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Planning For Correctional Healthcare Oversight In California: Recommendations from a Modified Delphi Process

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AMEND AT UCSF

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Amend at the University of California San Francisco School of Medicine (“Amend”) draws on public health, medical ethics, occupational health, and international correctional practices to inspire transformative change in carceral environments to reduce harm and promote the health and humanity of prison staff and people who are incarcerated.

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1. EXECUTIVE SUMMARY

As the federal *Plata* Receivership nears its conclusion, California faces a pivotal opportunity to establish a permanent system of oversight for prison healthcare. Since its creation in 2006, the Receivership has been associated with substantial improvements in healthcare quality, accountability, and infrastructure. Sustaining these gains will require an independent oversight body that promotes continuous quality improvement, ensures accountability, and reduces the risk of future constitutional deficiencies and litigation. Because no established model for comprehensive prison healthcare oversight exists in the United States, California has the opportunity to develop an approach that could inform correctional systems nationwide.

This report provides an evidence-based framework to guide development of a post- Receivership prison healthcare oversight body. It presents expert consensus recommendations, explains their rationale, and identifies key policy trade-offs where expert opinions diverged.

Recommendations were developed using a modified RAND/UCLA Delphi process, an established method for building expert consensus when empirical evidence alone is insufficient to guide policy. A multidisciplinary Panel with expertise in correctional healthcare, healthcare quality, oversight, constitutional litigation, public policy, state government, and lived experience with incarceration participated in three confidential survey rounds. Using anonymized feedback from each round, Panelists considered the oversight body's scope, governance, authority, funding, evaluation methods, reporting, and enforcement responsibilities. Questions reaching predefined consensus thresholds were finalized, while unresolved issues were refined and reconsidered.

Following three thematically-organized survey rounds, the Delphi Panel produced 24 findings, each supported by one or more recommendations. Consensus was strongest on creating an oversight body that is independent, transparent, proactive in identifying healthcare quality concerns, aligned with community care standards, and separated from operational prison healthcare management.

Establishing a post- Receivership oversight body will require legislative action, sustained funding, careful planning, and broad stakeholder engagement. Beginning the transition before the Receivership concludes, including an overlap period between the Receivership and its successor, will help preserve institutional knowledge and ensure continuity. By creating a durable, independent oversight system, California can protect the progress achieved under the *Plata* Receivership while establishing a national model for correctional healthcare oversight.

A list of the findings, grouped by theme, is included below; a more comprehensive explanation of each one, including pertinent recommendations and discussion, can be found under **Results** in the body of the report.

FINDINGS

HEALTHCARE OVERSIGHT BODY: SCOPE OF WORK AND METHODS

1. The healthcare oversight body should evaluate the full continuum of care (medical, dental, and mental health). While a healthcare oversight body would ideally have a unified mandate across adult and juvenile facilities, California's governance structures make this infeasible.
2. Healthcare oversight should promote and positively incentivize quality and quality improvement, rather than solely identifying deficiencies.
3. The healthcare oversight body should review the state budget for prison healthcare expenditures prior to its finalization. Review may include non-binding feedback, but the healthcare oversight body should not have approval authority over the budget.
4. The healthcare oversight body should review CCHCS strategic planning documents prior to their finalization. Review may include providing non-binding feedback, but the healthcare oversight body should not have approval authority over CCHCS's strategic plans.
5. The healthcare oversight body should be able to access individual patient records — with identifying information — in order to evaluate care quality.
6. The healthcare oversight body should have the authority to make unannounced inspections/visits to prisons and be able to visit any part of a prison and talk to any patient or staff member.
7. The healthcare oversight body should have the authority to review any relevant documents held by the state prison system.
8. The healthcare oversight body should oversee health-related programming, nutrition, and exercise as it relates to the physical and mental health of patients.
9. An assessment of population level health should be a primary focus for evaluating the quality of healthcare in the prison system. In addition, the healthcare oversight body should evaluate quality through a random sampling of individual medical records among complex and medically vulnerable patients, a review of healthcare appeals data, and the administration of confidential surveys to individual patients and staff members. The healthcare oversight body should also review internal policies/procedures related to healthcare, perform on-site inspections, and evaluate incident report data in its assessment of health system performance.
10. The healthcare oversight body should create a mechanism to allow both staff and patients to anonymously share concerns about healthcare delivery in the prison system. Other parties should be able to share concerns confidentially.

