/Alcohol Abuse</li> <li><input type="checkbox"/> History of Violence</li> <li><input type="checkbox"/> Escape History</li> <li><input type="checkbox"/> Law Enforcement and/or Judicial Objection</li> <li><input type="checkbox"/> Other: _____</li> </ul>
--	---

You must comply with the following **SPECIAL CONDITIONS OF PAROLE:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>A. Pay restitution, victim reparation</li> <li>B. Pay fines and/or costs of court</li> <li>C. No contact with victim(s), or victim's family</li> <li>D. No contact with codefendant(s)</li> </ul> | <ul style="list-style-type: none"> <li>E. HSE, Vo-Tech, or other education plan</li> <li>F. Curfew 10pm-6am</li> <li>G. Comply with conditions of R.S. 15:574.4.2</li> <li>H. Other Conditions/Additional Information:</li> </ul> |
|--|---|

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---

Date	Chairman, Parole Panel Committee on Parole
------	---

**BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS PAROLE DECISION.**

WITNESSED BY:

OFFENDER SIGNATURE	(DATE)	WITNESS PRINTED NAME	SIGNATURE	(DATE)
--------------------	--------	----------------------	-----------	--------

**<sup>1</sup>TRANSITIONAL WORK PROGRAM (TWP) PARTICIPATION (15:1111):**

An offender sentenced to any of the following crimes are eligible for TWP participation only during the last 6 months of incarceration, unless and except the offender has served a minimum of 15 years in the custody of DOC, in which case the offender is eligible for TWP during the last 12 months of incarceration:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> aggravated arson (14:51)        | <input type="checkbox"/> armed robbery (14:64)   | <input type="checkbox"/> attempted armed robbery (14:27 and 64)     |
| <input type="checkbox"/> attempted murder (14:27 and 29) | <input type="checkbox"/> forcible rape (14:42.1) | <input type="checkbox"/> habitual offenders (15:529.1) <sup>2</sup> |

An offender convicted of a sex offense as defined in 15:541 is not suitable for participation in a TWP.

<sup>2</sup> Habitual offenders with LOW RISK ASSESSMENT are eligible during last 12 months of term (15 yr minimum DOC custody not required)

**STATE OF LOUISIANA  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS  
CORRECTIONS SERVICES**

**Health Care Policy  
No. HCP42**



**09 January 2019**

**INSTITUTIONAL SERVICES / HEALTH CARE POLICIES  
Health Care Policy – Medical Release Procedures  
Medical Parole**

1. **OBJECTIVE:** To identify DPS&C offenders who represent a low public safety risk due to their significant health conditions and consider these offenders for medical parole.
2. **REFERENCES:** ACA Standards 5-6A-4347 and 5-6A-4357 (Adult Correctional Institutions); La.R.S. 14:30, 14:30.1, 15:574.4, 15:574.4.2 and 15:574.20; Medical Furlough and Medical Parole Flow Chart (attached); Department Regulation Nos. [HCP21](#) "Communicable and Infectious Diseases Infection Control Program," [HCP24](#) "Human Immunodeficiency Virus (HIV)," [HCP7](#) "Pharmaceuticals," and [OP-C-12](#) "DNA Protocols."
3. **POLICY:** It is the Secretary's policy that the Department shall have procedures to efficiently identify permanently disabled offenders or terminally ill offenders who, due to a medical condition, represent a low public safety risk and consider these offenders for medical parole. The authority to grant medical parole shall rest solely with the Committee on Parole.
4. **APPLICABILITY:** Deputy Secretary, Chief of Operations, Department's Medical/Mental Health Director, Department's Chief Nursing Officer, Director of Probation and Parole, Chairperson and Members of the Board of Pardons Committee on Parole, Regional Wardens, Wardens, and Administrators of local jail facilities where state offenders are housed. Each Unit Head shall be responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this policy.
5. **DEFINITIONS:**
  - A. **Health Care Facility:** For the purpose of this regulation, an acute care hospital, nursing home or other licensed medical facility which complies with all state and federal laws and regulations that is appropriate to meet the offender's medical and treatment needs.

- B. **Health Care Personnel:** Individuals whose primary duty is to provide health services to offenders in keeping with their respective levels of health care training or experience.
- C. **Health Care Practitioner:** Clinicians trained to diagnose and treat patients, such as physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners, and physician assistants.
- D. **Medical Parole:** A specific type of parole for offenders who, because of a medical condition, are determined by the Department to be a permanently disabled offender or terminally ill offender. Medical parole consideration shall be in addition to any other parole for which an offender may be eligible.
- E. **Permanently Disabled Offender:** For the purpose of this policy, any offender who is unable to engage in substantial gainful activity by reason of any medically determinable physical impairment which can be expected to result in death or which is or can be expected to be permanently irreversible, in accordance with the U.S. Social Security Administration's definitions in "Disability Evaluation Under Social Security."
- F. **Terminally Ill Offender:** For the purpose of this policy, any offender who is diagnosed with a terminal illness and death is expected within one year. The medical condition of a terminally ill offender is usually permanent in nature and carries a poor prognosis. (Note: "Terminally Ill Offender" definition is different for medical furlough.)

**6. MEDICAL PAROLE ELIGIBILITY:**

- A. Non-Medical Criterion
  - 1) Any offender sentenced to the custody of DPS&C may be considered for medical parole by the Committee on Parole except an offender:
    - a. Sentenced to death; or
    - b. Serving time for the violation of first-degree murder (R.S. 14:30); or
    - c. Serving time for the violation of second-degree murder (R.S. 14:30.1).
  - 2) Any offender who meets the medical parole eligibility criterion may be considered for medical parole, regardless of the offender's eligibility for traditional parole under the provisions of R.S. 15:574.4.

B. Medical Criterion

- 1) Any permanently disabled offender or terminally ill offender may be considered for medical parole.
- 2) Generally, medical parole consideration shall not be given to an offender when the offender's medical condition was present at the time of sentencing, unless the offender's overall condition has significantly deteriorated since that time.

NOTE: Medical criteria is only one of the many factors in determining the suitability of an offender for a medical parole. A multidisciplinary team conducts a thorough assessment, including a public safety risk assessment.

**7. MEDICAL PAROLE PROCEDURES:**

- A. The Warden at each institution shall appoint a multidisciplinary team to evaluate every medical parole request. The staff appointed to this team shall be permanently assigned unless the team member's position changes.
- B. Any treating health care practitioner with knowledge of an offender's terminal illness or permanent disability may initiate the process by completing a Medical Criteria Screening Form (Form [HCP41-a](#)) and submitting it to the Unit Medical Director for consideration.
- C. In addition, any staff, including, but not limited to, health care personnel, Wardens, Headquarters' Medical staff, with knowledge of an offender's terminal illness or permanent disability may request the Unit Medical Director to review the offender for medical parole consideration.
- D. The Unit Medical Director or designee shall:
  - 1) Evaluate every Medical Criteria Screening Form (Form [HCP41-a](#)) received and, based solely on the offender's medical information, advise that the offender:
    - a. Meets the medical criteria for medical parole consideration; or
    - b. Does not meet the medical criteria for medical parole consideration.

NOTE: The Unit Medical Director's evaluation shall be objective and fact-based regarding only the offender's medical condition meeting or not meeting the medical criteria.

- 2) If the Unit Medical Director advises that the offender meets the medical criteria and recommends the offender for medical parole consideration:

Complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's medical condition and submit to the Unit Warden for review.

- 3) If the Unit Medical Director declines to recommend the offender for medical parole consideration:
  - a. Send notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking, and
  - b. File the Medical Criteria Screening Form (Form [HCP41-a](#)) in the offender's medical record.

