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Assessing Medical Systems for the CA Prison Health Care Receivership:
QUALITY ASSESSMENT AND OVERSIGHT
July 1, 2024

I. BACKGROUND AND INTRODUCTION

Ia. This report

In December 2017, the California Prison Health Care Receivership Corporation (CPR) engaged Dr. Brie Williams and her Amend at UCSF program (previously the Criminal Justice & Health Program at UCSF) to conduct an independent assessment of specified California Correctional Health Care Services (CCHCS) medical systems and processes with the goals of:

- Assessing whether those CCHCS systems conform to community standard policy and practice in federal and/or California state ("community") integrated healthcare systems; and
- Developing recommendations to optimize those CCHCS systems in view of our findings

The project called for an assessment of four systems:

1) CCHCS mortality review policy and practice
2) CCHCS systems for recruiting and maintaining a qualified workforce (including peer review systems)
3) CCHCS patient safety program
4) Community and correctional approaches to quality assessment and oversight

Reports on the first three systems have been completed. In creating these reports, our approach was to establish community standards for each project based on reviews of multiple community integrated healthcare systems and to issue evidence-based policy and practice recommendations consistent with CCHCS's specific needs and constraints. **This report describes the last of the four items above, a comparative analysis of community and correctional approaches to healthcare quality assessment and oversight.**

Work on this report began in the summer of 2019 and the initial focus was to analyze the methods of quality evaluation utilized by the Office of Inspector General's (OIG) Medical Inspection Unit, compare these methods to community approaches to quality evaluation, and then make recommendations for how to strengthen oversight and quality assessment within CCHCS. In early 2020, this report was put on hold as CPR requested that Amend at UCSF shift to supporting CCHCS's response to COVID-19 (our report on COVID-19 in the California state prison system—and our other reports--can be found at https://cchcs.ca.gov/reports). Upon resumption of our work on this report in 2022, CPR requested a shift in the report's focus with the goal of drawing upon lessons from community and correctional healthcare settings to provide an analysis of two foundational questions:

1) How should healthcare quality be assessed in California state prisons?
2) How might external approaches to healthcare system oversight be used to inform plans for healthcare oversight following conclusion of the federal receivership?

Given the critical importance and breadth of these questions, this report should be considered a scoping review that describes the current landscape relevant to these two questions, makes a number of specific recommendations (summarized in Appendix A), and lays the foundation for subsequent investigation into remaining unanswered questions that are of vital importance as CCHCS creates a path to

emerge from federal receivership in a manner that builds upon and maintains the successes achieved in healthcare oversight over the past 18 years.

In contrast to prior Amend at UCSF reports, this report does not focus on current CCHCS (or OIG) processes and therefore does not directly compare CCHCS and community standards. Instead, we summarize the community landscape for healthcare quality assessment in the United States and describe how other U.S. correctional health systems are subject to oversight. Our overarching goal, however, remains the same as other reports – we aim to highlight best practices that are ripe for adoption within CCHCS. In doing so, we hope to aid CCHCS's ongoing advancement toward what we have termed a "**healthy healthcare system**," which we define as one that is self-examining, highly responsive to evolving community standards, and rooted in a systems-driven culture of patient safety, quality improvement, and ongoing learning. This definition is derived from the Institute of Medicine's seminal report on healthcare quality, *Crossing the Quality Chasm*,[1] which defines quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".

The recommendations in this report are based on the following activities:

- Review of relevant literature on healthcare quality assessment and oversight
- Analysis of quality assessment, compliance, accreditation, and oversight programs in community and correctional healthcare settings
- Stakeholder and key informant interviews

Ib. Intended audience

This report is intended for a broad audience. While many of the recommendations contained in the report could be directly adopted and implemented by CPR and CCHCS, there are many stakeholders in the prison healthcare system who have roles in the evaluation of healthcare quality or who may play a role in healthcare funding or oversight following the conclusion of the federal receivership. These external stakeholders—including advocacy groups, patient advisory councils, practicing healthcare professionals, lawmakers, academics, and attorneys—are also among the intended audiences of this report.

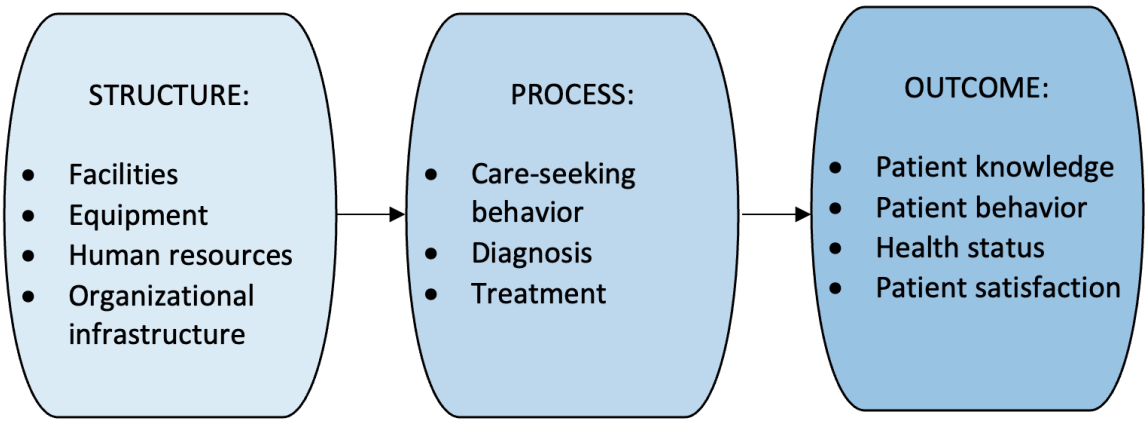
Ic. A framework for healthcare quality assessment: the Donabedian Model

The Donabedian model is the most widely accepted framework for assessing healthcare quality today. First proposed in 1966 and updated in 1988, Dr. Avedis Donabedian's model divides quality into three components: structure, processes, and outcomes (**Figure 1**).[2,3] *Structure* focuses on the settings in which healthcare is delivered, the qualifications of the healthcare workforce, and the organizational and administrative structures through which care is delivered. *Processes* comprise the components of care that are delivered (what diagnoses are made and what treatments are offered), as well as access to care and care seeking behaviors of patients. *Outcome*s include health status (e.g., mortality, hospitalization, disability, and rates of diseases and complications) as well as patient knowledge, behavior, and satisfaction.

Delivering high-quality healthcare requires attention to all three components and their individual elements. In evaluating these elements, Dr. Donabedian defined seven pillars

of quality to guide assessment.[4] These pillars were later modified to become the Institute of Medicine's six core aims of quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[1]

Figure 1. The Donabedian model: overview



This model, rooted in the core aim of establishing quality in healthcare, can be used to frame an approach to evaluation. For example, when considering the human resources within the structure of a healthcare system, one can ground the quality analysis in determining if the qualifications of healthcare personnel are sufficient to deliver care that is safe, effective, patient-centered, timely, efficient, and equitable. These qualifications alone, of course, are not sufficient to deliver high-quality care. Healthcare personnel must work with the appropriate equipment and within a supportive organizational infrastructure (e.g., other components of "structure") to ensure quality care. Furthermore, their patients must have sufficient knowledge and means to access care and—when doing so—healthcare professionals must make the correct diagnoses and offer evidence-based and patient-centered treatment (e.g., "process"). The process of care should not only maximize improvements in patient health status, but high-quality care must also account for patient satisfaction and empowerment through education and motivation for behavioral change if necessary (e.g., "outcome"). Of particular importance is how all three components are interdependent and how outcomes based on health status—while vital—present an incomplete picture of healthcare quality. A population with excellent health outcomes, for example, may not necessarily be receiving high-quality care if those outcomes are due to factors outside of the control of the healthcare system (such as genetic or environmental factors) or if the receipt of healthcare leaves these patients with poor knowledge of their own health or dissatisfaction with their healthcare providers.

The Donabedian model is not without criticism, and Dr. Donabedian himself acknowledged that his framework was open to reinterpretation and revision. Primary among the critiques of the Donabedian model is that it defines healthcare too narrowly by emphasizing healthcare delivery and deprioritizing social determinants of health which have been shown to strongly influence health outcomes.[5] Foundational to this critique is the concern that processes of healthcare may not lead to favorable health outcomes because of a failure to account for antecedent factors that influence outcomes such as genetics, socio-economic factors, health habits, beliefs, and preferences. The authors of this critique still favor the Donabedian structure-process-outcome model for assessing

quality but argue for focusing more on outcomes-based measures (over structure and process) and for risk-adjusting outcomes measures based on antecedent risk factors.

Despite these modest criticisms, we recommend using the Donabedian model as the framework for evaluating and analyzing quality assessment in California prisons. This is the most widely utilized framework in community healthcare settings and its adoption will ensure healthcare delivered to residents of California prisons is measured in line with community standards for quality assessment. Given that some unique challenges and opportunities in providing healthcare within prisons differ from community settings, we have identified instances in which antecedent risk factors or unique circumstances must be taken into account when using this approach to healthcare quality assessment.

Recommendation: The Donabedian model is an ideal framework from which to approach quality assessment in California prisons.

Id. An approach to healthcare oversight in correctional settings

In contrast to the widespread adoption of the Donabedian model for evaluating healthcare quality, there is no consensus on how to approach oversight of healthcare delivery in correctional settings, nor is there federal legislation informing such oversight. Currently, oversight of medical care in California prisons is governed by a court-appointed federal receiver, following a 2005 ruling in the longstanding case *Plata v. Schwarzenegger* (now *Plata v. Newsom*).[6] Mental healthcare oversight is conducted separately by a court-appointed special master following a separate lawsuit, *Coleman v. Wilson* (now *Coleman v. Newsom*) and disability accommodations are under the purview of a third case (*Armstrong v. Newsom*).[7]

This report is asked to envision what a healthcare oversight board could look like in California following the eventual conclusion of the receivership. While this topic is explored in section IV, readers should know that we envision an oversight board that is:

- independent from both the state prison system and political influence;
- collaborative and constructive in its work with the state prison system;
- comprised of a multidisciplinary group of healthcare professionals, as well as patient/inmate advocacy groups;
- able to enforce changes in healthcare delivery when care is found to be substandard.

II. QUALITY ASSESSMENT

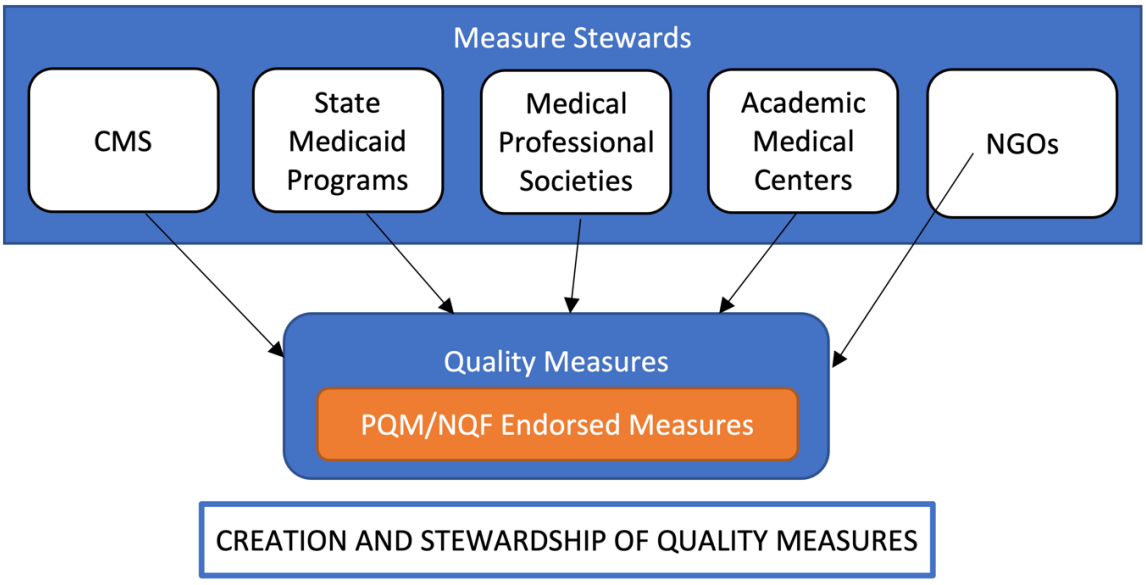
IIa. Introduction

Numerous governmental and non-governmental community organizations have created measures for assessing myriad aspects of healthcare quality in various settings. These measures are often organized around the structure-process-outcomes framework of the Donabedian Model. The most influential organizations creating these measures are key healthcare stakeholders such as the Centers for Medicare and Medicaid Services (CMS), Medicaid programs at the state level (e.g. Medi-Cal in California), medical professional societies, academic medical centers, and various healthcare related NGOs such as the Joint Commission and the National Committee for Quality Assurance (NQCA). These organizations create quality measures (e.g. the percentage of patients with diabetes and a hemoglobin a1c <8.0%) and then define the numerator and denominator of the measure, specifying which patients should be included and excluded from the measure. The organizations, called "measure stewards", also periodically review, update, or remove their measure(s) depending on the current medical understanding of quality healthcare for target populations.