HEALTHCARE OVERSIGHT BODY: SCOPE OF WORK AND METHODS

11. Data from complaints or concerns regarding healthcare delivery shared with the healthcare oversight body may be used to 1) identify trends and assess performance from aggregate data and 2) evaluate urgent and serious threats to the health of the prison population or the health of an individual. The healthcare oversight body should not be tasked with evaluating or responding to every complaint.
12. The healthcare oversight body should (whenever possible) align quality standards in the prison system with standards used in evaluations of community healthcare systems.

HEALTHCARE OVERSIGHT BODY: STRUCTURE, MEMBERS, AND FUNDING

13. The healthcare oversight body should be positioned within state government in a manner that insulates it from external political pressures. To the extent that the healthcare oversight body needs to be positioned within state government, housing it within the Health and Human Services Agency (HHS) is preferable.
14. The healthcare oversight body should receive a mandated amount of funding that is independent of the CDCR population and not renegotiated yearly in the state budgeting process. The amount of funding should be adjusted for inflation on a regular basis.
15. The leader of the healthcare oversight body should be a full-time employee who is appointed by the Governor's office with the advice and consent of the legislature.
16. The healthcare oversight body leader should be subject to term limits of approximately 5 years, although reappointment should be permitted. The leader may be removed by the appointing authority prior to the conclusion of their term due to undisclosed conflicts of interest, unethical behavior, and/or failure to perform the duties of their job.
17. The healthcare oversight body should consider assembling a volunteer advisory board made up of diverse stakeholders.

HEALTHCARE OVERSIGHT BODY: REPORTS, FOLLOW-UP, AND ENFORCEMENT

18. The healthcare oversight body should issue reports on healthcare delivery across the entire state prison system at least annually. Additional reports on healthcare delivery at individual prisons or on topics selected by the healthcare oversight body should be issued at intervals determined by need and the levels of staffing and funding provided to the healthcare oversight body.

HEALTHCARE OVERSIGHT BODY: REPORTS, FOLLOW-UP, AND ENFORCEMENT

19. Reports issued by the healthcare oversight body should avoid pass/fail scoring or the reliance on graded or scaled scoring of healthcare quality. Instead, reports should highlight successes and identify problems that need to be fixed and a timeline for corrective action.
20. CDCR/CCHCS and the Governor's office should be able to comment on reports before they are released to the public, but neither should have editorial control over the report.
21. The healthcare oversight body's methodology must be clearly described and publicly available.
22. Healthcare oversight body reports may both identify deficiencies in care and also suggest corrective actions to address these deficiencies. Reports should aim to disseminate best practices by highlighting successes across institutions.
23. When the healthcare oversight body identifies significant deficiencies in care, the enforcement of corrective actions should not fall to the healthcare oversight body itself. Instead, CCHCS/CDCR should develop a corrective action plan, and a separate government entity (e.g. the Governor's office or legislature) should be authorized to enforce the satisfactory implementation of the corrective action plan and to deploy additional resources (such as funding) or punitive measures, if needed, in consultation with the healthcare oversight body.
24. Corrective measures — whether enforced by the Governor's office or another entity — may be enacted if the prison healthcare system (as a whole or individual prisons) fails to adequately address significant deficiencies in care. Corrective measures may include appointment of new healthcare leadership, mandated population reduction, or a loss of local control over prison healthcare delivery. If a prison is eventually stripped of its authority to deliver healthcare services, it must either close or be subject to the appointment of a temporary healthcare overseer with broad powers to implement change.

2. BACKGROUND AND CONTEXT

Healthcare delivery in the California Department of Corrections and Rehabilitation (CDCR) has been under management of a federal court-appointed Receiver since 2006, after the *Plata* lawsuit established that prison medical care was inadequate and causing significant harm to incarcerated people.^{1, 2} Related litigation addressing mental healthcare (*Coleman v. Newsom*³) and disability rights (*Armstrong v. Newsom*⁴) has further shaped federal healthcare oversight in California state prisons.

The *Plata* Receiver was appointed to bring the state into compliance with constitutional standards under the Eighth Amendment's prohibition of cruel and unusual punishment. Over the past two decades, the *Plata* Receivership has driven significant reforms, alongside a substantial increase in healthcare and legal expenditures.