E. The Unit Warden or designee shall:

- 1) Ensure that multidisciplinary team members provide pertinent information relative to their discipline to aid in determining an offender's suitability for medical parole and document this information on Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#));
- 2) Evaluate every Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) received; and
- 3) Complete the Unit Warden's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's crime, criminal history, length of time served in custody, institutional conduct, any indications that the offender represents a low risk to himself or society, and how the offender's medical condition related to his overall risk to society and either:
  - a. Recommend the offender for medical parole consideration and submit the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) to the Department's Chief Nursing Officer for processing, or





- 1) If the Secretary forwards the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) to the Committee on Parole, the Committee on Parole shall hold a hearing, at which the Unit Medical Director or designee shall attend, and complete the Louisiana Board of Pardons, Committee on Parole Decision Form (See Attachment) by:
  - a. Granting medical parole, or
  - b. Declining to grant medical parole.
- 2) In considering an offender for medical parole, the Committee on Parole may require additional medical evidence produced or additional medical examinations conducted.
- 3) The Committee on Parole shall determine the risk to public safety and shall grant medical parole only after determining that the offender does not pose a threat to public safety.
- 4) As a condition of medical parole, the offender shall waive his right to medical confidentiality and privacy to ensure notification to the healthcare facility as outlined below in section 7. J. 2) d. of this regulation.
- 5) The Committee on Parole shall promulgate such rules as are necessary to effectuate La. R.S. 15:574.20, including rules relative to the conduct of medical parole hearings, eligibility, revocation, and the conditions of medical parole.
- 6) The authority to grant medical parole shall rest solely with the Committee on Parole and the Committee may establish additional conditions of parole in accordance with the provisions of La. R.S. 15:574.20.

I. Declination of Medical Parole Request

- 1) In the event that a medical parole request is declined at any point, reconsideration may be granted upon re-initiation of the process at the unit level.
- 2) In the event that a medical parole is not granted by the Committee on Parole, the offender may apply for a rehearing within the time frame applicable to a denial of parole, pursuant to La. R.S. 15:574.20.

J. Medical Parole Discharge Planning

1) Residence Plan

Offenders granted medical parole shall be discharged to either a health care facility or a home setting.

2) The Unit Health Authority or designee shall:

- a. Ensure that each offender's discharge planning begins prior to the offender's approval of medical parole and is completed immediately upon approval of medical parole in accordance with the provisions of this regulation, Department Regulation Nos. [HCP15](#) "Continuity of Care," [IS-F-1](#) "Release Procedures," [PS-C-1](#) "Louisiana Prisoner Reentry," and each unit's discharge policy;
- b. Ensure that the offender is enrolled in Medicaid or a health insurance plan prior to discharge;
- c. Ensure that a residence plan at a health care facility or a home setting is secured;
- d. Ensure that within 7 business days of the offender's approval of medical parole, the health care facility the offender is discharging to is notified of such decision;

NOTE: Pursuant to La. R.S. 15:574.20, it shall be the responsibility of the health care facility to provide notice to its residents and its residents' next of kin, curator, tutor, or person having power of attorney for the resident that the offender will be receiving treatment at the facility.

- e. Ensure that copies of the offender's pertinent medical records accompany the offender upon discharge and that a verbal report has been given to the receiving health care facility or caregiver at the home setting;
- f. Ensuring that an adequate supply of medication accompanies the offender upon discharge if being discharged to a home setting, pursuant to Health Care Policy No. [HCP7](#) "Pharmaceuticals;" and
- g. Pursuant to La. R.S. 15:574.4.2, ensure that the offender submit to infectious disease testing prior to discharge,

including but not limited to syphilis, HIV, Hepatitis A, Hepatitis B, and Hepatitis C via Infectious Disease Testing Prior to Parole (Form [HCP21-a](#)).

NOTE: Pursuant to La. R.S. 15:574.4.2, if the offender tested positive for any of the infectious diseases outlined above, the granting of the medical parole shall be conditioned upon the offender seeking advice and counseling from the appropriate health care and support services. Failure to seek or follow that advice shall result in the revocation of the offender's medical parole.

- 3) The Unit Warden or designee shall:
  - a. Ensure that prior to an offender's discharge on medical parole, the offender's DNA sample has been obtained and transmitted to the state DNA database maintained and administered by the Office of State Police, pursuant to Department Regulation No. [OP-C-12](#) "DNA Protocols," and
  - b. If a sex offender is granted medical parole, make all required notifications, pursuant to Department Regulation No. [IS-E-1](#) "Sex Offender Notification, Registration Requirements and Residence Plan."

K. Term of Medical Parole

- 1) The parole term of an offender granted medical parole shall be for the remainder of the offender's sentence, unless otherwise revoked in accordance with Section 7.L "Medical Parole Supervision and Revocation."
- 2) Offenders granted medical parole shall not earn diminution of sentence for good behavior (good time) while on medical parole, pursuant to La. R.S. 15:574.20.

L. Medical Parole Supervision and Revocation

- 1) Supervision of an offender granted medical parole shall consist of visits by the Division of Probation and Parole, in accordance with Probation and Parole Officer's Manual. (See Department Regulation No. P&P-1 "Probation and Parole Officer's Manual" for more information.)

- 2) If it is discovered through the supervision of the offender granted medical parole that his condition has improved such that he would not then be eligible for medical parole under the provisions of this policy, the Committee on Parole may order that the offender be returned to the custody of the Department to await a hearing to determine whether his parole shall be revoked.
- 3) Any offender whose medical parole is revoked due to an improvement in his condition, and who would otherwise be eligible for parole, may then be considered for traditional parole under the provisions of La. R.S. 15:574.4.
- 4) Any offender whose medical parole is revoked due to an improvement in his condition shall resume serving the balance of his sentence with credit given for the duration of the medical parole, pursuant to La. R.S. 15:574.20.
- 5) Medical parole may also be revoked for violation of any condition of parole established by the Committee on Parole.

**M. Prohibition of Commutation of Sentence**

No employee of the Department, including Wardens, shall recommend that the sentence of a permanently disabled offender or terminally ill offender be commuted due to the medical condition that qualifies him as a permanently disabled offender or terminally ill offender, pursuant to La. R.S. 15:574.20.

**8. MONITORING REQUIREMENTS/REPORTS:**

- A. The Unit Health Authority or designee shall identify all offenders who meet the medical criteria for a medical parole consideration and submit a quarterly report to the Chief Nursing Officer which includes, but is not limited to, the following information on each identified offender:
  - a. Name;
  - b. DOC number;
  - c. Age;
  - d. Medical/ mental health diagnosis;
  - e. Current medical treatment;
  - f. Assistance required;
  - g. Housing location;
  - h. Time served;
  - i. GTPS date;
  - j. Full term date; and
  - k. If the offender is currently serving time for a sex offense.

- B. The Department's Chief Nursing Officer shall submit a quarterly report to the Secretary which includes, but is not limited to:
  - 1) The number of offenders who meet the medical criteria for medical parole consideration;
  - 2) The number of offenders who were granted a medical parole; and
  - 3) The number of offenders who were declined to be recommended for medical parole consideration at any point during the process outlined in this regulation.
  
- C. The Division of Probation and Parole shall:
  - 1) Monitor offenders that have been granted a medical parole in accordance with Probation and Parole Officer's Manual until the offender's death or the expiration of sentence, and
  - 2) Submit a monthly report of all medical paroles to the Secretary, Department's Chief Nursing Officer and the Committee on Parole's Parole Board Chair. The report shall include, but is not limited to, the following information on each offender granted a medical parole:
    - a. Name;
    - b. DOC number;
    - c. Location;
    - d. Date the medical parole was granted;
    - e. Date the offender left the unit on a medical parole;
    - f. Latest narrative report from the Probation and Parole officer;
    - g. Date and time of death, if indicated; and
    - h. Any other information deemed to be appropriate.

**9. DPS&C OFFENDERS HOUSED IN NON-DPS&C FACILITIES:**

- A. A DPS&C offender housed in a non-DPS&C facility shall be considered for a medical parole in the same manner as a DPS&C offender housed in a DPS&C facility.
  
- B. Medical parole eligibility for a DPS&C offender housed in a non-DPS&C facility shall be in accordance with Section 6. "Medical Parole Eligibility."
  