This section will describe the measures as a way to quantify healthcare quality, while Section III of this report will detail how these measures are used in the healthcare landscape (e.g. for accreditation, reimbursement, etc.).

Batelle—a private non-profit organization focusing on defining and promoting healthcare quality under contract to the federal government—currently oversees the Partnership for Quality Measures (PQM) which serves as the clearing house for quality measures from over 130 diverse measure stewards.[8] Until March 2023, this work was done by the National Quality Forum (NQF).[9,10] Principal among its activities, PQM (and, previously, the NQF) reviews and endorses a subset of the thousands of healthcare quality measures in circulation through periodic review and an ad hoc process (**Figure 2**).

Figure 2. Quality measure and endorsement process

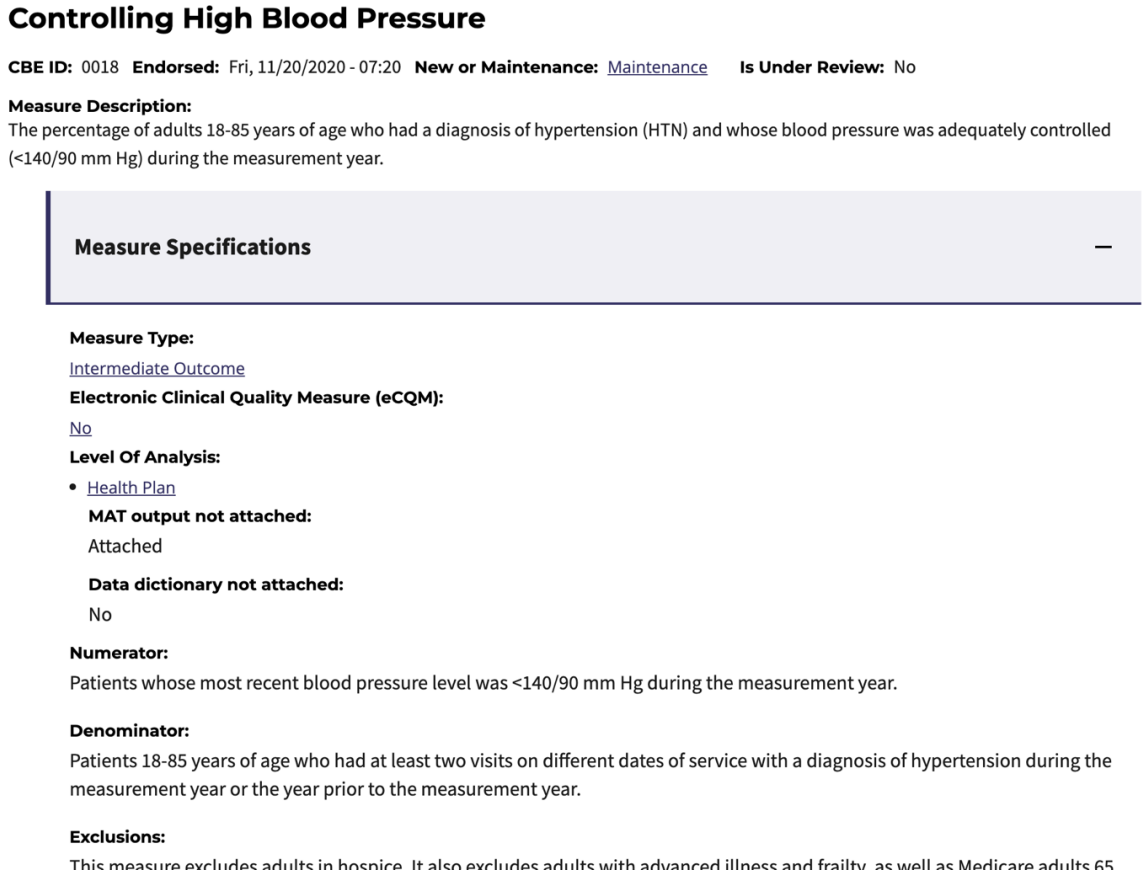


Endorsement entails review and consensus-based decision making among multiple relevant stakeholders involved in healthcare from both the public and private sector. Traditionally, endorsement focuses on measures meeting the following criteria:[11]

- ***Important to measure*** *and report to keep a focus on priority areas, where the evidence is highest that measurement can have a positive impact on healthcare quality.*
- ***Scientifically acceptable****, so that the measure when implemented will produce consistent (reliable) and credible (valid) results about the quality of care.*
- ***Useable and relevant*** *to ensure that intended users — consumers, purchasers, providers, and policy makers — can understand the results of the measures and are likely to find them useful for quality improvement and decision-making.*
- ***Feasible to collect*** *with data that can be readily available for measurement and retrievable without undue burden.*

PQM compiles a searchable web-based list of both endorsed and unendorsed measures and relevant details (numerator, denominator, risk adjustment, associated medical condition, care setting, history of review/endorsement, and measure steward). Measures can also be sorted by clinical conditions, National Quality Strategy priorities, target population, and use (**Figure 3**): https://p4qm.org/measures

Figure 3. Screenshot of quality measure from Partnership for Quality Measurement website



Controlling High Blood Pressure

CBE ID: 0018 **Endorsed:** Fri, 11/20/2020 - 07:20 **New or Maintenance:** Maintenance **Is Under Review:** No

Measure Description:
The percentage of adults 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Measure Specifications –

Measure Type:
Intermediate Outcome
Electronic Clinical Quality Measure (eCQM):
No
Level Of Analysis:
- Health Plan

MAT output not attached:
Attached

Data dictionary not attached:
No

Numerator:
Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

Denominator:
Patients 18-85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.

Exclusions:
This measure excludes adults in hospice. It also excludes adults with advanced illness and frailty, as well as Medicare adults 65

Notably, PQM does not set a benchmark of "quality" for each measure (or incentives related to any benchmark), but other organizations may use the measures in this way (potential uses are described next to each measure on the PQM website). As of April 2024, PQM listed 1,215 quality measures, among which 379 were endorsed. Measures may also be sorted based on the Donabedian Model of structure (7 endorsed outcomes), process (162 endorsed outcomes), and outcomes (125 endorsed outcomes). **Most relevant to CCHCS, is the ability to search and sort measures by care setting (ambulatory, inpatient, post-acute, etc.), target population (age, gender, etc.), and the appropriate level of analysis (clinician, facility, health plan, etc.).** While there will never be perfect overlap between endorsed measures and the priorities and healthcare needs of patients under the care of correctional healthcare systems, endorsed measures are high-impact, nationally recognized standards for how to define quality and measure it in a quantifiable and reproducible way.[12]

IIb. Structure

Healthcare structure concerns the facilities, equipment, human resources, and organizational infrastructure necessary to deliver care. Within the Donabedian framework, assessments of healthcare structure are least aligned (compared to process and outcomes measures) with the quality measures on the Partnership for Quality Measurement website, particularly in relation to outpatient medical care. Consequently, a different approach to evaluating the structure of healthcare within CCHCS is needed.

Covered Benefits and Human Resources

As a starting point for approaching the structure of medical care within California prisons, we recommend considering 1) what healthcare benefits are available to prison residents and 2) how easily residents may access these benefits. Benefits may include covered medications, surgeries and procedures, and care from specialist providers and non-physician healthcare professionals such as dentists, physical therapists, psychotherapists, respiratory therapists, and rehabilitation specialists. **To ensure a minimum standard of benefits that is commensurate with community practices, we support aligning the benefits offered to residents of California prisons—at a minimum—with those covered by Medi-Cal, the California Medicaid program. Such an alignment would be particularly important upon the conclusion of the federal receivership when healthcare delivery in state prisons could be under increasing external pressure to limit benefits as a cost saving measure.** While a review of all benefits offered to patients in California prisons is beyond the scope of this report, our impression is there is currently a close but not total alignment in benefits and that both prison health benefits and Medi-Cal benefits are generous when compared to other state programs.

The most direct and beneficial way to bring about this alignment would be by ending the Medicaid Inmate Exclusion Policy (MEIP), which was a provision of the Social Security Amendments of 1965.[13] This provision prevents correctional facilities from receiving federal matching Medicaid funds for the care of prison residents who would otherwise be eligible for Medicaid, unless they are hospitalized or cared for in a medical facility for at least 24 hours (or unless they are within 90 days of release following California's recently approved section 1115 waiver[14]). Eliminating MEIP would incentivize state prison systems to provide medical care through Medicaid, which would ensure eligibility to the

same benefits as the state's Medicaid program, increase funding, and require healthcare provision in prisons to meet the Conditions for Coverage and Conditions of Participation, the health and safety standards which "are the foundation for improving quality and protecting the health and safety of beneficiaries."[15,16]

Unfortunately, completely eliminating MEIP will require federal legislation which is unlikely in the current political climate. A more feasible approach to reform, which has also been advocated by others,[17] would be to align benefits offered to prison residents with those covered by the state Medicaid program. This approach would help codify the importance of access to a minimum package of services that is periodically reviewed and updated by federal and state insurance authorities. Given the unique medical needs and vulnerabilities of the incarcerated population, however, alignment of health coverage with Medi-Cal benefits should be considered a *minimum* standard. **Higher rates of comorbid mental health conditions, substance use disorders, and age-adjusted frailty and medical comorbidities in the incarcerated population,[18,19] would require health officials to conduct periodic reviews to determine which <u>additional</u> benefits should be offered to meet the needs of incarcerated patients, particularly if assessments of care quality identify deficiencies in care due to inadequate benefit coverage.**

While attempting to provide a legal definition of how healthcare in California prisons can meet the constitutional standard established in *Estelle v. Gamble* is beyond the scope of this report, it is important to note that providing a package of benefits that aligns with Medicaid standards would help ensure that incarcerated individuals receive "services at a level reasonably commensurate with modern medical science and a quality acceptable within prudent professional standards" as described in this ruling.[20]

Codifying a set of covered medical benefits, however, is only part of the work of ensuring that the way healthcare is structured facilitates quality care. The Donabedian model draws attention to the need for quality facilities, equipment, human resources, and organizational infrastructure necessary to deliver care. These elements need to be appropriately distributed across the healthcare system (either within CCHCS facilities or through contracts with community healthcare providers) to provide the benefits described above in a timely matter. Regarding human resources, our group prepared a report titled *Assessing Medical Systems for the CA Prison Health Care Receivership: Maintaining a Qualified Provider Workforce* in 2019 which can serve as a blueprint for hiring qualified staff, particularly primary care providers.[21] Section IIIe of this report also describes community approaches to accreditation and certification of healthcare delivery programs that are designed to ensure adequate staffing and may be adopted by CCHCS.

Access to Care

While not all difficulty with access to care may be due to inadequate staffing, **an appropriate surrogate marker of adequate staffing is how easily prison residents can access different types of care such as their primary care team (e.g. nursing triage, routine primary care evaluation, and urgent care), specialty care, diagnostics, dental services, and interpreter services. It is important to remember that adequate staffing also includes sufficient numbers of correctional officers to be able to transport patients to internal and external appointments safely and without inordinate delay. Currently, CCHCS tracks these measures** and reports their

definitions and trends, stratified by institution through an immensely valuable publicly available dashboard of numerous healthcare quality measures which should be continued in this robust form following the conclusion of the receivership.[22,23] Other structural measures of care quality reported on the publicly available version of the dashboard include assessments of staff vacancies and hiring processes as well as daily workloads for PCPs and RNs. Patient experience surveys that may be adopted by CCHCS (such as CAHPS, described in section IIIc) as well as patient advisory councils at each facility can also help healthcare leadership assess access to care on the local level.

Equipment and Facilities

Evaluations of equipment and facilities is ideally undertaken by periodic facility visits from an oversight board (a concept to be discussed in greater detail in later sections). These should include both announced and unannounced visits and both visual inspection of the healthcare environment but also structured confidential interviews with frontline staff and leadership to ensure they have the materials necessary to perform the duties of their job. Site visit inspection tools, such as those used during Joint Commission surveys, could be adapted as a framework for approaching evaluation of the facilities. Patients should also be interviewed confidentially and anonymously regarding the environments in which they receive care, among other structured questions.

Recommendation: The healthcare services offered to residents of California prisons should—at a minimum—align with benefits offered to Medi-Cal beneficiaries. Additional services should be offered based on deficiencies in care identified in other activities described throughout this report.

Recommendation: Evaluations of equipment and facilities is ideally undertaken by periodic facility visits from an oversight board. These visits should be announced and unannounced and should include both visual inspection of the healthcare environment but also structured confidential interviews with frontline staff, leadership, and patients.