The system is now approaching a critical transition. Each prison must be delegated back to the Secretary of CDCR in a complex process that includes medical inspections undertaken by the Office of the Inspector General (OIG), tracking of quality indicators collected by CDCR staff, and independent evaluation by the *Plata* Receiver. As of June 2026, healthcare operations at 31 of 34 California state prisons had been delegated back to the Secretary of CDCR,⁵ with full dissolution of the *Plata* Receivership anticipated following completion of this process. **Once delegation is complete, California must implement a durable, court-approved plan for oversight of healthcare delivery in its state prisons. Planning for post-Receivership oversight must begin now and ideally would include overlap between appointment of the oversight leadership group and the Receivership.**

The transition away from Receivership oversight carries significant implications for both patient care and state resources. Over the past two decades, efforts to reform prison healthcare in California have been accompanied by substantial increases in spending, with annual medical costs rising from \$1.2 billion in 2005–2006 to \$3.1 billion in 2025–2026 (inflation-adjusted).^{6–8} In addition, over \$200 million has been spent by the state on legal fees across all three class action lawsuits between fiscal year 2017/2018 and 2023/2024.^{9–11} **As oversight responsibilities return to the state, establishing an effective and durable healthcare oversight framework will be critical to sustaining improvements in healthcare, ensuring accountability, and reducing the risk of renewed litigation.**

However, no widely accepted model exists in the United States to guide comprehensive, proactive oversight of correctional healthcare systems. Most states lack formal oversight bodies and instead rely on litigation to address healthcare quality failures after they occur. Others that have exited federal receivership have faced challenges sustaining effective oversight mechanisms. Oversight of community healthcare offers useful tools but is not fully applicable to correctional settings.¹²

In California, oversight outside the *Plata* Receivership is conducted by the Office of the Inspector General (OIG), whose Medical Inspections Unit relies primarily on case reviews, site inspections, and assessments of compliance with internal policies.¹³ While these methods offer useful insights, they rely on a small, selectively chosen set of cases and fail to capture details of system-wide performance, population health outcomes, or key dimensions such as preventive care, patient experience, and internal patient safety systems.

These limitations, alongside an absence of a “gold standard” approach to prison healthcare oversight, highlight the need for a robust, enduring framework that can be used in California and beyond to address the unique needs for healthcare oversight in prisons.

3. PURPOSE AND SCOPE OF THIS REPORT

The purpose of this report is to create an evidence-based framework for policymakers to rely upon in the creation of a post-Receivership prison healthcare oversight body. Drawing on a consensus-based modified Delphi process involving diverse experts and stakeholders, it offers recommendations to support a high-quality, patient-centered, and accountable prison healthcare system that aligns with evolving community standards.

The report is intended for stakeholders across the California Department of Corrections and Rehabilitation (CDCR) healthcare system, including CDCR and California Correctional Health Care Services (CCHCS) leadership and staff; the Offices of the Federal *Plata* and *Coleman* Receivers; the overseeing federal courts; litigants; the Governor's office; healthcare professionals and patients; and external stakeholders such as policymakers, advocacy organizations, and academics.

This report:

- Presents expert consensus recommendations for oversight of prison healthcare in California.
- Explains the rationale for each recommendation.
- Assesses trade-offs where expert recommendations diverged.

These recommendations are designed to guide the development of a high-quality, evidence-based framework for prison healthcare oversight that is patient-centered, aligned with evolving community standards, and informed by best practices from community and correctional settings.

4. METHODS

4.1 Overview of Approach

We used a modified Delphi method to develop the recommendations in this report. This approach builds consensus among experts and stakeholders (the Delphi Panel) around complex problems lacking clear evidence-based solutions.¹⁴ The process included three confidential survey rounds in which the Delphi Panel answered qualitative and quantitative questions, reviewed aggregated group responses, and revised their views over time. (Surveys available from Amend at UCSF upon request.)