- C. Medical parole procedures for DPS&C offenders housed in a non-DPS&C facility shall be as follows:

- 1) A physician, if available, shall complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's medical condition and submitting it to the Warden for review.
- 2) If a physician is unavailable, the Department's Medical/ Mental Health Director shall coordinate with the non-DPS&C facility to complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)).
- 3) The Warden shall complete the Unit Warden's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) and submit it to the Department's Chief Nursing Officer.

NOTE: The Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) may be omitted if a physician is unavailable to complete. In such cases, the Warden shall also submit any pertinent medical records.

- 4) The remaining medical parole procedures shall be in accordance with sections 7.F through 7.M. of this regulation.

s/James M. Le Blanc  
Secretary

Attachments:

[HCP41](#) [Flow Chart for Compassionate Release, Medical Parole, and Medical Treatment Furlough](#)  
[HCP42](#) [Louisiana Board of Pardons, Committee on Parole Decision Form](#)

Forms:

[HCP41-a: Medical Criteria Screening Form](#)  
[HCP41-c: Recommendation for Medical Parole or Medical Treatment Furlough](#)  
[HCP21-a: Infectious Disease Testing Prior to Parole](#)

This policy supersedes Health Care Policy No. HC-06 dated 16 June 2016.

**Reviewed as of: October 1, 2019**

**STATE OF LOUISIANA  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS  
CORRECTIONS SERVICES**

**Health Care Policy  
No. HCP46**



**28 November 2018**

**INSTITUTIONAL SERVICES / HEALTH CARE POLICIES  
Health Care Policy – Medical Release Procedures  
Medical Treatment Furlough**

1. **OBJECTIVE:** To identify DPS&C offenders who represent a low public safety risk due to their significant health conditions and consider these offenders for medical treatment furlough.
2. **REFERENCES:** ACA Standards 4-4347 and 4-4357 (Adult Correctional Institutions); La. R.S. 14:30, 14:30.1, 15:574.4, 15:574.4.2 and 15:574.20; Department Regulation Nos. [HCP15](#) "Continuity of Care," [HCP21](#) "Communicable and Infectious Diseases Infection Control Program," [HCP24](#) "Human Immunodeficiency Virus (HIV)," [HCP7](#) "Pharmaceuticals," IS-F-1 "Release Procedures," [PS-C-1](#) "Louisiana Prisoner Reentry," [OP-C-12](#) "DNA Protocols," [JO-1](#) "Basic Jail Guidelines," and P&P-1 "Probation and Parole Officer's Manual."
3. **POLICY:** It is the Secretary's policy that the Department shall have procedures to efficiently identify limited mobility offenders who, due to a medical condition, represent a low public safety risk and consider these offenders for medical treatment furlough. The authority to grant medical treatment furlough shall rest solely with the Committee on Parole.
4. **APPLICABILITY:** Deputy Secretary, Chief of Operations, Department's Medical/Mental Health Director, Department's Chief Nursing Officer, Director of Probation and Parole, Chairperson and Members of the Board of Pardons Committee on Parole, Regional Wardens, Wardens, and Wardens and Sheriffs or Administrators of local jail facilities where state offenders are housed. Each Unit Head shall be responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this policy.
5. **DEFINITIONS:**
  - A. **Health Care Facility:** For the purpose of this regulation, an acute care hospital, nursing home or other licensed medical facility which complies with all state and federal laws and regulations that is appropriate to meet the offender's medical and treatment needs.

- B. **Health Care Personnel:** Individuals whose primary duty is to provide health services to offenders in keeping with their respective levels of health care training or experience.
- C. **Health Care Practitioner:** Clinicians trained to diagnose and treat patients, such as physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners, and physician assistants.
- D. **Limited Mobility Offender:** For the purpose of this regulation, any offender who, due to an underlying medical condition, is unable to perform activities of daily living without assistance or is bedbound, including but not limited to prolonged coma or mechanical ventilation. Limited mobility offenders shall only be discharged to a health care facility.

NOTE: This definition of limited mobility offender is specific to medical treatment furlough. (See Department Regulation No. [HCP41](#) "Compassionate Release" for the definition of limited mobility offender specific to compassionate release.)

- E. **Medical Treatment Furlough:** A specific type of supervised release for offenders who, because of a medical condition, are determined by the Department to be a limited mobility offender and the use of a health care facility for medical treatment purposes is utilized.
- F. **Multidisciplinary Team:** For the purpose of this regulation, a team that includes at a minimum, representatives from the following areas: Warden or designee, Medical Department, Mental Health Department, Classifications, and Security.

**6. MEDICAL TREATMENT FURLOUGH ELIGIBILITY:**

- A. Non-Medical Criterion

Any offender sentenced to the custody of DPS&C may be considered for medical treatment furlough by the Committee on Parole, except an offender:

- 1) Sentenced to death, or
- 2) Serving a sentence for a conviction of first degree murder (La. R.S. 14:30).

- B. Medical Criteria



- 1) Any limited mobility offender may be considered for a medical treatment furlough.
  - a. Limited mobility offenders shall require rehabilitative and/or ongoing skilled nursing care to complete activities of daily living, such as bathing, dressing, transferring, toileting, and eating; and
  - b. Limited mobility offenders shall meet the individual admission requirements for the health care facility that he is being discharged to.
  - c. Generally, medical treatment furlough consideration shall not be given to an offender when the offender's medical condition was present at the time of sentencing, unless the offender's overall condition has significantly deteriorated since that time.

NOTE: Medical criteria is only one of the many factors in determining the suitability of an offender for a medical treatment furlough. A multidisciplinary team conducts a thorough assessment, including a public safety risk assessment.

**7. MEDICAL TREATMENT FURLOUGH PROCEDURES:**

- A. The Warden at each institution shall appoint a multidisciplinary team to evaluate every medical treatment furlough request. The staff appointed to this team shall be permanently assigned unless the team member's position changes.
- B. Any treating health care practitioner with knowledge of an offender's limited mobility may initiate the process by completing a Medical Criteria Screening Form (Form [HCP41-a](#)) and submitting it to the Unit Medical Director for consideration.
- C. In addition, any staff, including, but not limited to, health care personnel, Wardens, and Headquarters' Medical staff, with knowledge of an offender's limited mobility may request the Unit Medical Director to review the offender for medical treatment furlough consideration.
- D. The Unit Medical Director or designee shall:
  - 1) Evaluate every Medical Criteria Screening Form (Form [HCP41-a](#)) received and, based solely on the offender's medical information, advise that the offender:

- a. Meets the medical criteria for medical treatment furlough consideration; or
- b. Does not meet the medical criteria for medical treatment furlough consideration.

NOTE: The Unit Medical Director's evaluation shall be objective and fact-based regarding only the offender's medical condition meeting or not meeting the medical criteria.

- 2) If the Unit Medical Director advises that the offender meets the medical criteria and recommends the offender for medical treatment furlough consideration:

Complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's medical condition and submit to the Unit Warden for review.

- 3) If the Unit Medical Director declines to recommend the offender for medical treatment furlough consideration:
  - a. Send notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking; and
  - b. File the Medical Criteria Screening Form (Form [HCP41-a](#)) in the offender's medical record.

E. The Unit Warden or designee shall:

- 1) Ensure that multidisciplinary team members provide pertinent information relative to their discipline to aid in determining an offender's suitability for medical treatment furlough and document this information on Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#));
- 2) Evaluate every Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) received; and
- 3) Complete the Unit Warden's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's crime, criminal history, length of time served in custody, institutional conduct, any indications that the offender represents a low risk to

himself or society, and how the offender's medical condition related to his overall risk to society and either:

- a. Recommending the offender for medical treatment furlough consideration and submitting the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) to the Department's Chief Nursing Officer for processing; or
- b. Declining recommending the offender for medical treatment furlough consideration, sending notice of declination to the Department's Chief Nursing Officer for data collection and tracking, and filing the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) in the offender's medical record.

F. The Department's Medical/Mental Health Director shall:

- 1) Evaluate every Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) received for compliance with applicable law and policy, and
- 2) Complete the Department's Medical/Mental Health Director's portion of the recommendation by:
  - a. Recommending the offender for medical treatment furlough consideration and submitting it to the Department's Secretary for review, or
  - b. Declining to recommend the offender or medical treatment furlough consideration and sending notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking.