IIc. Process and outcomes

Partnership for Quality Measurement (PQM) endorsed measures are particularly enriched with process and outcome measures within the Donabedian model.[10] As of April 2024, there were 1037 structure and outcomes measures, of which 287 were endorsed. Upon our review, there were 103 process measures and 41 outcomes measures that were potentially applicable to CCHS patients as they focused on the care of adults in primarily outpatient settings (**Appendix B**).

We recommend that a committee of quality experts from the oversight board and CCHCS work together every two years to review process and outcome quality measures and determine which measures are most appropriate for adoption. Adopted measures should first focus on the highest priority measures (i.e. those most associated with patient health and wellbeing) that affect the most patients (**Table 1**). Adopted measures should be tracked, improved upon (if necessary), and reported publicly. This committee should include representation from incarcerated patients and/or their representatives. Although PQM endorsed measures should not be the only measures considered for inclusion, we recommend starting with a review of these measures (and HEDIS measures, described in Section IIIb) as they represent the closest list the medical community has to an industry standard of peer reviewed, quantifiable, and reproducible measures that focus on the most important outcomes to patients.[24] Other sources of quality measures tailored to correctional settings—such as those promoted by the National Commission on Correctional Health Care (NCCHC)—will be discussed in Section IV. **CCHCS, the oversight board, and patient representatives should also be encouraged to continue to identify or create their own measures and become measure stewards as gaps in the PQM measures for correctional settings are identified. That said, every opportunity for greater alignment with PQM endorsed measures should be taken and we recommend the committee focus on maximizing the adoption of appropriate measures as opposed to looking for ways to avoid bringing these measures to bear in a correctional setting.**

Table 1. Prioritizing measures for adoption

	Few Patients	Many Patients
Low Impact	Low priority	Intermediate priority
High Impact	Intermediate priority	Top priority

It should be recognized, as well, that CCHCS has already done tremendous work in compiling a robust, publicly available dashboard of quality indicators as described in Section IIb and has also transparently reported near-real time data regarding COVID-19 testing, infections, deaths, and immunizations since the early stages of the pandemic.[22,23,25] The dashboard glossary is similarly modeled to the PQM website with methodologic descriptions of each measure, background information, and internal CCHCS goals on measure performance. Many of the currently adopted measures are PQM endorsed measures (especially those used by the Healthcare Effectiveness Data and Information Set; HEDIS) and many measures—whether PQM endorsed or otherwise—are derived from the CCHCS Quality Management's biennial Performance Improvement Plan which aims to identify priorities for improving care quality across the entire system. In other words, **our call for a committee of multiple stakeholders to periodically review PQM endorsed and other measures for inclusion into the dashboard should focus on adding to the impressive work already being done through the CCHCS dashboard and the Performance Improvement Plan. This committee could meet after CCHCS has drafted the Performance Improvement Plan (but before finalization) and could serve as a collaborative process involving external experts (from the oversight board) and patient representatives to further strengthen the adoption of quality measures and plans for measurement and improvement.** Our hope is that the oversight board—while remaining independent and

beholden solely to the interests of CCHCS patients—would function not in a punitive manner (unless egregious evidence of indifference and lapses in care are found) but instead as an outside group of quality experts who strengthen work already being done by CCHCS.

Finally, it is important to acknowledge work that has already been done in the alignment of quality measures with correctional healthcare as this could be used as a model for approaches in California prisons. In 2011, the RAND Corporation led a series of studies with the aim of identifying quality measures for adoption in California prisons. Their methods and findings could inform how best to periodically review quality measures for inclusion into systems of healthcare quality monitoring in California prisons. Across three publications, researchers identified measures through the following approaches:

1) Review of 1,731 quality indicators for adoption in a prison setting by a panel of academic and non-profit healthcare quality experts using a modified Delphi approach. This review identified 79 high-priority indicators for inclusion. This list, and the modified Delphi method for consensus building, could serve as an strategy for the biennial review of PQM measures.[12]
2) A series of structured interviews with CDCR stakeholders and related offices to identify gaps in care quality to inform measure selection in 2008 and 2009. These interviews identified gaps in measuring patient experience, the death review process, access to care, and select chronic disease management as highest priority at the time.[26]
3) Snowball sampling to identify prison systems outside of California that had taken demonstrable steps toward quality improvement, followed by key informant interviews to identify best practices from peer institutiions.[27]

Recommendation: Whenever applicable, Partnership for Quality Management (PQM) endorsed measures should be adopted by CCHCS for tracking and reporting, particularly high priority measures that apply to large numbers of CCHCS patients.

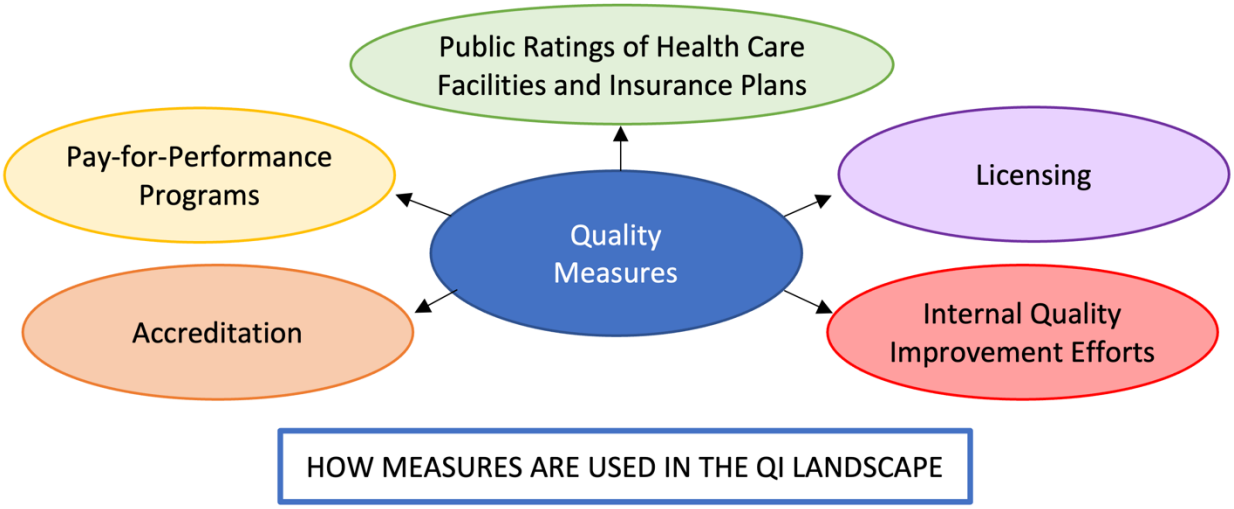
Recommendation: A committee of quality experts from the oversight board and CCHCS should work together every two years—after CCHCS has completed an initial draft of its Performance Improvement Plan—to review process and outcome quality measures and determine which additional measures are most appropriate for adoption.

III. COMMUNITY RATINGS, BENCHMARKS, AND ACCREDITATION

IIIa. Introduction

Quality measures—irrespective of PQM endorsement—are used in myriad community settings. These measures have an impact on community accreditation of healthcare facilities, pay-for-performance programs, publicly reported ratings of facilities or insurance plans, licensing of healthcare facilities, and internal quality improvement efforts (**Figure 4**). It is important to recognize, however, that a simple "cut and paste" approach to applying community quality measures to quality assessment and oversight in corrections is not advisable. Given how different the health needs and oversight considerations are for the California prison population, review of these measures for adoption by CCHCS (and determining how select measures are going to be used in oversight) should be considered a *minimum* standard. Additional work has been done, and will surely need to continue, to determine which additional quality measures will need to be created and how they will influence oversight (as discussed in later section of this report). In this section we give an overview of select community uses of quality measures and highlight the opportunities for strengthening healthcare delivery in California prisons based on these programs.

Figure 4. Measure use in community healthcare settings



IIIb. HEDIS Measures

In the 1990s, the Centers for Medicare and Medicaid Services (CMS) contracted with the National Committee for Quality Assurance (NCQA) to assess the quality of care being delivered to patients in Medicare Advantage plans. NCQA created a set of quality indicators called HEDIS (Healthcare Effectiveness Data and Information Set) measures, which are updated periodically. Many HEDIS measures are also PQM endorsed measures. While Medicare Advantage plans are required to report their HEDIS data to CMS in order to participate in Medicare, many other private insurance plans also use HEDIS measures to track and report their own plan's quality. HEDIS measures are publicly reported with the goals of 1) allowing purchasers and consumers to make reliable comparisons of health plan performance and 2) facilitating plan identification of opportunities for improvement. NCQA reports that over 227 million people in the United

States are enrolled in health plans that report HEDIS data, which is the current industry standard for measuring the performance of health plans.[28] Measures are divided into five categories and the largest category (Effectiveness of Care) has multiple sub-categories centered around common medical conditions (**Table 2**). Multiple measures comprise each category or sub-category and some measures are composite measures that have multiple components.

Table 2. HEDIS Measures 2023*

Category	# of Measures
Effectiveness of Care	52
Prevention and Screening	10
Respiratory Conditions	4
Cardiovascular Conditions	4
Diabetes	4
Musculoskeletal Conditions	1
Behavioral Health	12
Medication Management and Care Coordination	2
Overuse / Appropriateness	9
Measures Collected Through the Medicare Health Outcomes Survey	3
Measures Collected Through the CAHPS Health Plan Survey	3
Access / Availability of Care	5
Utilization	5
Risk Adjusted Utilization	5
Measures Reported Using Electronic Clinical Data Systems	11
TOTAL	**78**

**Some HEDIS measures (e.g. Diabetes Care) are a composite measure comprised of multiple sub-indicators*

HEDIS measures feed into publicly reported data and are a key component of health plan evaluations as described later in this section. The measures, however, are not without limitations. For one, HEDIS measures focus on the management of many common medical conditions, particularly those found in outpatient practice. This makes the measures appealing for adoption across the CCHCS system, but they are not representative of the breadth of care provided to all patients (in fact, CCHCS tracks measures on their dashboard which are well beyond the breadth of HEDIS measures). Second, HEDIS measures focus on the Process portion of the Donabedian model, which is typically not valued as highly by patients as Outcomes measures (which are, admittedly, more difficult to measure). Finally, data collection can be onerous and technically demanding and includes a compliance audit to assure data integrity before public reporting.[29]

While HEDIS measures are not without limitations, they are a ubiquitous and integral part of the quality assessment landscape, individual measures are built upon consensus definitions of care quality, and measures focus largely on outpatient primary care delivery. As such, **we recommend that CCHCS collect, track, and publicly report HEDIS measures for all measures relevant to their patient population. Furthermore, by aligning the collection and reporting of CCHCS measures with community health**

plans, direct comparisons of the quality of care delivered in these two segregated systems will be possible.

Recommendation: All HEDIS measures that are relevant to the CCHCS patient population should be collected, tracked, and reported on the public dashboard as part of the assessment of the quality of care delivered by CCHCS.

IIIc. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Patient assessments of their experiences with healthcare providers, health facilities, and health plans are integral to evaluating the Structure and Outcomes portions of the Donabedian model. Patient (or consumer) assessment is dominated by Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. These surveys—developed by the Agency for Healthcare Research and Quality (AHRQ) and administered by certified vendors—are the industry standard for patient assessments of satisfaction, provider communication, access, and care coordination in various care arenas (**Table 3**).[30]

Table 3. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Types
Patient Experience with Providers
Clinician and Group
Hospice
Home Health Care
Surgical Care
American Indian
Patient Experience with Condition-Specific Care
Cancer Care
Mental Health Care
Enrollee Experience with Health Plan and Related Programs
Health Plan
Dental Plan
Home and Community-Based Services
Patient Experience with Facility-Based Care
Emergency Department
Hospital (Adult and Children)
In-Center Hemodialysis
Nursing Home
Outpatient and Ambulatory Surgery

Some studies have also demonstrated that patient satisfaction on CAHPS surveys is associated with better performance on clinical care measures and patient-reported health status.[31,32] What is not known, however, is how CAHPS surveys will perform in correctional settings. To our knowledge there have been no academic studies of CAHPS surveys among this patient population. **We recommend a pilot period of administering CAHPS surveys across CCHCS, with an initial focus on the Clinician and [medical] Group, Mental Health Care, and Health Plan Surveys at all facilities.** The Hospice Survey, Adult Hospital Survey, and Nursing Home Survey should be piloted at the California Medical Facility, the California Health Care Facility, and the skilled nursing facility at CCWF, respectively. We suspect that CAHPS surveys will give proactive, detailed information on patient experiences that will also allow for comparison to non-correctional settings in a way that the current system of relying on 602 appeals does not. We would recommend the state fund an academic evaluation of the CAHPS survey pilot

described here in order to better understand its impact and limitations. Key health metrics from CAHPS surveys should also be published on the public dashboard.