G. The Department's Secretary shall:

- 1) Evaluate every Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) received, and
- 2) Complete the Department's Secretary's portion of the recommendation by:
  - a. Recommending the offender for medical treatment furlough consideration and forwarding the case to the Committee on Parole for a hearing;

- b. Seeking additional information prior to rendering a decision regarding medical treatment furlough recommendation; or
- c. Declining to recommend the offender for medical treatment furlough consideration and sending notification of declination to the Warden and the Department's Chief Nursing Officer for data collection and tracking.

H. Committee on Parole

- 1) If the Secretary forwards the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) to the Committee on Parole, the Committee on Parole shall hold a hearing, at which the Unit Medical Director or designee shall attend, and complete the Louisiana Board of Pardons, Committee on Parole Decision Form (See Attachment) by:
  - a. Granting medical treatment furlough, or
  - b. Declining to grant medical treatment furlough.
- 2) In considering an offender for medical treatment furlough, the Committee on Parole may require additional medical evidence produced or additional medical examinations conducted.
- 3) The Committee on Parole shall determine the risk to public safety and shall grant medical treatment furlough only after determining that the offender does not pose a threat to public safety.
- 4) As a condition of medical treatment furlough, the offender shall waive his right to medical confidentiality and privacy to ensure notification to the healthcare facility as outlined below in section 7. J. 2) d. of this regulation.
- 5) The Committee on Parole shall promulgate such rules as are necessary to effectuate La. R.S. 15:574.20, including rules relative to the conduct of medical treatment furlough hearings and the conditions of medical treatment furlough release.
- 6) The authority to grant medical treatment furlough shall rest solely with the Committee on Parole and the Committee may establish additional conditions of medical treatment furlough in accordance with the provisions of La. R.S. 15:574.20.

I. Declination of Medical Treatment Furlough Request

- 1) In the event that a medical treatment furlough request is declined at any point, reconsideration may be granted upon re-initiation of the process at the unit level.
- 2) In the event that a medical treatment furlough is not granted by the Committee on Parole, the offender may apply for a rehearing within the time frame applicable to a denial of parole, pursuant to La. R.S. 15:574.20.

J. Medical Treatment Furlough Discharge Planning

1) Residence Plan

Limited mobility offenders granted medical treatment furlough shall only be discharged to a health care facility.

2) The Unit Health Authority or designee shall:

- a. Ensure that each offender's discharge planning begins prior to the offender's approval of medical treatment furlough and is completed immediately upon approval of medical treatment furlough, in accordance with the provisions of this regulation, Department Regulation Nos. [HCP15](#) "Continuity of Care," [IS-F-1](#) "Release Procedures," [PS-C-1](#) "Louisiana Prisoner Reentry," and each unit's discharge policy;
- b. Ensure that the offender is enrolled in Medicaid or a health insurance plan prior to discharge;
- c. Ensure that a residence plan at a health care facility is secured;
- d. Ensure that within 7 business days of the offender's approval of medical treatment furlough, the health care facility the offender is discharging to is notified of such decision;

NOTE: Pursuant to La. R.S. 15:574.20, it shall be the responsibility of the health care facility to provide notice to its residents and its residents' next of kin, curator, tutor, or person having power of attorney for the resident that the offender will be receiving treatment at the facility.

- e. Ensure that copies of the offender's pertinent medical records accompany the offender upon discharge and that a verbal report has been given to the receiving health care facility; and

- f. Pursuant to La. R.S. 15:574.4.2, ensure that the offender submit to infectious disease testing prior to discharge, including but not limited to syphilis, HIV, Hepatitis A, Hepatitis B, and Hepatitis C via Infectious Disease Testing Prior to Parole (Form [HCP21-a](#)).

NOTE: Pursuant to La. R.S. 15:574.4.2, if the offender tested positive for any of the infectious diseases outlined above, the granting of the medical treatment furlough shall be conditioned upon the offender seeking advice and counseling from the appropriate health care and support services. Failure to seek or follow that advice shall result in the revocation of the offender's medical treatment furlough.

- 3) The Unit Warden or designee shall:
  - a. Ensure that prior to an offender's discharge on medical treatment furlough, the offender's DNA sample has been obtained and transmitted to the state DNA database maintained and administered by the Office of State Police, pursuant to Department Regulation No. [OP-C-12](#) "DNA Protocols," and
  - b. If a sex offender is granted medical treatment furlough, make all required notifications, pursuant to Department Regulation No. [IS-E-1](#) "Sex Offender Notification, Registration Requirements and Residence Plan."

K. Term of Medical Treatment Furlough

- 1) The term of an offender granted medical treatment furlough shall be for the remainder of the offender's sentence, unless otherwise revoked, in accordance with Section 7.L. of this regulation.
- 2) Offenders granted medical treatment furlough shall not earn diminution of sentence for good behavior (good time) while on medical treatment furlough, pursuant to La. R.S. 15:574.20.

L. Medical Treatment Furlough Supervision and Revocation

- 1) Supervision of an offender granted medical treatment furlough shall consist of visits by the Division of Probation and Parole, in accordance with Probation and Parole Officer's Manual. (See Department Regulation No. P&P-1 "Probation and Parole Officer's Manual" for more information.)

- 2) If it is discovered through the supervision of the offender granted medical treatment furlough that his condition has improved such that he would not then be eligible for medical treatment furlough under the provisions of this policy, the Committee on Parole may order that the offender be returned to the custody of the Department to await a hearing to determine whether his parole shall be revoked.
- 3) Any offender whose medical treatment furlough is revoked due to an improvement in his condition, and who would otherwise be eligible for parole, may then be considered for traditional parole.
- 4) Any offender whose medical treatment furlough is revoked due to an improvement in his condition shall resume serving the balance of his sentence with credit given for the duration of the medical treatment furlough, pursuant to La. R.S. 15:574.20.
- 5) Medical treatment furlough may also be revoked for violation of any condition of parole established by the Committee on Parole.

**M. Prohibition of Commutation of Sentence**

No employee of the Department, including Wardens, shall recommend that a limited mobility offender's sentence be commuted due to his limited mobility, pursuant to La. R.S. 15:574.20.

**8. MONITORING REQUIREMENTS/REPORTS:**

A. The Unit Health Authority or designee shall identify all offenders who meet the medical criteria for a medical treatment furlough consideration and submit a quarterly report to the Chief Nursing Officer which includes, but is not limited to, the following information on each identified offender:

- 1) Name;
- 2) DOC number;
- 3) Age;
- 4) Medical/mental health diagnosis;
- 5) Current medical treatment;
- 6) Assistance required;
- 7) Housing location;
- 8) Time served;
- 9) GTPS date;
- 10) Full term date; and
- 11) If the offender is currently serving time for a sex offense.

- B. The Department's Chief Nursing Officer shall submit a quarterly report to the Secretary which includes, but is not limited to:
  - 1) The number of offenders who meet the medical criteria for medical treatment furlough consideration;
  - 2) The number of offenders who were granted a medical treatment furlough; and
  - 3) The number of offenders who were declined to be recommended for medical treatment furlough consideration at any point during the process outlined in this regulation.
  
- C. The Division of Probation and Parole shall:
  - 1) Monitor offenders that have been granted a medical treatment furlough in accordance with Probation and Parole Officer's Manual until the offender's death or the expiration of sentence, and
  - 2) Submit a monthly report of all medical treatment furloughs to the Secretary, Department's Chief Nursing Officer and the Committee on Parole's Parole Board Chair. The report shall include, but is not limited to, the following information on each offender granted a medical treatment furlough:
    - a. Name;
    - b. DOC number;
    - c. Location;
    - d. Date the medical treatment furlough was granted;
    - e. Date the offender left the unit on a medical treatment furlough;
    - f. Latest narrative report from the Probation and Parole officer;
    - g. Date and time of death, if indicated; and
    - h. Any other information deemed to be appropriate.

**9. DPS&C OFFENDERS HOUSED IN NON-DPS&C FACILITIES:**

- A. A DPS&C offender housed in a non-DPS&C facility shall be considered for a medical treatment furlough in the same manner as a DPS&C offender housed in a DPS&C facility.
  
- B. Medical treatment furlough eligibility for a DPS&C offender housed in a non-DPS&C facility shall be in accordance with section 6. of this regulation.



C. Medical treatment furlough procedures for a DPS&C offender housed in a non-DPS&C facility shall be as follows:

- 1) A physician, if available, shall complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) by evaluating and providing information on the offender's medical condition and submitting it to the Warden for review.
- 2) If a physician is unavailable, the Department's Medical/ Mental Health Director shall coordinate with the non-DPS&C facility to complete the Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)).
- 3) The Warden shall complete the Unit Warden's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) and submit it to the Department's Chief Nursing Officer.

NOTE: The Unit Medical Director's portion of the Recommendation for Medical Parole or Medical Treatment Furlough (Form [HCP41-c](#)) may be omitted if a physician is unavailable to complete. In such cases, the Warden shall also submit any pertinent medical records.

- 4) The remaining medical treatment furlough procedures shall be in accordance with sections 7.F through 7.L. of this regulation.

s/James M. Le Blanc  
Secretary

Attachments:

[HCP41 Flow Chart for Compassionate Release, Medical Parole, Medical Treatment Furlough](#)

[HCP42 Louisiana Board of Pardons, Committee on Parole Decision Form](#)

Forms:

[HCP41-a: Medical Criteria Screening Form](#)

[HCP41-c: Recommendation for Medical Parole or Medical Treatment Furlough](#)

[HCP21-a: Infectious Disease Testing Prior to Parole](#)

**Reviewed as of: October 1, 2019**

# Attachment C: 2018 – 2021 Medical Releases by Type of Release

Attachment C. 2018-2021 Medical Releases by Type of Release

	Approved	Approval Percentage	Denied	Denial Percentage	Other	Total Considered
<b>Compassionate Release</b>	32	89%	3	8%	1	<b>36</b>
<b>Medical Parole</b>	22	57%	27	48%	7	<b>56</b>
<b>Medical Treatment Furlough</b>	18	70%	24	52%	4	<b>46</b>

# Attachment D: 2018 – 2021 Medical Releases by Charge

Attachment D. 2018-2021 Medical Releases by Charge

Offense Category	Approved	Denied	Cancelled	Died	Pending	Released	Grand Total
Drug	5	2				3	10
Property	6						6
Violent	54	47	1	5			107
Sex Offense	8	18		2			28

# Attachment E: 2018 – 2021 Medical Releases by Gender

Attachment E. 2018-2021 Medical Releases by Gender

	Approved	Denied	Died	Released	Cancelled	Pending	Total
<b>Compassionate Release</b>	<b>32</b>	<b>3</b>	<b>1</b>				<b>36</b>
Female Individuals	2						2
Male Individuals	30	3	1				34
<b>Medical Parole</b>	<b>22</b>	<b>27</b>	<b>2</b>	<b>4</b>		<b>1</b>	<b>56</b>
Female Individuals	4						4
Male Individuals	18	27	2	4		1	52
<b>Medical Treatment Furlough</b>	<b>18</b>	<b>24</b>	<b>3</b>		<b>1</b>		<b>46</b>
Female Individuals	1	1					2
Male Individuals	17	23	3		1		44
<b>Total</b>	<b>72</b>	<b>54</b>	<b>6</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>138</b>

# Attachment F: 2018 – 2021 Medical Releases by Race

Attachment F: 2018-2021 Medical Releases by Race

	Approved	Denied	Died	Released	Cancelled	Pending	Total
<b>Compassionate Release</b>	<b>32</b>	<b>3</b>	<b>1</b>				<b>36</b>
Black Individuals	21	2	1				24
White Individuals	11	1					12
<b>Medical Parole</b>	<b>22</b>	<b>27</b>	<b>2</b>	<b>4</b>		<b>1</b>	<b>56</b>
Black Individuals	15	17	1	1			34
White Individuals	7	9	1	3		1	21
<b>Medical Treatment Furlough</b>	<b>18</b>	<b>24</b>	<b>3</b>		<b>1</b>		<b>46</b>
Black Individuals	12	17	3		1		33
White Individuals	6	7					13
<b>Total</b>	<b>72</b>	<b>54</b>	<b>6</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>138</b>

# Attachment G: 2018 – 2021 Days Between Decision and Death

Attachment G: 2018-2021 Days Between Decision and Death

	Compassionate Release	Medical Parole	Medical Treatment Furlough
<b>Approved</b>			
Average Days between Approval and Death	65	153	460
Count of Individuals	32	22	18
<b>Denied</b>			
Average Days between Denial and Death	71	260	479
Count of Individuals	3	27	24

# Attachment H: Testimonials from Stakeholders

## Community Doctors

### ***Dr. Daniel Brady - Attending physician at a community hospital***

“In general, we care for a lot of incarcerated patients at, often very ill patients who have been lost to close follow-up and failed by the system.

Recently, for example, I had a patient at the end of his life with metastatic lung cancer. His diagnosis and work up for treatment were very delayed due to a lack of appropriate appointments. He was really a palliative case at this point, so we wanted to get him home with his sister. The barriers of the prison system are such that we were not able to do so, and unfortunately, he passed away in the hospital. I've seen this repeatedly with patients who, in our opinion, are eligible for compassionate release. There's a lot of red tape that we have to go through, and we are rarely ever successful in getting these patients released to see their families in a timely fashion. One common barrier is that the facility often wants to see the patient again themselves, to reassess, requiring transportation back and forth. This delay is frustrating as they are not trusting our opinions as medical professionals. It's not a streamlined process. It would be helpful if there were clear guidelines that we could go by to get things done efficiently.

With this particular patient, we were able to get approval for family to visit; however, the family lived 5 hours away and were not able to make it. Once he was end-stage and transitioned to comfort care, he

qualified for hospice. If he were not incarcerated, we could have transferred him to inpatient hospice closer to his family. Typically, once qualified, patients can be transferred as quickly as 24 hours. Instead, he spent his final week in the hospital and passed away at UMC. His sister was never able to see him.”

### ***Dr. Anjali Niyogi - Attending physician at a community hospital and Chair of the HR 51 Taskforce***

“We as treating physicians of incarcerated patients in the hospital are in a limbo. We are seeing somebody who is really sick and knowing that we need to figure out the best option in a very limited time period, but not knowing how to communicate that with the patient or the family, not understanding what the process is, and not knowing what steps we can take to make the process smoother for DOC and for the patients. There is also the aspect of sticking to our oath of providing the best care for these individuals regardless of and despite their incarceration status. In my experience, reaching out to DOC medical directors and facility directors has been well-received from the DOC's standpoint. The initial step in doing that that outreach is pretty smooth but after that everything becomes very opaque. I often don't know what to do afterwards, particularly for patients that are very sick and I don't know if they will die while they are waiting. It's heartbreaking to think they might go to back the facility and die there instead of having the chance to be with friends and

family. I wish there was bilateral communication between us and the DOC - in some ways these are our shared patients.

I also wish there were guidelines or conversations around people who aren't terminally ill and don't have serious incapacitation, but I have concerns about them being in crowded jails or prisons for other reasons, such as having no immune system. I wish there was a way to minimize future potential complications for those patients and work with the DOC to do that. The DOC says they will try to keep people safe but we know people come back to the hospital with infections and worsening medical conditions. There are places where those patients can be treated and have specialists but are not necessarily a more costly hospital setting. I know there are processes in place, like medical parole and medical treatment furlough, but they are underutilized. I don't quite know how as a treating physician to do anything but keep them in a very expensive hospital setting for their medical safety, but there should be more thought as to what we can do without using up healthcare dollars or DOC dollars. Sometimes they just need a skilled nursing level at a LTAC facility where there is more consistency in their care."