It is also possible that the CAHPS surveys will ultimately not prove to be a reliable way of understanding patient experiences with healthcare in CCHCS. **We also support CCHCS leadership's existing plans to strengthen and formalize a system to obtain feedback on healthcare delivery from each institution's Inmate Advisory Council (IAC). The IAC could also be tasked with helping to interpret CAHPS survey results and provide feedback on how CCHCS responds to survey findings.**

> **Recommendation:** CCHCS should pilot the use of applicable Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys across prisons and fund an academic study to understand its impact and limitations. Key metrics from CAHPS surveys should be reported on the CCHCS public dashboard.

IIId. California Health Care Quality Report Cards

One of the primary uses of HEDIS measures and CAHPS surveys is to complete report cards for HMO and PPO health plans operating across the United States. While ratings and benchmarks exist at a multitude of levels across the healthcare system (individual provider, medical group, health plan, and care location), we argue that—for the purposes of quality evaluation—California prisons are best evaluated and benchmarked at the level of the health plan. Care delivery in CCHCS is most analogous to an HMO, such as Kaiser Permanente, wherein the health plan is fully integrated with the medical groups caring for plan members.

Figure 5. Kaiser Permanente – Southern California HMO 2022-2023 Report Card

Source: https://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=KAISER_S

We recommend that CCHCS participate in the California Health Care Quality Report Cards program. Health plan report cards in California are created and published by the State of California's Office of the Patient Advocate (OPA) using a methodology developed with input from the non-governmental Integrated Healthcare Association's (IHA) Technical Measurement Committee.[33,34] Scorecards use a subset of HEDIS measures that are applicable to HMO and PPO plans, CAHPS data, and data from the IHA's quality reporting program called AMP (Align. Measure. Perform.).[35] Grading (based on a 1 to 5 star rating system) for each aspect of care is benchmarked to

the percentile score of HMOs or PPOs across the county who report identical HEDIS and CAHPS data. Scores are excluded in domains that do not have sufficient data points from the health plan. Report cards are released annually (**Figure 5**).

There are numerous benefits to participating in the report card system and to reporting healthcare quality data from CCHCS that is identical to publicly reported health plan data outside of corrections (particularly if data are collected using the same rigorous methodology and benchmarked to national outcomes). Such reporting would further break down the artificial barriers that exist between correctional and community health systems in the United States and would help hold California prisons to recognized standards as opposed to looking for ways in which the systems cannot be compared to each other.

As described previously, CCHCS already collects and tracks an impressive amount of patient-level quality data (some of which are HEDIS measures) and further alignment with community measures should not lead to a reduction in tracking other measures which CCHCS has already deemed to be important internally. Instead, wherever possible, measures should be added to align with community measures (such as the HEDIS, CAHPS, and AMP measures) in order to facilitate benchmarking with community healthcare delivery.

The main detriment to collecting HEDIS measures, administering CAHPS survey data, and participating in Health Care Quality Report Cards is financial. While determining the cost of an approach that relies on audited HEDIS measures and independently collected CAHPS data is beyond the scope of this report, **we encourage stakeholders to adequately fund a program that relies on the same methodology as community systems so as to ensure data integrity and facilitate comparisons between the two.**

We would be remiss to not mention some of the many additional programs that rate and compare quality of care across the United States that were also considered for recommendation (and may ultimately prove to be suitable for adoption by CCHCS). These include the following:

- CMS Care Compare[36]: Similar to the California Health Care Quality Report Cards, CMS provides publicly reported data rating (on a five star scale) of healthcare at various levels (hospitals, nursing homes, hospice care, inpatient rehabilitation, dialysis facilities, etc.). CCHCS participation would be challenging as much of the underlying data is abstracted through participation in Medicaid and Medicare. Furthermore, ratings do not provide detailed information on outpatient care.
- CMS Hospital Outpatient Quality Reporting[37]: This program, which is tied into incentive payments from Medicare and Medicaid, focuses on ED visits, observation services, and outpatient surgical services.
- CMS Health Insurance Exchange Quality Rating System (QRS)[38]: This federal program rates health plans as a condition for participation in state-based health insurance marketplaces established under the Affordable Care Act and is the basis for California's Health Care Quality Report Cards (reported data are divided into categories of medical care, member experience, and plan administration with ratings on a 1 to 5 star scale). We favor participation in California's version of QRS to facilitate comparisons to health plans within the state. The main difference

between this program and the California program is that star ratings are only available when registering for a plan during open enrollment and more of the underlying data are accessible through the California program, thus increasing transparency.

- Leapfrog Group[39]: A leading independent patient safety and quality evaluation group, the Leapfrog Group is best tailored to evaluating hospitals and ambulatory surgery centers.

Recommendation: CCHCS should collect HEDIS data and CAHPS survey data in order to facilitate participation in the California Health Care Quality Report Cards.

Recommendation: Stakeholders should ensure that CCHCS has both adequate funding and positive incentives to collect and report HEDIS and CAHPS data using the same standards required of community health plans.

IIIe. Patient-Centered Medical Home (PCMH) Recognition

While HEDIS measures and the California Health Care Quality Report Cards evaluate care at the level of the health plan, the Patient-Centered Medical Home (PCMH) recognition program evaluates primary care practices and their ability to commit to continuous quality improvement while providing comprehensive care focused on the needs of the patient.[40] The two primary agencies that award PCMH recognition or certification are the National Committee for Quality Assurance (NCQA) and the Joint Commission.

NCQA Patient-Centered Medical Home (PCMH) Recognition

The National Committee for Quality Assurance (NCQA) oversees PCMH practice recognition and has thus far recognized over 10,000 practices. PCMH recognition is tied to financial incentives from some insurers but is also the most widely recognized independent marker of quality practice-based primary care, making it a suitable community benchmark for adoption by CCHCS at the level of the institution. Furthermore, NCQA cites multiple independent studies associating PCMH recognition with improved care quality, reduced costs, and increased staff and patient statisfaction.[41,42]

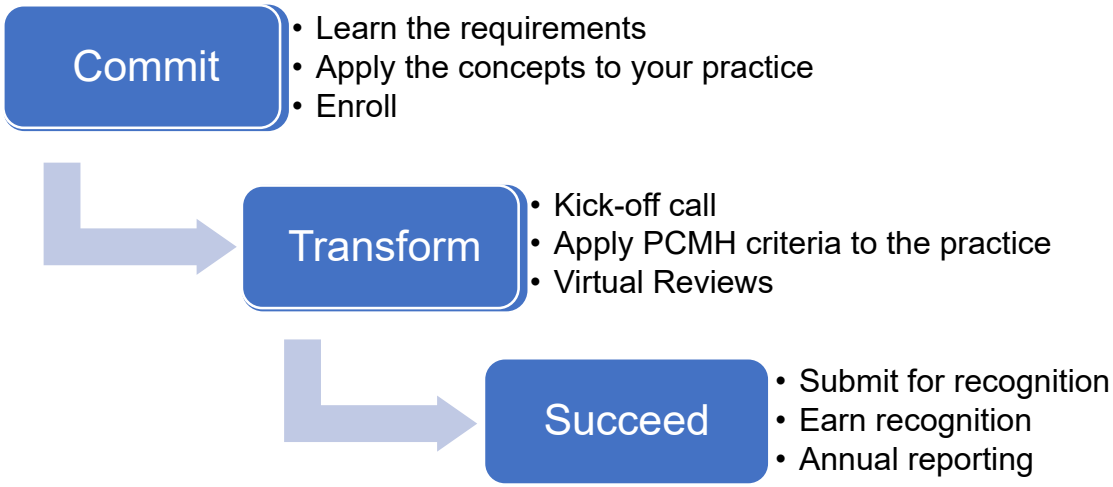
NCQA's PCMH recognition process (**Figure 6**) begins with a self-review of program requirements which are centered around 6 concepts, each with its own criteria. Yearly reporting of data is required. To earn recognition, a program must meet all 40 core criteria and earn at least 25 credits of elective criteria:

- Concept: Team-Based Care and Practice Organization
  - ⇒ Example criterion: regular patient care team meetings or a structured communication process focused on individual patient care
- Concept: Knowing and Managing Your Patients
  - ⇒ Example criterion: use a standardized tool to screen for depression and follow up on a positive screen
- Concept: Patient-Centered Access and Continuity
  - ⇒ Example criterion: provide same-day appointments for routine and urgent care

- Concept: Case Management and Support
  ⇒ Example criterion: establish a system for identifying patients who may benefit from care management
- Concept: Care Coordination and Care Transitions
  ⇒ Example criterion: practice systematically manages lab and imaging tests by 1) flagging overdue results, 2) flagging abnormal results, and 3) notifying patients of normal and abnormal results
- Concept: Performance Measurement and Quality Improvement
  ⇒ Example criterion: monitor at least five quality measures across four categories (immunization, other preventive care measures, chronic and acute care clinical measures, behavioral health measures)

Most criteria focus on the structure of care, followed by some process measures. NCQA's PCMH recognition program creates an evidence-based roadmap for practice organization, but it does not measure quality at the level of the patient (aside from the criteria that practices select quality measures to track). This makes PCMH recognition an ideal complement to the use of HEDIS measures, NQF endorsed measures, and the process and outcome measures already being tracked on CCHCS's dashboard.

Figure 6. NCQA Patient-Centered Medical Home (PCMH) Recognition Process



Source: http://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/process/

Of note, CCHCS already has adopted many of the principles of NCQA's PCMH program through the implementation of the Complete Care Model (CCM) for primary care delivery in the institutions.[43] California's Complete Care model is tailored to prison-specific care delivery in ways that PCMH recognition is not. Furthermore, a minority of NCQA's PCMH criteria may not be applicable to care delivery in a prison setting (e.g. criteria related to delivering timely clinical advice by telephone) so adaptation would need to be made for CCHCS institutions to participate in PCMH recognition.

Where NCQA's PCMH recognition program is most valuable, however, is as an independently verified (data reported by practices are randomly audited) community standard for the organization of primary care delivery. **A requirement for ongoing PCMH recognition at all institutions (via NCQA or the Joint Commission) would be an immensely valuable part of a future oversight and quality assurance model that would ideally be in place prior to the conclusion of the federal receivership.**

The Joint Commission PCMH Certification

The Joint Commission evaluates, accredits, and certifies healthcare organizations and programs throughout the United States. The Joint Commission is best known for its accreditation of hospitals (approximately three quarters of U.S. hospitals are accredited), but it also accredits ambulatory care across organizations. Furthermore, it awards certification to specific programs within an organization (e.g. palliative care programs or stroke centers), including offering a PCMH certification, analogous to NCQA's recognition program (PCMH stands for Primary Care Medical Home in the Joint Commission's documents). Joint Commission accreditation and certification are pursued voluntarily but many payors (such as Medicaid, Medicare, and many private insurers) require Joint Commission accreditation (but not necessarily PCMH certification) as part of the conditions of participation (CoP) for their health plan.

Much like NCQA's PCMH accreditation, the Joint Commission's certification focuses on how care is organized and delivered in ambulatory practices so there would be little utility to pursing PCMH recognition from both. The two PCMH programs do have key differences, however. For one, NCQA recognition is achieved at the level of practice, while Joint Commission certification is at the level of the organization. Functionally, this means CCHCS could potentially pursue a single Joint Commission PCMH certification that would cover all institutions, whereas NCQA recognition would likely be awarded at the level of the institution. Furthermore, **Joint Commission PCMH certification requires the organization to also meet the criteria for its ambulatory care accreditation**.

The only comparative study we could find between the two programs evaluated changes in three years' worth of CMS data from Federally Qualified Health Centers (FQHCs) that had undergone different types of PCMH recognition, compared to control practices that had not undergone any PCMH recognition.[44] Both **NCQA and Joint Commission PCMH recognition were associated with reductions in all-cause admissions, improvements in quality-of-care measures, and improvements in select healthcare utilization metrics.** NCQA recognition was additionally associated with improvements in diabetes outcomes and a slower rate of increase in Medicare expenditures (although the smaller samples size of Joint Commission programs could explain why these findings were not significant). Joint Commission programs demonstrated a reduction in ED visits as well, whereas NCQA programs did not.

From our evaluation, we believe that **either NCQA recognition or Joint Commission certification of the PCMH programs across CCHCS would represent meaningful steps forward in the alignment of healthcare in California prisons with the state's community standards**. While it is uncertain how care delivery would change when

outside certification is added to CCHCS's existing Complete Care Model, there is strong potential for further improvements in quality of care, patient experience, employee job satisfaction, and cost savings. The Joint Commission approach offers the simplicity of a single certification at the level of the organization (potentially covering all of CCHCS's primary care programs) and the benefit of harmonizing with the organization's ambulatory care accreditation which includes on-site inspection of the physical facilities (which is not part of the NCQA recognition process). Purely from the perspective of PCMH, however, we have a slight preference for NCQA recognition. For one, this type of PCMH recognition is the most commonly pursued in the community and it has a slightly larger base of evidence informing its efficacy. While the process of achieving recognition across all CDCR institutions would be more onerous than a single organizational-level certification, developing a healthy healthcare system requires the decentralization of expertise and continuous quality improvement outside of headquarters and down to the regional and local levels where care is delivered. NCQA recognition provides greater assurance that each institution would develop the knowledge, skills, and attitudes to improve quality in their own practice setting (particularly if the alternative is Joint Commission PCMH certification obtained at the statewide level). If NCQA's PCMH recognition were adopted by CCHCS, however, there would still be benefit to the Joint Commission's ambulatory accreditation process which includes evaluation of the physical environment of care, infection prevention and control measures, and patient safety programs, among 16 categories of care quality.[45]

Our understanding is that CCHCS has requested funding necessary to obtain Joint Commission accreditation at all facilities across all sites. We strongly support this decision and view accreditation—particularly if it is tied to concurrent PCMH certification—as an important part of a comprehensive plan of oversight and quality assurance. We would urge CCHCS to pursue both accreditation and PCMH certification at the level of the institution (as opposed to CCHCS as a whole) to establish quality improvement expertise more firmly across institutions (as has been done previously with the accreditation of select CCHCS programs, such as the behavioral health units at San Quentin State Prison, Folsom State Prison, and the California Health Care Facility and ambulatory care at the California Institution for Women). Furthermore, Joint Commission certification should also extend to applicable specialty areas of CCHCS care delivery such as palliative care and hospital level care.

Recommendation: Each institution should obtain and maintain NCQA or Joint Commission PCMH recognition prior to the conclusion of the federal receivership.

Recommendation: We support CCHCS's current pursuit of Joint Commission accreditation across all institutions.

IIIf. Health Equity Accreditation

In addition to PCMH recognition, NCQA and other organizations (such as the Joint Commission and the Utilization Review Accreditation Commission) have begun offering independent programs for health equity accreditation in recent years. In NCQA's words, the purpose of accreditation is to "help health systems, health plans, and other care

organizations advance health equity…[through] evaluating and elevating the health of the populations they serve". This involves a particular focus on identifying and eliminating health disparities between different, broadly defined, demographic and social groups.[46] NCQA offers two programs (Health Equity Accreditation and Health Equity Accreditation plus) depending on how much health equity work an organization has previously done. The accreditation process with NCQA takes approximately 12 months.

Given their recent creation, there is little information in the academic literature or general public domain regarding the efficacy of health equity programs or the degree of adoption. Nevertheless, the case for CCHCS to evaluate the health equity of their patients is strong, particularly as achieving health equity could contribute to enormous gains in population health and health savings (for example, if racial disparities in healthcare were eliminated across the U.S., it is estimated to result in savings of $93 billion in excess medical care costs[47]). As advocated by NCQA, achieving health equity in populations of interest need not involve investigation of health disparities solely at the level of gender, age, race, and ethnicity. In the carceral context, demographic groups of interest and investigation should also include factors such as disability, prison, security level, housing configuration, gang/other group/political affiliations, language preference, and co-morbid substance use disorders and mental health disorders, to name a few.

The NCQA accreditation process takes approximately 12 months and begins with a consultative call with a program expert, followed by review of the Standards and Survey Tool, and then a gap analysis to determine which areas an organization may not be meeting standards (these three steps take approximately 3 months). Following the gap analysis, a pre-application and then application may be submitted. **We recommend that CCHCS first complete the first three steps of this process (up to the gap analysis) to better understand health equity standards and explore areas where the organization may improve. These steps should be paired with a publicly reported, comprehensive equity-based report on high-priority quality measures to better understand equity across the state system** (much of these data are already being tracked and reported in registries and on the public dashboard). Following the gap analysis and the statewide equity report key stakeholders (CCHCS and the federal receiver or the post-receivership oversight board) should make a determination of if health equity accreditation should be pursued.

Recommendation: CCHCS should complete the initial steps of the NCQA Health Equity Accreditation (up to the application portion) and prepare a publicly available report on health equity (broadly defined) among its patients.

Recommendation: Based on the results of the exploration of NCQA Health Equity Accreditation and the statewide health equity report, CCHCS should work with the oversight body to determine if pursuing accreditation will help it strengthen health outcomes for vulnerable populations.

IIIg. Financial Incentives and Pay-for-Performance

In community systems, much of the financial impetus for investing in quality measurement comes in the form of incentive payments (higher insurance reimbursement for organizations meeting prespecified quality of care metrics), conditions of participation (CoP) in government health plans such as Medicare and Medicaid, and participation in the health insurance exchange marketplace. While there is a growing movement to automate as much data collection as possible through electronic health records, collecting and reporting data is technically challenging, time consuming, and costly. Interfacing with numerous regulatory agencies, adapting to changes in programs over time, and assuring compliance with these programs is similarly difficult and resource intensive. It would be naïve to assume that health insurance plans, organizations, and medical practices would voluntarily participate in these programs if the only financial incentive were to potentially lessen legal exposure due to a substandard provision of care. Instead, the positive financial incentives created by organizations—such as CMS—with enormous financial clout have created the necessary impetus for insurance companies and healthcare providers to invest in quality evaluation and improvement. As described in our group's report on the CCHCS Patient Safety Program, **when health systems have positive incentives for "doing the right thing" they generally perform better and are more likely to self-identify deficiencies in care than when the primary system backstopping quality of care consists of punitive measures** applied when care is substandard.[48]

Given the structure of healthcare delivery and financing in California prisons—which operates closer to a single-payer system with a fixed budget and is in most instances forbidden from participating in Medicaid and Medicare—the financial incentives created in community healthcare cannot be easily adapted to healthcare delivery within CCHCS. Consequently, **stakeholders must create new forms of incentives for CCHCS to both proactively collect and improve upon the health metrics identified here and to participate in the programs recommended throughout this report. One of the greatest threats to the end of the receivership is the risk of progressively underfunding healthcare in California prisons, particularly as residents lack political capital and healthcare costs continue to rise.**

Recommendation: External stakeholders should design financial incentives for CCHCS to proactively collect and improve upon health metrics and to participate in the programs recommended throughout this report.

IV. OVERSIGHT IN CORRECTIONAL SETTINGS

IVa. Overview

Oversight of healthcare in correctional facilities across the United States comes in many forms. While some oversight boards focus exclusively on healthcare delivery, many evaluate conditions of confinement more generally, of which healthcare is only one part. Given the focus of this report, **this section will summarize oversight boards related to healthcare delivery in state prisons**. Most striking in this landscape is the lack of an overarching legal or professional standard adopted across all prisons and the fact that many state prison systems have no independent oversight board (healthcare or otherwise). Oversight groups, when they do exist, are a diverse group of governmental and non-governmental organizations to which some states have ceded oversight authority (either voluntarily or as a result of court-ordered changes). At the macro-level, state prison healthcare system oversight most commonly comes in the following forms:

- Corrections-specific accreditation organizations
- Governmental organizations that are independent of the state prison system
- Non-governmental organizations that have been given statutory authority to evaluate the conditions of confinement in the prison system
- Adoption of community accreditation and licensing standards in select correctional settings

Backstopping these oversight mechanisms are the courts which, by design, are reactionary to deficiencies in healthcare rather than proactive or preventive. Furthermore, residents of correctional facilities seeking redress for substandard healthcare through the courts are frequently unsuccessful, particularly since the passage of the Prison Litigation Reform Act (PLRA) of 1996, which made it much more difficult for people who are incarcerated to file a lawsuit.[49] Only when repeated and serious systemic violations of care standards are found may courts step into the role of either mandating changes or providing direct and comprehensive oversight by placing a correctional system under a receivership. A receivership is a "last resort" measure has been applied to two other states—Florida and Texas—in addition to California in the last 50 years. Court ordered changes (which—if not met—can result in a receivership) are more common, as is currently the case in Arizona. As a result of a class action suit (*Parsons v. Ryan*), the Arizona Department of Corrections, Rehabilitation, and Reentry is currently under a court order to improve healthcare staffing and delivery and last year announced the creation of a multi-disciplinary oversight body tasked with evaluating healthcare and conditions of confinement .[50]

IVb. Corrections-specific accreditation

The two leading corrections-specific healthcare accreditation bodies in the United States are the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). This analysis will focus on the NCCHC with the goal of deriving best practices that could be adopted to California prisons. In contrast to the NCCHC, the ACA is less independent with more connection to correctional bureaucracies. The ACA's standards are largely written by a leadership team that is made up of sheriffs and corrections administrators.[51]

The NCCHC—first incorporated as a non-profit in 1983—offers three types of voluntary accreditation: 1) facility health services (for jails, prisons, and juvenile confinement

facilities), 2) mental health services, and 3) opioid treatment programs. In addition, the NCCHC offers individual certification through the Certified Correctional Health Professional Program, organizes an annual educational meeting of correctional professionals, oversees the *Journal of Correctional Health Care*, and offers consulting and continuing education credits.

The accreditation process for facilities is voluntary and is based on the NCCHC *Standards* relevant to the type of accreditation being pursued.[52] The most recent edition of the NCCHC's *Standards for Health Services in Prisons* was published in 2018 and includes 60 standards (**Appendix C**) divided into 7 sections: Governance & Administration (n=10), Health Promotion, Safety, & Disease Prevention (n=9), Personnel & Training (n=9), Ancillary Health Care Services (n=8), Patient Care & Treatment (n=10), Special Needs & Services (n=7), and Medical-Legal Issues (n=7). Standards are either labeled as essential (compliance with all essential standards is required for accreditation) or important (compliance with 85% of important standards is required for accreditation). Each standard is broadly defined and without a set benchmark for meeting the conditions of accreditation (most are evaluated holistically and not quantitatively). Some standards have a single compliance indicator while others have multiple sub-components being evaluated (text box).

Example NCCHC Standards (2018)

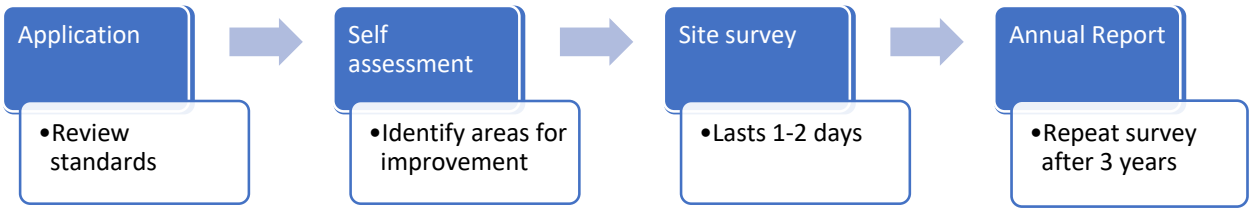
- Standard P-A-01 Access to Care: Inmates have access to care for their serious medical, dental, and mental health need
  - Compliance Indicator: The responsible health authority identifies and eliminates any unreasonable barriers, intentional and unintentional, to inmates receiving health care

- Standard P-E-07 Nonemergency Health Care Requests and Services: Inmates' nonemergent health care needs are met
  - Compliance Indicators:
    1. All inmates, regardless of housing assignments, are given the opportunity to submit oral or written healthcare requests at least daily
    2. The healthcare requests are collected daily by health staff
    3. Healthcare requests are reviewed and prioritized daily by qualified healthcare professionals, or are the healthcare liaison if applicable
    4. A face-to-face encounter for health care request is conducted by a qualified healthcare professional, or by the healthcare liaison (if applicable) within 24 hours of receipt by healthcare staff
    5. Patients are evaluated in a clinical setting as indicated
    6. All aspects of the healthcare request process, from review and prioritization to subsequent encounter, are documented and timed
    7. The frequency and duration of responses to health services requests is sufficient to meet the health needs of the inmate population
    8. All aspects of the standard are addressed by written policy and defined procedures

The accreditation process begins when individual correctional facilities submit applications for accreditation (**Figure 7**). Facilities then complete a self-survey questionnaire based on the *Standards* with the goal of identifying areas for improvement.

About 12 months after the self-assessment, facilities undergo a site survey that typically lasts 1-3 days. Surveys involve reviewing health records, policies, and procedures, conducting interviews with staff and residents, and touring the facility. Following accreditation, facilities must submit an Annual Maintenance Report to the NCCHC and are subjected to a site survey every 3 years to maintain their accreditation. The cost of accreditation is paid by the facility to the NCCHC.