***Dr. Marcia Glass – Attending physician at a community hospital and HR 51 Task Force designee***

I am an internal medicine doctor at University Medical Center in New Orleans, and I run the palliative care fellowship at Tulane. I first started getting interested in the issue of compassionate release and medical parole about six years ago when I had a patient admitted from

Elayn Hunt Prison who had been tied to a bed for one year. He had advanced dementia, he could not answer questions, and he had a wound on his back that was so deep that it tracked to the bone. He was referred to me as a palliative care doctor to comment on whether he needed end of life care. Determining that he was within weeks of dying, I asked why he was still in prison. I was told that it's very hard to get someone out on compassionate release, and that staff could try, but that it probably wouldn't work.

Every time that I have tried to get a patient compassionate release over the last five years, I have not been successful. A couple years ago, I had a patient at University Medical Center who was dying from cancer. He was already pardoned by the parole board, but his pardon had not been signed by the governor for at least two years. He was within days of dying in our hospital. Standard of care is to get these patients home or get them to a hospice facility, but we had to keep him in our lockdown unit. We went to the prison board and asked for his compassionate release, which they agreed to consider. While he was waiting to get compassionate release, he died at University Medical Center.

On top of these longstanding issues, now we have the added complications from COVID, which can have a prolonged recovery for a lot of people. They're still in prison, and now they're oxygen dependent. That requires a lot of resources – physical therapy, and sometimes dialysis. Some of those patients have also already been pardoned and are also waiting for the governor's signature, and now we're giving them advanced care for COVID complications indefinitely. I appealed to the prison medical director for one such patient and asked why we could



not expedite her medical parole or compassionate release. He told me that she probably would not qualify because she can walk – so the medical director was not even going to try.

As a doctor, this is frustrating. It's not the standard of care in the rest of the country. When I bring this up with other prison advocacy groups, they're shocked by our stories. I think that there are easy ways we can provide better care, save the taxpayers money, and treat dying people in the community appropriately with the health care professionals available, instead of letting people die tied to a bed in a prison where they don't belong."

## **DPS&C Staff**

### ***Cindy Park, Nurse Practitioner at LSP who is directly involved in initiating the process of Compassionate Release/Medical Parole/Medical Furlough***

"Whenever I know that a patient has a terminal illness or a life expectancy of less than two months, I initiate a letter on their behalf in which I write about their medical history, their prognosis, I put supporting documentation from the physicians that have treated the patient at outside hospitals. And I submit the letter along with a video of the patient's health status in which I show what they're physically able or not able to do, what their physical appearance looks like, how incapacitated they are. And I submit that. I work with a nurse that does a lot of that for me, but I write what their abilities are, how much care they need. And then that is submitted to an interdisciplinary team in which it includes a mental health person, it includes myself, it includes security, classification,

and the warden over medical... My statement is based on the medical condition of that patient, mental health will base their decision on whether they think he's a candidate based on their information, and classification will base their decision based on his classification records. We will, as a group, decide whether he is a candidate, and every individual will write what they think, whether he's a candidate or not based on their specialty. And that then gets submitted to the warden over corrections regardless, even if everybody thinks he's not a candidate it still gets submitted to the warden over at corrections. And he reviews the case, reviews the video, and he makes his decision. The head warden over at Angola which right now is Tim Hooper makes a decision on whether that patient is a candidate for compassionate release or not. If he thinks that he's a candidate for compassionate release, based on everything, his security, his discipline record, everything. If he decides he is, it is submitted to headquarters and the secretary makes the ultimate decision whether he's a candidate for compassionate release.

If it's a compassionate release then it does not go in front of the parole board. It's just the Secretary of Corrections who makes that decision, whether the patient is released or not. And if he makes that decision, then he's released based on the Secretary of Corrections' decision. For compassionate release, I find out at what level he was denied at, but I don't get any other information.

My job is to medically make the decision. Of course, from a medical standpoint, I think [a patient] should be able to go. I'm never really aware of what their charges were and I prefer not to, sometimes I have no choice but to know what their charges

were, what their crimes were. But my decision is based on their medical problems, their medical history. Their prison records and everything else, I don't know about any of that and I prefer not to know. So, I mean of course I want them all to leave because I think that but I don't know the whole entire picture about all their other prison records and all that. From a medical standpoint, I do want them to be able to get out and be with their family, but I don't also know what their crimes entailed, what their disciplinary records were and all that.

The patients are seen at outside facilities whether it's oncology, whether it's you know emergency room physicians, whether it's their admitting specialists at the hospital. Generally, they've seen a palliative care provider if they're hospitalized at the hospital where they're being treated. But generally when they're discharged from there, they're discharged with recommendations for end of life care, hospice, palliative care and we take over from there. Every patient that comes to me with end of life care that we admit to Hospice I always do a compassionate release on when their condition is warranted. But every patient I write a compassionate release letter on eventually.

The way I do the process there's nothing I can see that could be changed. We follow the policy and the procedures. I can't think of anything right now that needs to be changed, in my opinion. I mean I may think of something. You know I haven't really thought about the answer to that question.”

**Francis Abbott – Executive Director,  
Louisiana Board of Pardon &  
Committee on Parole**

“Since the legislature enacted the medical parole process and then later expanded in to medical treatment furlough, our Board has worked diligently to provide meaningful opportunities to offenders eligible for these programs. In 2020 our Board worked with Representative Duplessis to amend LA R.S. 15:574.3 and increase the information the DPS&C can provide for all parole hearings to include “physical, mental or psychiatric condition of the offender”. We employ evidence based practices in all of our decision making processes. As the State’s sole discretionary releasing authority, we strive to expand our knowledge base by seeking training from various medical and mental health professionals bi-annually and incorporate those topics in to our operations every day. In addition to the standard factors our Board considers, the medical staff of the DPS&C provide a great deal of information including video documentation of an offender’s condition in advance of hearings. Also on the day of the hearing a medical professional from the housing facility is present to answer questions from our Board Members. Our Board is committed to addressing the needs of offenders with medical and mental health ailments within the confines of the law.”

### **Formerly Incarcerated People**

***Checo Yancy, HR 51 Task Force Vice Chair and formerly incarcerated at Louisiana State Penitentiary where he co-founded the hospice program***

“I was sentenced to a life sentence at Angola. My third job there was to be a librarian. I enjoyed learning the law and working a little bit on my case. It gave me an opportunity to be in the law library for

eight to ten hours a day, if I wanted to. I got a chance to go out and I was assigned to the hospital. I learned a lot about people being sick and it was just unbelievable how they treated people that got sick. The hospital really caught my attention because when someone gets sick and close to dying, they would put them in a room by themselves. [They would leave them] in a cold room in a bed, hook the tubes up, and they would leave them in a cold room by themselves. I was like wow, I pray and hope that I never get sick and die in this place, because when you think about it nobody wants to die alone. And there was no button to touch like they do in a regular hospital room where you have something to bring the nurse in. There was none of that. This person is just laying in that room by themselves. It was just heartbreaking to me.

Sometimes the other inmate counsel would come over to the hospital because they wanted to see their clients and work on their cases. That's how I learned about medical parole and compassionate release. I read up about the law, the regulations and DOC policy, who qualified and who didn't qualify, and what the steps were. I can remember many guys who I worked on their case, and I was the inmate counsel who was assigned to the hospital, so it was my job to type up the paperwork, type up the form or the motion and forward it. The nurse would sign off on it, Dr. Barnes would sign off on it, the medical director of the hospital would sign off on it, and then it was forwarded to the warden and the warden would sign off on it. Then it went to headquarters and if it was approved that person actually got out.

There was a few, there wasn't that many [people who got out] because you had to really be sick sick sick. And the family had to agree that they could take care of you.

Then there was another part of it, where if someone wanted their loved one out and if you got that far, then they would send a person from probation and parole out to your house to find out if you could actually take care of this person that's coming home to you. Which meant 24 hours service, someone's always got to be home, did you have a hospital bed, were you able to have an ADA toilet and shower and bathe that person. And if we were able to do that and hook them up with Medicare, then they would cover all those things. But a person had to actually prove that they could take care of that person, and all those components were in place.

I would say over the years that I was there and did medical parole, I may have been successful on maybe 10 cases. And I saw some guys who we didn't get it done fast enough and they transitioned to death. We didn't make it. It was heartbreaking.