Figure 7. NCCHC accreditation process



Unfortunately, evaluating the merits of NCCHC accreditation is challenging for a number of reasons:

- The NCCHC does not publicly release the names of accredited facilities
- The NCCHC does not provide data on which organizations are accredited, what the accreditation process found, nor the percentage of organizations seeking accreditation that achieve it [note: a study presented to the California legislature on accreditation in 2010 indicated that 31 states had some or all of their prisons accredited by the NCCHC or the ACA[53]]
- The medical literature evaluating the accreditation process or outcomes associated with accreditation is lacking

In addition, several accredited ACA and NCCHC facilities have been found to not meet their constitutional obligation to provide a minimum standard for healthcare services and the courts have repeatedly declined to use ACA or NCCHC accreditation in their evaluations of care quality.[54] Data are similarly unclear regarding any healthcare quality benefits to the NCCHC's Certified Correctional Health Professional (CCHP) Program which allows individuals to earn this certification by studying the *Standards* and passing an 80-100 question test (the exam has an 82.5% pass rate). One study found low numbers of professionals seeking certification (an average of 17 per state in 2015 with 150 in California) and a trend toward increases in certification in response to legal threats.[51]

Based on the current state of data regarding NCCHC accreditation and CCHP certification, we cannot make a clear recommendation on the benefits or pitfalls of seeking accreditation. Additionally, we believe that creating separate sets of standards and accreditation for healthcare in prisons may impede progress to achieving high-quality care in prisons and we thus favor the adoption of community-based accreditation programs such as those offered by the Joint Commission. Furthermore, the lack of transparency regarding the NCCHC findings and accreditation process runs counter to the goals of a healthy oversight and quality evaluation program whose validity, in part, relies on publicly available data and scrutiny

from outside stakeholders. We are aware, however, that a randomized trial of offering accreditation to jails is currently being planned which will assess patient outcomes based on the presence or absence of accreditation and we look forward to re-evaluating the merits of accreditation as more data become available.[55]

We do recognize the NCCHC's *Standards*, however, as a valuable reference from which to adopt corrections-specific quality measures to complement PQM's list of measures as has been previously done by CCHCS. In our assessment, 62% of the NCCHC's standards focus primarily on policies, procedures, and access to care (i.e. the "structure" of healthcare in the Donabedian model). This balance is the opposite of PQM's endorsed measures, which favor process and outcomes metrics that are tied closely to the metrics valued most by patients – morbidity, mortality, and quality of life. While these patient-centered metrics should remain the focus of any healthcare quality evaluation when feasible, the NCCHC's *Standards* can serve as an ideal complement for evaluating the structure of healthcare delivery and the many challenges that are unique to providing care in the correctional environment.

Recommendation: A biennial meeting of quality experts from a California state prison healthcare oversight board and CCHCS (to review process and outcome quality measures for adoption) should also review the structure metrics promoted by the NCCHC for potential adoption.

Recommendation: If NCCHC accreditation of individual prisons is pursued, accreditation alone should not be considered as sufficient evidence of adequate oversight or quality of care in a given prison.

IVc. Oversight boards: governmental and non-governmental

As described previously, oversight in state prison systems occurs at the state level, if it exists at all. Some oversight boards focus exclusively on healthcare delivery while others evaluate conditions of confinement more generally. There is no federal, legal, or professional oversight standard adopted across all prisons, so one must look to states individually when evaluating models for adoption in California.

The most comprehensive publication on the landscape of prison oversight in the United States—compiled by researchers at the University of Texas—was released in 2020.[56] To be included as an oversight entity in this analysis, the entity must meet the following criteria:

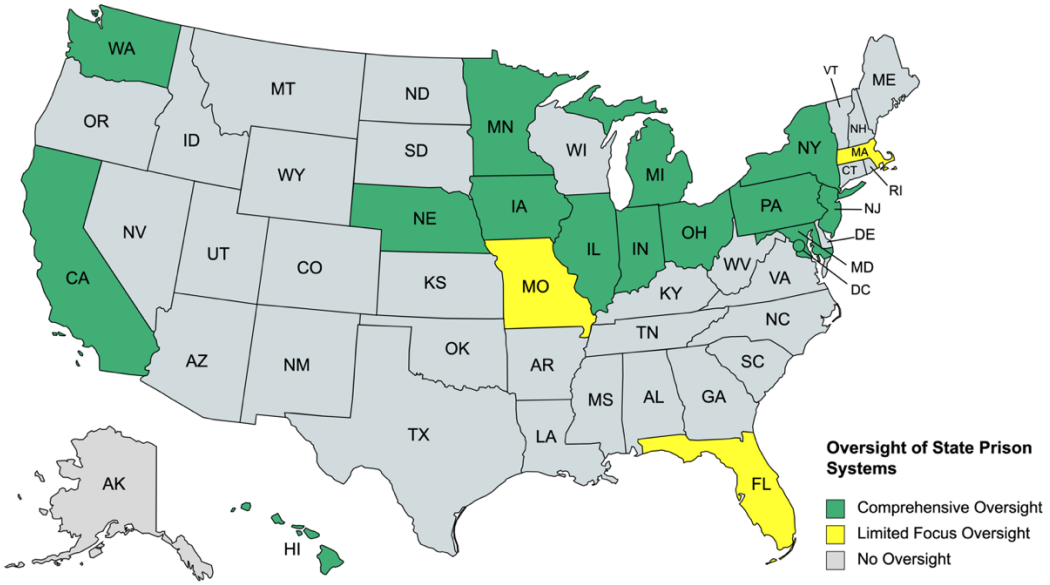
1. It is independent from the correctional agency it oversees;
2. Its primary function is to monitor conditions of confinement, prevent ill-treatment, or investigate complaints of incarcerated people;
3. It has a formal or informal right of access into correctional facilities to accomplish that function; and
4. It is actively engaged in this work.

Using this definition, only 17 state prison systems and the District of Columbia have oversight entities (**Figure 8**). The following types of oversight entities exist across these states:

- Government, comprehensive (covers conditions of confinement broadly, including healthcare): California, District of Columbia, Hawaii, Indiana, Iowa, Maryland, Michigan, Minnesota, Nebraska, New Jersey, Ohio, Washington
- NGO or Advisory, comprehensive: Illinois (John Howard Association of Illinois), New York (Correctional Association of New York, CANY), and Pennsylvania (Pennsylvania Prison Society, PPS)
- Government, limited focus: Florida (only related to healthcare), Massachusetts (only related to solitary confinement)
- NGO or Advisory, limited focus: Missouri (Citizens Advisory Committee, only related to reviewing resident grievances)

Of note, two more states (Oregon and Virginia) created oversight bodies in 2023 but they are yet to publicly report on their activities.

Figure 8. Oversight of state prison systems



While this scoping report does not include a deep dive into the systems of oversight in other states, **our initial analysis has left us with serious concerns about the ability of any current state prison healthcare oversight model to break the cycle of court-ordered reforms that play out repeatedly across the country following findings of inadequate care (let alone ensuring durable, equitable, and high-quality care for incarcerated people)**.

For one, there is tremendous variation in the strength, staffing, and mission of each of these oversight models. For example, the oversight bodies in Nebraska and Indiana have just one employee each. Additionally, while the oversight entities described here are independent from the department of corrections in the state, many of them are the biproduct of judicial and political compromise and lack authority, enforcement mechanisms, and adequate funding from the start. They are also subject to strong political

influence over their funding, activities, and leadership. Recent actions in the legislatures of Hawaii, Florida, and Ohio, for example, have led to dramatic budget cuts and have demonstrated how these oversight entities may be beholden to the state government. Further complicating the evaluation of state models of oversight (if they exist) is the lack of data on comparative health outcomes for incarcerated people across states as little health outcome data is reported at the state level.

IVd. Experiences of other state prison systems emerging from federal oversight

Florida and Texas are the two other states whose prison systems were subject to overview by a receivership in the last 50 years. Florida's receivership lasted from 1972 to 1993. As part of the conditions for terminating the receivership, the Florida legislature created an independent state agency in 1986 known as the Correctional Medical Authority (CMA) to monitor healthcare in state prisons and advise the governor and legislature regarding the quality of care provided and the level of funding needed in the annual budget. The CMA describes its mandate as such:[57]

- Reviewing and advising the Secretary of Corrections on the Florida Department of Corrections (FDC) health services plan, including standards of care, quality management programs, cost containment measures, continuing education of healthcare personnel, budget and contract recommendations, and projected medical needs of inmates.
- Reporting to the Governor and legislature on the status of FDC's healthcare delivery system, including cost containment measures and performance and financial audits.
- Conducting surveys of the physical and mental health services at each correctional institution every three years and reporting findings to the Secretary of Corrections.
- Reporting serious or life-threatening deficiencies to the Secretary of Corrections for immediate action.
- Monitoring corrective actions taken to address survey findings.
- Providing oversight for FDC's quality management program to ensure coordination with the CMA.
- Reviewing amendments to the healthcare delivery system submitted by FDC prior to implementation.

To carry out this mission, the CMA is composed of a volunteer board whose members are appointed by the Governor and confirmed by the Florida Senate (each member serves a term of four years). The staff consists of six to seven full time employees who employ independent contractors to complete healthcare surveys at each Florida prison every three years. Survey reports are followed by CMA monitoring of corrective action plans until the facilities are in compliance with accepted community standards. The CMA worked under the oversight of the receivership for the first 7 years of its existence, until the receivership was terminated in 1993. In 2011 the Florida legislature did not fund the CMA, imperiling its ability to meet its statutory requirements. The following year it was funded by the executive branch of the state government and since this time it has been housed as an independent state agency within the executive branch.[58] We were unable to find any peer reviewed manuscripts evaluating the work of the CMA in the medical literature.

The Texas Department of Criminal Justice (TDCJ) was placed under a federal receivership in 1980. In 1994, the state created the Correctional Managed Health Care Committee (CMHCC) which "coordinates the development of statewide policies for the delivery of correctional health care and serves as a representative forum for decision making in terms of overall health care policy."[59] The correctional healthcare system in Texas is a partnership between Texas Tech University Health Sciences Center (TTUHSC), The University of Texas Medical Branch (UTMB) at Galveston and the Texas Department of Criminal Justice. CMHCC does not function as an oversight board but is instead an organization that develops the contracts that govern the statewide managed care plan that provides care to TDJC residents (members include representatives of TDJC, TTUHSC, and UTMB). TTUHSC contracts with TDCJ to provide complete medical services for prison residents in West Texas while UTMB provides medical services for prison residents in the rest of the state.[60] The academic partners are responsible for both recruiting and hiring healthcare personnel as well as delivering primary care, specialty care, pharmaceutical services, and specialty care—when necessary—that is delivered in the community. This arrangement allowed Texas to emerge from its receivership in 1999, 5 years after the creation of CMHCC. The arrangement, however, has not been without problems. A Texas State audit conducted in 2011 found that UTMB had set reimbursement amounts independently without external review and was inappropriately billing the state for excess fees.[61]

Due to the cautionary experiences of post-receivership oversight in Florida and Texas—as well as the inadequate oversight mechanisms in place in other states—**there is no one state that California can look to when designing a system of oversight following the conclusion of the federal receivership. Furthermore, history suggests there is a high risk of forming a post-receivership oversight entity (if any is formed at all) without the mandate or resources necessary for the job. We would recommend that the new California oversight board attempt to lead the formation of a collective of independent state prison healthcare oversight bodies with the goal of sharing best practices and informing legislation.**

Recommendation: Given the heterogeneity of the few existing state oversight models and the lack of state-level data on the quality of care delivered to incarcerated people, our evaluation of models of oversight utilized by other states (including those emerging from federal oversight) reveals significant concerns about these models and does not yield a clear blueprint for oversight that could be adopted for California prisons.

Recommendation: California's new prison healthcare oversight board should attempt to form a collective of similar state-level oversight bodies with the goal of sharing best practices and informing state and federal legislation.

IVe. Key features of an oversight board's charter

The lack of federal guidance on healthcare oversight in prisons stands in stark contrast to the approaches of peer countries and has resulted in a patchwork system of correctional oversight at the state level, if it exists at all. Residents of correctional facilities

may seek redress through the courts but too often this is only after harm has been done and lawsuits may not result in mandatory evidence-based improvements in health systems that are necessary to prevent future adverse outcomes and promote high quality care. A strong oversight board is particularly important because incarcerated individuals lack political capital, which creates little incentive for state governments to invest the resources necessary to ensure high quality care.

Given the lack of clear standards regarding the composition and duties of a prison healthcare oversight board, our primary recommendation is that **a consensus advisory group of multiple stakeholders (including the receiver, other members of the current CCHCS Governing Body[62], and outside representatives) should create a charter governing a future oversight board.** The representatives of the advisory group drafting the board's charter should collectively meet the qualifications described for the composition of the board itself (described subsequently in **Table 5**), although there is no mandate that the board be composed of individuals who also created its initial charter. **We recommend that this advisory group be convened as soon as possible to allow for an extended dialogue on best practices for oversight and the eventual creation of the board well in advance of the conclusion of the receivership.**

The advisory group's creation of a charter for the oversight board should draw on the work of other stakeholders who have attempted to define the key features of oversight through comparative study of domestic and international approaches in both correctional and non-correctional settings. One such example is the American Bar Association's Resolution on Independent Correctional Oversight, which describes 20 essential elements for the oversight board (**Table 4**).[63]

Table 4. ABA's 20 essential elements of an oversight board

1.	Independent from the correctional agency
2.	Funded/staffed
3.	Head has a fixed term, only removed for just cause
4.	Inspection teams have expertise/training
5.	Conducts regular inspections
6.	Can inspect all operations/conditions
7.	Array of means to gather and substantiate facts
8.	Facility and government officials must cooperate fully
9.	Work is collaborative and constructive
10.	Can conduct inspections as scheduled or unannounced
11.	Can inspect any records
12.	Can conduct confidential interviews
13.	Procedures for staff and residents to transmit information confidentially about conditions
14.	Safeguards in place for staff and residents who transmit information to the oversight board so that there is no retaliation or threat of retaliation
15.	Facilities can review reports and provide feedback before dissemination to the public (but facilities do not "approve" the reports)
16.	Monitoring reports incorporate legal requirements, best correctional practices, and other criteria objectively

17.	Reports are public
18.	Facility administrators are required to respond publicly to reports w/ plans that are implemented
19.	Monitors continue to assess and report on previously identified problems
20.	The jurisdiction (such as the legislature) has safeguards to make sure the monitoring entity is meeting its purpose, including an annual report

Given the lack of clear standards in the United States, we advocate for the creation of an oversight board that is designed to meet the standards advocated by the ABA. Furthermore, we also advocate for an oversight board with the additional features described in **Table 5**.

Table 5. Additional key features of a healthcare oversight board in CA prisons

1.	Includes at least one senior representative from a community healthcare organization, academic medical center, health insurance company, the California state legislature, and a patient/inmate advocacy group, in addition to a formerly incarcerated person, a family member of a currently incarcerated person, and a former CCHCS employee
2.	Includes subject matter experts in healthcare quality assessment, operations, correctional healthcare delivery, regulatory affairs, patient safety, international healthcare oversight in corrections, informatics, and clinical care in key domains (primary care, women's health, mental health, dentistry, nursing, and pharmacology)
3.	Overlaps with the federal receivership prior to assuming sole oversight authority
4.	Functions independently from political influence and members can only be replaced for good cause
5.	Utilizes both objective and quantitative data in addition to holistic assessments
6.	Creates reports and assessments that focus on patient experience and outcomes as the key indicator

Recommendation: A charter governing the oversight board should be created based on a consensus advisory group of multiple stakeholders, including the receiver, other members of the current CCHCS Governing Body, and outside representatives.

Recommendation: The advisory group tasked with creating a charter for the oversight board should be convened as soon as possible to allow for an extended dialogue on best practices for oversight and the eventual creation of the board well in advance of the conclusion of the receivership.

Recommendation: The oversight board should abide by the essential elements described in **Tables 4 and 5.**

IVf. Oversight board activities

This report has described an approach to healthcare quality evaluation in California state prisons and a number of activities that should be undertaken by a new oversight board. Aforementioned oversight board activities include the following:

- Making periodic announced and unannounced facility visits which should include a visual inspection of the healthcare environment (equipment and facilities) and structured confidential interviews with frontline staff, leadership, and patients.
- Reviewing and approving CCHCS's biennial Performance Improvement Plan with a focus on integrating quality measures from community programs (such as HEDIS measures and other NQF endorsed measures) and correctional organizations (e.g. NCCHC standards) as appropriate.
- Creating incentives for CCHCS to collect and improve upon health metrics and to participate in the programs recommended throughout this report (e.g. CAHPS surveys, PCMH designation, California Health Care Quality Report Cards, and Joint Commission accreditation).
- Attempting to form a collective of similar state-level oversight boards with the goal of sharing best practices and informing state and federal legislation as needed.

This is only a partial list of oversight board activities and, ultimately, the advisory group drafting the board's charter will need to further detail the scope of the board's work. We recommend that the charter also consider the additional activities described in **Table 6**. Of particular importance is creating an oversight board with enforcement mechanisms that are also aligned with financial incentives. Care should be taken to promote a culture of collaboration between CCHCS and the oversight body and to avoid a relationship that is antagonistic. That said, the oversight body must have an enforcement mechanism if an institution (or statewide prison leadership) were found to have major deficiencies in care, if CCHCS were failing to improve unsafe systems, or if CCHCS were not sufficiently funded to provide adequate care. In these instances, the oversight body should have the ability to place an institution (or CCHCS as a whole if widespread problems are identified) into a temporary receivership where local control is lost and control of the institution (including financing) is made by an independent receiver appointed and supervised by the oversight body.

Table 6. Potential activities of the healthcare oversight board in CA prisons

1.	Approval from the board to pass the state's budget for prison health expenditures
2.	Close communication with statewide and regional health leadership as well as leadership in each institution to better foster dissemination of quality improvement responsibilities to each prison
3.	Periodic in-person assessment of each facility
4.	Creation of publicly available individual institution reports, which make recommendations for improvement and include institutional ratings that carry both financial and other consequences if minimum standards are not met following a period of remediation
5.	Advice on CCHCS's strategic planning and problem solving; leverages relationships with external experts to solve identified problems as needed
6.	A financially driven enforcement mechanism when systemic, significant deficiencies in care or unsafe systems are discovered (including the ability to put

	an institution into a temporary receivership-type relationship if major problems are not adequately and expeditiously addressed by state or local leaders)

Recommendation: The charter governing the oversight board should consider the activities described in **Table 6.**

Recommendation: If significant deficiencies in care or unsafe systems are identified and not adequately and expeditiously addressed, the oversight board should have the ability to place an institution (or CCHCS as a whole if widespread problems are identified) into a temporary receivership-type relationship where local control is lost and control of the institution (including financing) is made by an independent receiver appointed and supervised by the oversight body.

V. OVERVIEW AND NEXT STEPS

Va. Overview

Determining the appropriate quality assessment and oversight framework for CCHCS is challenging because neither of these domains has a clear gold standard in community settings. Instead, a patchwork system defining quality and appropriate oversight exists with input from multiple stakeholders, including private and government insurers, medical professional societies, and governmental and non-governmental regulatory and accreditation agencies. In fact, this report describes only a fraction of the quality metrics and oversight bodies active in the United States, with a focus on approaches and programs that are most relevant to CCHCS.

Even fewer quality assessment and oversight standards exist for U.S. correctional settings, where a disturbing lack of healthcare oversight has contributed to substandard care and a lack of longitudinal knowledge on what approaches may be most helpful in correctional settings. Consequently, California prison health leaders—who have made significant strides in improving care quality throughout the receivership—have a tremendous opportunity to step into this void and define a robust system of quality and oversight that can serve as a gold standard for corrections in the rest of the country. Our hope is that the recommendations contained within this report can serve as a roadmap for how this system should be designed.

While community standards for quality evaluation and oversight in healthcare may be patchwork and imperfect, the quality and patient safety movement in U.S. healthcare of the last quarter century (and comparable programs around the world) have led to enormous health gains for millions of people. These systems have also shown the ability to constantly evolve with the medical literature and have a strong evidence base for improving meaningful patient outcomes. Every effort should be made to borrow from these systems and adapt them to a new gold standard appropriate to the unique context of California prisons. **If there is a single theme that runs through this report it is that one should avoid creating separate expectations for healthcare delivery and quality in prisons when compared to the community.** Wherever possible, artificial barriers between community and correctional quality evaluation and oversight should be broken down, and CCHCS should be adopting the evolving gold standards used in community settings. Policymakers and stakeholders should be continuously looking for ways to integrate community-based approaches to healthcare delivery in prisons such as:

- Alignment of medical benefits with those offered by insurance programs such as Medi-Cal
- Adoption of quality metrics such as HEDIS measures and those endorsed by the Partnership for Quality Management (PQM)
- Integration of patient-experience surveys in the evaluation of care quality, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- Accreditation (such as that offered by the Joint Commission) and patient-centered medical home (PCMH) designation
- Creation of an independent expert oversight board with representation from diverse stakeholders and a single-minded focus on delivering outstanding patient-centered medical care; the board should also have a clear mandate for how to respond to systemic findings of substandard care and an appropriate budget to support systems improvement and remediation at facilities

Finally, the primary aim of CCHCS as it plans to emerge from the receivership should shift away from focusing primarily on healthcare delivery and instead move toward a more holistic approach to wellness. This includes a focus—where applicable—on patient-centered health outcomes as described in this report, but also on a better integration of different silos of health and wellness, including medical care and mental healthcare (an artificial boundary worsened by the separate *Plata* and *Coleman* cases), nutrition, exercise, improved connections between patients and loved ones beyond prison walls, and robust programming to strengthen opportunities for education, religious worship, vocational training, and community building. These latter social determinants of health are just as important as the process of healthcare delivery—if not more so—to the wellness of patients.

Recommendation: As CCHCS emerges from the receivership, it should shift its focus to a more holistic approach to wellness that breaks down silos between medical care, mental healthcare, nutrition, exercise, community building and programming for patients.

Vb. Next steps

As detailed in this report, there is much work to be done in the realms of quality assessment and oversight of healthcare in California prisons. In particular, **planning for a transition in oversight at the end of the receivership—even if this is a number of years away—should begin now**. As this report is largely a scoping review, there are a number of areas that require additional investigation for potential incorporation into the quality assessment and oversight landscape of California prisons.

To maximize impact, this report should be disseminated for direct comment and feedback. Furthermore, we strongly advocate for this report to be used as a starting point to convene multidisciplinary expert panels of patients, stakeholders, and external healthcare experts to further flesh out the key details necessary to creating a governing charter for the oversight body that is able to fulfill a robust mandate (**Table 7**). Key remaining questions, to be addressed include:

1. Who exactly should be on the oversight body, how should they be selected (and by whom) and appointed, and what should be their general scope of work? How should the perspective of patient advisors and prison healthcare professionals be integrated into the oversight body? To what extent and through which budgetary mechanism should they be compensated? Should this oversight body have a budget?
2. To whom / which state agency(ies) should the oversight body report? How can the oversight body be insulated from political interference? How may the oversight body obtain additional financing for CCHCS/CDCR if this is necessary to address inadequate health and medical care?
3. What mechanisms should the oversight body have at its disposal to ensure that any identified deficiencies in care are properly addressed?
4. How can an oversight body work to positively incentivize quality and quality improvement as opposed to only relying on problem-identification mechanisms?

5. How should quality and quality improvement be measured, incentivized, and articulated with the oversight body in the prison setting?

Following the gains in healthcare delivery under the receivership, California now has the opportunity to design a robust model of prison healthcare oversight that leads the nation and can serve as a roadmap for other states. Through a collaborative effort—that draws upon the voices of prison and community healthcare experts, internal stakeholders, and patients—this opportunity can turn into a reality, with a profoundly positive impact on the health and wellness of prison residents.

Table 7. Next steps to begin now

1. Disseminate this report to CCHCS leadership, stakeholders, and external experts in healthcare quality and oversight for direct comment and feedback
2. Conduct further investigation into key areas such as 1) Partnership for Quality Management (PQM) measures which should be added to the CCHCS dashboard now, 2) prison healthcare oversight systems used in other states, and 3) international approaches to prison healthcare oversight
3. Convene an Oversight Advisory Panel (of experts in prison conditions, prison healthcare oversight, and oversight bodies for community healthcare) tasked with creating recommendations for the governing charter of the oversight body
4. Convene a Patient Healthcare Advisory Panel that includes people currently and/or formerly incarcerated to provide recommendations for the governing charter of the oversight body
5. Integrate feedback from this report, additional investigation of quality and oversight models, and recommendations from the Oversight Advisory Panel and the Patient Healthcare Advisory Panel into a series of highly-detailed evidence-based recommendations for post-receivership oversight in California

VI. APPENDICES

Appendix A. List of recommendations from this report

Recommendation: The Donabedian model is an ideal framework from which to approach quality assessment in California prisons.

Recommendation: The healthcare services offered to residents of California prisons should—at a minimum—align with benefits offered to Medi-Cal beneficiaries. Additional services should be offered based on deficiencies in care identified in other activities described throughout this report.

Recommendation: Evaluations of equipment and facilities is ideally undertaken by periodic facility visits from an oversight board. These visits should be announced and unannounced and should include both visual inspection of the healthcare environment but also structured confidential interviews with frontline staff, leadership, and patients.

Recommendation: Whenever applicable, Partnership for Quality Management (PQM) endorsed measures should be adopted by CCHCS for tracking and reporting, particularly high priority measures that apply to large numbers of CCHCS patients.

Recommendation: A committee of quality experts from the oversight board and CCHCS should work together every two years—after CCHCS has completed an initial draft of its Performance Improvement Plan—to review process and outcome quality measures and determine which additional measures are most appropriate for adoption.

Recommendation: All HEDIS measures that are relevant to the CCHCS patient population should be collected, tracked, and reported on the public dashboard as part of the assessment of the quality of care delivered by CCHCS.