Then Norris [Henderson], myself, and some other guys started a hospice program. We were trained by the Louisiana Department of Health, the feds, and the nurses came in and trained a group of guys how to be hospice volunteers. We learned how to do that: How to sit with someone and how to feed that person. I learned how to do petitions, walk them through to the nurse, a lot of them were denied, some were granted, and some people died there. After that we actually started up a burial committee, because people were dying alone and being put in a hole. We started with our organization - Norris, myself, and some other guys - we started the burial crew. So all of that really worked together -- There were inmate ministers in prison, so we asked the inmate prisoners, would they agree to come out and officiate the funeral just like you would do on the outside. Although you were buried on the inside, we wanted to do it

with dignity.

The DOC has to recognize and notify people that that person is continued for compassionate release or medical parole. Sometimes he's going right back into the same neighborhood where the incident happened. Sometimes you can't go back to the same community where you came from. You have to do a notification that the person is coming back to the neighborhood. I think it's very important to ask that family if they want that person out.

I do this work because I know what it's like to be in prison, be released, and nobody cares. The work that we're doing putting this committee together, I understand what it is to get all components. Everyone [should be] going on the same regulation. Why is it at Hunt they're doing it one way, at Angola they're doing it another way, at Wade they're doing it another way, at Washington Parish you're doing it another way, and at Raymond Laborde they're doing that different? If you have a DOC regulation, why not have a form where everyone checks the same box? Everyone [should be] playing by the same set of rules. Everyone should have the same form so all the institutions are working from the same game plan."

***Johnny Thompson, Task Force Member and a formerly incarcerated person who worked in prison healthcare at the Louisiana State Penitentiary***

"During COVID, they closed some of the facilities down and they only treated people with serious illnesses. If they showed the physical signs of anything, they would give them 2 tylenols in there and set

up an appointment for them 1-2 months away. That's one of the reasons I became a dorm representative for the elderly. It was something else. My job assignment was healthcare - I would take them to the shower, assist them, hold them by the arm, push their wheelchair.

Our biggest concern was the elderly inmates during COVID. There was not any space for social distancing, because there were 86 men in the dorm. They were assigning the older guys to bottom bunks. A few guys got sick and they were sent to Camp J, which is where people who had COVID were sent for 14 days. At one time Camp J was a disciplinary camp, like if you were caught fighting. It's messed up.

The only way they were getting released is if they were on parole. They don't consider age or medical concerns at all, especially if their crime is serious. They did not care about age. I know a lot of people who were trying to go through the compassionate release process but they all just gave up. A lot of them went to the parole office and were told to come back in 5 years.

I've seen a few guys die - usually of a heart attack or stroke. It was hard for them to get preventative care because they were not going to bother with you unless had a serious illness. You had to show some serious signs of suffering."

***Family Members of Currently or Formerly Incarcerated People***

***Janice Parker, mother of currently incarcerated patient***

"It's been a long journey. My son was injured in 2010 playing football. He was hit during one of the plays, and he went down

and he never was able to regain his strength. He was admitted at UMC and diagnosed as a quadriplegic, paralyzed from the neck down. He stayed at UMC from February until April 2010. He was granted compassionate release and stayed in two outside facilities until October 2011.

My son was sent to Angola on October 17, 2011, supposedly due to a revocation of his compassionate release. My son has no idea why it was revoked and neither do I, to this day. We are still trying to work on getting him out, but for some reason the Department of Corrections still hasn't granted him medical parole. We don't know why.

Since he has been back at Angola, he has been having a lot of different health issues. He's been having issues with infections, weight loss, and now he is having issues with his suprapubic catheter. There is always something going on with the catheter and it gets changed every week or even more frequently. I'm not a medical professional, but I've never heard of this frequency of changing a catheter. I know when his catheter is acting up and he is in pain. It's horrible. They did a CAT scan on him 2 weeks ago, but we haven't heard anything. It's hard to talk to the doctors to know what is going on with him since there is no one I can talk to and I am not there with him.

He is bedbound and he needs medical care 24 hours a day. The orderlies do their best to help him but they are not trained to deal with a quadriplegic. I really hope my son can get out since there are no follow-ups, no therapy, nobody to speak with him about the mental aspects of his suffering. He is trying to deal with this on his own. He says "I'm tired" and he is not sure if he can make it another month. I have to hear his stories and I can't even get there to

help him. I'm here, he's there. Even if the visitation is open, which it hasn't been for three years due to COVID, I still have to leave him there in his condition. In spite of him being in prison for what he did, he is still a human being that got hurt. They are playing some type of game to let him out and they revoked his compassionate release. To this day, we do not know why he is back there. What did he do to get his compassionate release revoked? He can't even move! He can't even knock over a flower vase. I don't know his doctor, and I don't know if his doctor is checking on him.

I am so concerned for his safety, especially with the COVID outbreaks, staffing shortages, and lack of security. He is defenseless. When I call they always say everything is okay with him but he could be half dead.

It is confusing to apply for medical parole because the policies change. I am so glad my son has his state of mind, and I am so glad he is able to communicate with me because I know he won't lie to me like they will. I know they will lie to me.

It is so hard to talk to anyone about what is going on and to get some paperwork, something simple, and it's like everybody looks like they are on the chain together, and they can't break it. I would wish this on nobody. It has been ten years of this, and it's just so much. His medical care is very poor."

***Mary Smith-Moore, Task Force Member and sister of formerly incarcerated patient***

"Most families don't know about this [medical parole]. They don't know how to call anyone or find an advocate. As soon as

a family member's health starts to fail, and if they have comorbidities or something that could potentially cause death, the families need to be mailed this information from the prison system that these options are available to that particular inmate. Not everyone has someone there to speak for them or an attorney. I think the prison system needs to take some initiative to make sure they get everything they're deserving. If this is something they can do to go home, they need to make that available to them and their families."

***Elrico and Heather Alex, brother and sister-in-law of incarcerated patient***

"It started sometime in June. He went into the hospital on June 18th. He stopped calling, and when he stopped calling we didn't know what was going on. I started calling DCI to find out about him and I got the runaround. At the end of July or beginning of August, we found out he was in the hospital. But we didn't get any phone call or anything. I just kept calling the DCI [Dixon Correctional Institute] nurse and she would tell me how he was doing and what the hospital reported. Then the doctors at the hospital started calling Elrico. We got more information from the doctors than from DCI. I left messages for different wardens to call, and nobody ever called. We got one phone call from him in the hospital, and that was it.

In October we got to start spending time with him. He got [compassionate] release on October 21st. He stayed out for 5 weeks, when we got to spend time with him. He was in his own room. During the week we could call him and FaceTime, and on the weekends we could go spend the weekend with him. While he was in the room, he got a probation and parole

officer. She came in and told him where he could live, he couldn't live in Lafayette or Acadiana or Vermillion Parish. Also during that time in the 5 weeks, a probation officer in New Iberia came here and made sure he had a room to live in at our house.

On November 24th my phone rang and it was him. He looked like he wanted to cry. He said someone was there to put shackles on him again. I could hear the man in the back saying 'Call DCI, call DCI, call DCI.' They just didn't want to tell us that [his compassionate release] was revoked. He was probably a little better and so he could go back to jail. They say that his probation got revoked because he was too close to his victim's home – The distance was too close from our address. All of this was on Thanksgiving Eve. We were on our way over there to spend it with him. Then he called to say he was being shackled up.

We were told that he was going to stay in the hospital at Angola. Then he called again saying that they had put him back in the jail. We were told once that he couldn't be around anyone with infections because any infections would kill him. He couldn't even go back in the hospital or the jail because of the infections in the jail. And now he's back with the other inmates. He's not in the infirmary anymore.

There should be better communication with the family. The system is very messed up. People make mistakes in their life. They end up in prison behind mistakes. He is a good person, he just made a mistake. I just don't understand when a person is incarcerated and sick, why wouldn't they give them the proper care they should have. At least communicate with the family and let them know what's going on."