Recommendation: CCHCS should pilot the use of applicable Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys across prisons and fund an academic study to understand its impact and limitations. Key metrics from CAHPS surveys should be reported on the CCHCS public dashboard.

Recommendation: CCHCS should collect HEDIS data and CAHPS survey data in order to facilitate participation in the California Health Care Quality Report Cards.

Recommendation: Stakeholders should ensure that CCHCS has both adequate funding and positive incentives to collect and report HEDIS and CAHPS data using the same standards required of community health plans.

Recommendation: Each institution should obtain and maintain NCQA or Joint Commission PCMH recognition prior to the conclusion of the federal receivership.

Recommendation: We support CCHCS's current pursuit of Joint Commission accreditation across all institutions.

Recommendation: CCHCS should complete the initial steps of the NCQA Health Equity Accreditation (up to the application portion) and prepare a publicly available report on health equity (broadly defined) among its patients.

Recommendation: Based on the results of the exploration of NCQA Health Equity Accreditation and the statewide health equity report, CCHCS should work with the oversight body to determine if pursuing accreditation will help it strengthen health outcomes for vulnerable populations.

Recommendation: External stakeholders should design financial incentives for CCHCS to proactively collect and improve upon health metrics and to participate in the programs recommended throughout this report.

Recommendation: A biennial meeting of quality experts from a California state prison healthcare oversight board and CCHCS (to review process and outcome quality measures for adoption) should also review the structure metrics promoted by the NCCHC for potential adoption.

Recommendation: If NCCHC accreditation of individual prisons is pursued, accreditation alone should not be considered as sufficient evidence of adequate oversight or quality of care in a given prison.

Recommendation: Given the heterogeneity of the few existing state oversight models and the lack of state-level data on the quality of care delivered to incarcerated people, our evaluation of models of oversight utilized by other states (including those emerging from federal oversight) reveals significant concerns about these models and does not yield a clear blueprint for oversight that could be adopted for California prisons.

Recommendation: California's new prison healthcare oversight board should attempt to form a collective of similar state-level oversight bodies with the goal of sharing best practices and informing state and federal legislation.

Recommendation: A charter governing the oversight board should be created based on a consensus advisory group of multiple stakeholders, including the receiver, other members of the current CCHCS Governing Body, and outside representatives.

Recommendation: The advisory group tasked with creating a charter for the oversight board should be convened as soon as possible to allow for an extended dialogue on best practices for oversight and the eventual creation of the board well in advance of the conclusion of the receivership.

Recommendation: The oversight board should abide by the essential elements described in **Tables 4 and 5.**

Recommendation: The charter governing the oversight board should consider the activities described in **Table 6.**

Recommendation: If significant deficiencies in care or unsafe systems are identified and not adequately and expeditiously addressed, the oversight board should have the ability to place an institution (or CCHCS as a whole if widespread problems are identified) into a temporary receivership-type relationship where local control is lost and control of the institution (including financing) is made by an independent receiver appointed and supervised by the oversight body.

Recommendation: As CCHCS emerges from the receivership, it should shift its focus to a more holistic approach to wellness that breaks down silos between medical care, mental healthcare, nutrition, exercise, community building and programming for patients.

Appendix B. Select Partnership for Quality Management (PQM) Measures

Criteria

For inclusion on this list, each measure must be 1) endorsed by PQM, 2) applicable to adults, and 3) potentially related to outpatient medical care provided to the CCHCS patient population. Ultimately, not all measures on this list will be useful and measures not on this list may be valuable to CCHCS.

This list was compiled based on a review of the NQF Quality Positioning System (QPS) website as of October of 2022.
https://www.qualityforum.org/Qps/QpsTool.aspx

Structure Measures

CBE ID	Measure Title
2904	Contraceptive Care - Access to LARC (other)

Process Measures

CBE ID	Measure Title
0654	Acute Otitis Externa: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
0653	Acute Otitis Externa: Topical Therapy
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
0223	Adjuvant chemotherapy is recommended, or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer
0220	Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0 or Stage IB – Stage III hormone receptor positive breast cancer
3620	Adult Immunization Status
0326	Advance Care Plan
0566	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
0087	Age-Related Macular Degeneration: Dilated Macular Examination
1662	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
3541	Annual Monitoring for Persons on Long-Term Opioid Therapy
0105	Antidepressant Medication Management
0118	Anti-Lipid Treatment Discharge
0116	Anti-Platelet Medication at Discharge
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

3475e	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
0142	Aspirin prescribed at discharge for AMI
1800	Asthma Medication Ratio
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
2701	Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour)
0117	Beta Blockade at Discharge
2372	Breast Cancer Screening
0643	Cardiac Rehabilitation Patient Referral From an Outpatient Setting
0553	Care for Older Adults (COA) – Medication Review
0032	Cervical Cancer Screening
0033	Chlamydia Screening in Women
0034	Colorectal Cancer Screening
0055	Comprehensive Diabetes Care: Eye Exam (retinal) performed
3389	Concurrent Use of Opioids and Benzodiazepines
3453	Continuity of Care after Inpatient or Residential Treatment for Substance Use Disorder
3312	Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs
3590	Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment
3175	Continuity of Pharmacotherapy for Opioid Use Disorder
0102	COPD: inhaled bronchodilator therapy
0091	COPD: Spirometry Evaluation
0066	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
0067	Coronary Artery Disease (CAD): Antiplatelet Therapy
0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
2872e	Dementia: Cognitive Assessment
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
0056	Diabetes: Foot Exam
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
3532	Discouraging the routine use of occupational and/or supervised physical therapy after carpal tunnel release.
3500	Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients
3497	Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

3489	Follow-Up After Emergency Department Visit for Mental Illness
0576	Follow-Up After Hospitalization for Mental Illness (FUH)
2080	Gap in HIV medical visits
0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
2079	HIV medical visit frequency
3210e	HIV viral suppression
3211e	Prescription of HIV Antiretroviral Therapy
3752e	HIV Annual Retention in Care
3755e	STI Testing for People with HIV
1641	Hospice and Palliative Care – Treatment Preferences
3645	Hospice Visits in the Last Days of Life
3593	Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs
1659	Influenza Immunization
0431	Influenza Vaccination Coverage Among Healthcare Personnel
3558	Initial Opioid Prescribing for Long Duration (IOP-LD)
0004	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
3461	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)
0555	INR Monitoring for Individuals on Warfarin
0255	Measurement of Phosphorus Concentration
3617	Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure
0097	Medication Reconciliation Post-Discharge
0537	Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate
0384	Oncology: Medical and Radiation - Pain Intensity Quantified
0383	Oncology: Medical and Radiation - Plan of Care for Pain
2594	Optimal End Stage Renal Disease (ESRD) Starts
2517	Oral Evaluation, Dental Services
0053	Osteoporosis Management in Women Who Had a Fracture
0210	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life
2856	Pharmacotherapy Management of COPD Exacerbation
0673	Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem
2993	Potentially Harmful Drug-Disease Interactions in the Elderly
2083	Prescription of HIV Antiretroviral Therapy
3589	Prescription or administration of pharmacotherapy to treat opioid use disorder (OUD)
0041	Preventive Care and Screening: Influenza Immunization

0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0563	Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
3636	Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel
0219	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer
1859	RAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy
2523	Rheumatoid Arthritis: Assessment of Disease Activity
2524e	Rheumatoid Arthritis: Patient-Reported Functional Status Assessment
3316e	Safe Use of Opioids – Concurrent Prescribing
0046	Screening for Osteoporosis for Women 65-85 Years of Age
1519	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)
3455	Timely Follow-Up After Acute Exacerbations of Chronic Conditions
1858	Trastuzumab administered to patients with AJCC stage I (T1c) – III human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
0022	Use of High-Risk Medications in the Elderly (DAE)
2940	Use of Opioids at High Dosage in Persons Without Cancer
2950	Use of Opioids from Multiple Providers in Persons Without Cancer
3400	Use of Pharmacotherapy for Opioid Use Disorder (OUD)
0577	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
2511	Utilization of Services, Dental Services

Outcomes Measures

CBE ID	Title
3490	Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
3665	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
3666	Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain
1623	Bereaved Family Survey
1460	Bloodstream Infection in Hemodialysis Outpatients
0005	CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child
0517	CAHPS Home Health Care Survey (experience with care) NQF#: 0517
2651	CAHPS Hospice Survey, Version 9.0

3597	Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System
3227	CollaboRATE Shared Decision Making Score
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)
1741	Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0
2903	Contraceptive Care – Most & Moderately Effective Methods
0018	Controlling High Blood Pressure
3422	CoreQ: AL Family Satisfaction Measure
3420	CoreQ: AL Resident Satisfaction Measure
2616	CoreQ: Long-Stay Family Measure
2615	CoreQ: Long-Stay Resident Measure
2614	CoreQ: Short Stay Discharge Measure
0711	Depression Remission at Six Months
0710e	Depression Remission at Twelve Months
1884	Depression Response at Six Months- Progress Towards Remission
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
0425	Functional Status Change for Patients with Low Back Impairments
3461	Functional Status Change for Patients with Neck Impairments
2978	Hemodialysis Vascular Access: Long-term Catheter Rate
2967	Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Measures
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
0216	Percentage of patients who died from cancer admitted to hospice for less than 3 days
0213	Percentage of patients who died from cancer admitted to the Intensive Care Unit (ICU) in the last 30 days of life
0071	Persistence of Beta-Blocker Treatment After a Heart Attack
3568	Person-Centered Primary Care Measure PRO-PM
2375	PointRight ® Pro 30™
2827	PointRight® Pro Long Stay(TM) Hospitalization Measure
1454	Proportion of patients with hypercalcemia
2888	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions
3612	Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System
2962	Shared Decision Making Process

Appendix C. NCCHC Standards for Health Services in Prisons (2018)

Section A – Governance and Administration

P-A-01	Access to Care
P-A-02	Responsible Health Authority
P-A-03	Medical Autonomy
P-A-04	Administrative Meetings and Reports
P-A-05	Policies and Procedures
P-A-06	Continuous Quality Improvement Program
P-A-07	Privacy of Care
P-A-08	Health Records
P-A-09	Procedure in the Event of an Inmate Death
P-A-10	Grievance Process for Health Care Complaints

Section B – Health Promotion, Safety, and Disease Prevention

P-B-01	Healthy Lifestyle Promotion
P-B-02	Infectious Disease Prevention and Control
P-B-03	Clinical Preventive Services
P-B-04	Medical Surveillance of Inmate Workers
P-B-05	Suicide Prevention and Intervention
P-B-06	Contraception
P-B-07	Communication on Patients' Health Needs
P-B-08	Patient Safety
P-B-09	Stop Safety

Section C – Personnel and Training

P-C-01	Credentials
P-C-02	Clinical Performance Enhancement
P-C-03	Professional Development
P-C-04	Health Training for Correctional Officers
P-C-05	Medication Administration Training
P-C-06	Inmate Workers
P-C-07	Staffing
P-C-08	Healthcare Liaison
P-C-09	Orientation for Health Staff

Section D – Ancillary Health Care Services

P-D-01	Pharmaceutical Operations
P-D-02	Medication Services
P-D-03	Clinical Space, Equipment, and Supplies

P-D-04	On Site Diagnostic Services
P-D-05	Medical Diets
P-D-06	Patient Escort
P-D-07	Emergency Services in Response
P-D-08	Hospital in Specialty Care

Section E – Patient Care and Treatment

P-E-01	Information on Health Services
P-E-02	Receiving Screening
P-E-03	Transfer Screening
P-E-04	Initial Health Assessment
P-E-05	Mental Health Screening and Evaluation
P-E-06	Oral Care
P-E-07	Nonemergency Health Care Requests and Services
P-E-08	Nursing Assessment Protocols and Procedures
P-E-09	Continuity, Coordination, and Quality of Care During Incarceration
P-E-10	Discharge Planning

Section F – Special Needs and Services

P-F-01	Patients with Chronic Disease and Other Special Needs
P-F-02	Infirmary-Level Care
P-F-03	Mental Health Services
P-F-04	Medically Supervised Withdrawal and Treatment
P-F-05	Counseling and Care of the Pregnant Inmate
P-F-06	Response to Sexual Abuse
P-F-07	Care for the Terminally Ill

Section G – Medical-Legal Issues

P-G-01	Restraint and Seclusion
P-G-02	Segregated Inmates
P-G-03	Emergency Psychotropic Medication
P-G-04	Therapeutic Relationship, Forensic Information, and Disciplinary Actions
P-G-05	Informed Consent and Right to Refuse
P-G-06	Medical and Other Research
P-G-07	Executions

VII. ACKNOWLEDGEMENTS

We wish to acknowledge the numerous CCHCS employees who participated in the meetings, email correspondence, and interviews related to this report. We are also grateful for the participation of outside medical experts who contributed their time and expertise to discussions on quality assessment and oversight in community and correctional healthcare environments. The ideas, experiences, and candor of those who donated their time were to this initiative were essential to informing many of the recommendations in this report.

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