***Eloise Smith, sister of incarcerated patient***

“He’s having issues with his leg and his foot, and he had to wait 9 months to have surgery on it. He has a really bad limp now. He’s on blood thinners and medicine for cholesterol. Last year he went up for clemency but they denied him on his previous record. His previous record was from when he was younger, in his teens or twenties. That shouldn’t have had nothing to do with why he’s still in there. I’ve raised so many questions and I don’t get answers. I don’t even know who to talk to. I tried to get a hold of the warden there, and it’s like pulling teeth.”

***James Stevens, brother of previously incarcerated person***

“We went through Tulane Law Clinic and they got her out through medical parole, not compassionate release. She did not have health problems when she entered LCIW, but developed nasal cancer, lymphoma. The cancer started in her sinuses, moved through two lymph nodes, and it had already spread to her entire body. It took her ten to eleven months before they actually did something. It takes them a very long time for them to do anything. I feel like this could have gotten caught way earlier. She was writing to the medical bay for months and nothing came about it. I do understand that COVID was raging and all that good stuff. I mean if someone is complaining of serious symptoms, that should be addressed.”

**Individuals Involved in Medical Release Efforts in Louisiana**

***Matthew Foster, Task Force Member***

***and an attorney representing a currently incarcerated patient***

“I became first involved with my client’s case in 2019. His mother found my name on the bar association website and explained that her son was paralyzed from the neck down and living at the Louisiana State Penitentiary. He had been injured in a football accident in 2010 and since then he has been paralyzed and completely immobile. He needs complete and total care over all his tasks of daily living – eating, going to the bathroom, being rolled over so he doesn’t get bed sores. He also has several other health conditions, including diabetes.

I immediately recognized his continued imprisonment as unjust and I wasn’t sure there was anything I could do. After a little research, I discovered that this client was a perfect candidate for release under the State’s recently passed medical furlough law. I offered to reach out to those at LSP who could initiate the process, naively assuming that once the right people knew the situation my client was in, it would just be a matter of getting the right paperwork completed so that he could be transferred somewhere appropriate.

I first reached out to the then-medical director at LSP, Dr. Lavespere. He agreed that my client met the medical criteria for release. The medical staff at LSP drafted a recommendation for medical furlough and sent it to the Department of Public Safety and Corrections. I reviewed it and thought it looked great. For reasons that I still don’t know to this date, Secretary LeBlanc declined to forward the recommendation to the parole board.

Another recommendation for medical furlough was made on my client’s behalf in late 2020, which was again denied for non-

medical reasons in 2021, this time by the LSP warden. What is most frustrating about these recommendation denials is that they are done without explanation. It is deeply troubling that medically-eligible inmates can be denied furlough or parole for non-medical reasons without explanation and without opportunity to present their case to the medical parole board.

I've been told different things when I've tried to reach out to the Department of Corrections to find out why my client's recommendations have never been forwarded to the medical parole board. I've been told that there have been behavioral concerns, that there was something to do with his health condition, different things. The client is also unable to get information. It's very frustrating. It is very hard for his mother to understand why he is still there. There's not a good system in place for communication and there is a lack of decision-making transparency.

It is also needlessly confusing to have compassionate release, medical furlough, and medical parole separated into three different schemes. Furthermore, it's very difficult to understand the process and what my involvement as an attorney is. There is no way to be automatically updated on the status of a recommendation for release. It was incumbent upon me to follow up with written requests for information. It was very frustrating. It's also not clear to me what the role of an attorney at a medical parole hearing would be.

The most frustrating thing is that this has nothing to do with his medical condition. There can't be much of a dispute that he's medically eligible. The current medical parole/furlough statute makes clear that

risk to public safety is the paramount non-medical concern. La. R.S. 15:574.20 (D)(1) ("In the assessment of risk, emphasis shall be given to the offender's medical condition and how this relates to his overall risk to society"); (E) ("The committee on parole shall determine the risk to public safety and shall grant medical parole or medical treatment furlough only after determining that the offender does not pose a threat to public safety"). The notion that a quadriplegic receiving round-the-clock nursing care would pose a risk to public safety is absurd, which I assume is the reason his recommendation has never been put before the medical parole board. There must be something else but I don't know what the reason is. This lack of transparency is a major problem that should be addressed. If DOC medical staff identifies an offender that is eligible, it should be the sole job of the medical parole board to make a final determination as to public risk. This would guard against recommendations being declined arbitrarily and capriciously, and also guarantee that medically eligible offenders (and their counsel) have some participation and are apprised of the reasons for any denial of release."

***Zoe Reier, administrative assistant at the Promise of Justice Initiative***

"I talked to hundreds of incarcerated people and their loved ones who were hoping to spend their final days with their families. I spoke to terminally ill patients, people with paralysis and other serious physical disabilities, many of whom had spent decades in prison already. We worked with a large team of doctors and medical volunteers, who screened these patients and wrote letters to DOC on their behalf, but we still weren't able to



see anyone released as a result of this process.

We applied on behalf of dozens of people who were not receiving proper medical treatment in custody, and were often seriously ill and near the end of their lives. None of them were granted compassionate release or medical parole. I hope to see this process revised as a result of the HR51 legislation, so that we can find a way for them to live out the rest of their days with those they love, beyond prison walls.”

## **Survivors of Crime**

### ***Rose Preston, appointee from Louisiana Survivors for Reform***

“It is understandable that crime survivors would have reservations about an inmate’s medical release from prison. It is helpful to know that such releases are rigorously examined and involve strict criteria, and is only for inmates who are typically in the final phase of their life, or have a serious debilitating illness. This means that many factors are carefully considered, such as the inmate’s record, how much time they have served, what parole supervision will be in place, where they will be located - and of course notification to crime survivors, plus safeguards that prevent the inmate contacting the crime survivors (unless a program such as Restorative Justice is being utilized, which can be of great assistance to survivors). Currently, only a minuscule amount receive such medical releases (0.2% of the prison population, or about 15 prisoners a year over the past 15+ years), despite many more being eligible. Medical release helps to lessen the burden on prison medical staff and their systems for dealing with sick

inmates, thereby opening access for other prisoners. A related and salient aspect is that this greatly reduces financial burdens on a prison system that is always straining to meet basic health guidelines - because those seeking medical releases are those whose needs most tax the prison health system. It is striking that Medicaid funds are denied for those incarcerated, but are allowed for those on medical release - in 2020, these costs for potentially eligible inmates (who likely won’t pose a threat to the community if released) amounted to just under \$100 million, costs the various prisons had to absorb. For these reasons, I support medical release.

Many of the current practices seem to be in critical need of an overhaul, especially given the inconsistency of differing criteria that various prisons employ, some of which seem arbitrarily decided. A streamlined, standardized state system is thus clearly needed, with set deadlines for the various junctures involved, such as screening and referrals, or appeals - and also including timely notifications for crime victims/survivors. Another issue is that splitting the medical release between three types (compassionate release, medical release and medical treatment furlough) seems unnecessarily cumbersome and confusing. It is also clear that there must be better communication between levels of medical staff and correctional personnel, and that the process be transparent and documented, and to allow patient advocates and families to initiate the process. It’s unconscionable that no explanation is provided for denying or revoking medical release, and this should not be allowed to perpetuate. There are many proposals carefully thought out in this Task Force’s report that involve timely, ethical solutions. Including this Task Force to help oversee this process

can be a way to bring some oversight and parity, by involving formerly incarcerated inmates, while also keeping the needs of crime survivors in view.”

# House Resolution 51 Task Force Members

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Chair: Dr. Anjali Niyogi, M.D., MPH

Co-Chair: Checo Yancy, VOTE

Secretary: Nishi Kumar, Promise of Justice Initiative

Rep. Edward "Ted" James, LA House of Representatives

Rep. Barry Bagley of LA House of Representatives

Rep. Royce Duplessis of LA House of Representatives

Dr. Randy Lavespere, Department of Public Safety and Corrections

Stacye Rodriguez, Department of Public Safety and Corrections

Karissa Page, Louisiana Department of Health, Bureau of Health Services  
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Melissa Mendoza, Louisiana Department of Health, Office of Public Health

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# House Resolution 51

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