The Delphi method was developed by RAND more than 70 years ago as a way to improve policy decision making based on the consensus of experts.¹⁴ This method and its uses have evolved over time. Stakeholder participation has become more common, in recognition of the critical importance of experiential knowledge.¹⁵ It has also been adapted to diverse situations in medical care, including

outcome measurements in clinical trials, curriculum creation, utility of medical or surgical approaches in the absence of high-quality evidence, and in the assessment of healthcare quality.¹⁶ According to RAND, the Delphi method is best used “in forward-looking studies on topics for which expert opinion is the only source of evidence and for studies that explore areas of agreement and disagreement on complex issues.”¹⁴

We selected the Delphi method because no established “gold standard” exists for oversight of correctional healthcare systems in the United States. Available evidence is fragmented, and experiential knowledge from both experts and stakeholders is essential. The modified Delphi approach enabled us to systematically integrate multiple perspectives into evidence-informed, consensus-based recommendations for prison healthcare oversight.

Figure 1.
Delphi Panel retention



4.2 Panel Selection and Retention

The Delphi Panel was convened by the study team at Amend at UCSF, who served as facilitators but did not participate as Panelists to minimize bias. Panelists were selected to reflect a diverse range of expertise and lived experience relevant to correctional and community healthcare oversight. Panel recruitment was designed to include individuals with the following areas of expertise:

- Prison healthcare delivery (both leadership and front-line provision of care)
- Prison healthcare receipt (formerly incarcerated people)
- Current California prison healthcare oversight

- Prison healthcare oversight practices outside of California (U.S. and abroad)
- Healthcare oversight outside of corrections (licensing, reimbursement, credentialing)
- State government expertise: structure and funding

We identified Panelists through literature review, consulting with known experts, and targeted snowball sampling. All Panelists were recruited via email and were provided with a summary of the Delphi method and the overall goals of the project. Panelists who were unfamiliar with healthcare delivery in U.S. correctional settings were also provided with two brief overviews of the topic from the academic literature.^{17,18}

To improve Panel recruitment and retention, we set a pre-specified limit of three rounds of surveys.¹⁹ Panelists received a stipend upon completing all three survey rounds; some Panelists declined compensation voluntarily and others could not be compensated due to public employment regulations.

Invitation and retention numbers for Delphi Panelists are shown in [Figure 1](#). Panelists brought expertise in correctional healthcare delivery (leadership and frontline provision of care), oversight of correctional healthcare (in California, other states, and internationally), patient advocacy and lived experience of incarceration, healthcare regulation in community health systems, state healthcare policy, research on U.S. correctional oversight, Eighth Amendment litigation, and/or advising the court in the *Plata* case.

A full list of Panelists appears in [Appendix 7.1](#). **Participation in the Delphi Panel does not imply that individuals (or their employer) endorsed any specific finding in this report.** In rare instances, quoted responses have been lightly edited to preserve Panelist anonymity.

The study was reviewed and approved by the UCSF Institutional Review Board.

4.3 Survey Design

We administered surveys electronically using Qualtrics (Qualtrics Survey Software; Provo, UT: 2025), which Panelists completed asynchronously. We encouraged Panelists to skip survey questions that were outside of their area of expertise, if they did not have a strong opinion, or if they did not want to answer for other reasons. At the outset, we asked Panelists to evaluate their confidence related to seven content domains as an additional measure of the breadth of the Panel's expertise.

We developed the first survey based on a scoping review about what is known regarding healthcare oversight and quality evaluation in correctional and community settings.¹² We organized survey items under the topics described in [Table 1](#).

We used responses from each round of surveys to inform the design of subsequent surveys. Questions reaching consensus were removed, while others were revised, expanded, or repeated as needed.

In each new round of surveys, we provided Panelists with a summary of the results and anonymized quotations representing different perspectives from the prior survey round to allow Panelists to reconsider their responses based upon group feedback. To ensure fidelity to the initial survey responses, two additional Delphi Panel facilitators reviewed surveys used in subsequent rounds

to ensure that the new quantitative response options reflected the themes that emerged from the prior round and that new survey questions captured concepts raised by Panelist responses.

Table 1. Delphi Panel survey topics and organization

SCOPE OF WORK AND METHODS
Type of healthcare delivery subject to oversight (e.g. medical care, mental health care, dental care).
Types of correctional institutions in California that would be subject to oversight.
Prison programming that may be under the purview of the healthcare oversight body (e.g. nutrition, out-of-cell time).
Methods used by the healthcare oversight body to evaluate healthcare quality.
Types of privileged and confidential information that the healthcare oversight body may access to evaluate healthcare quality.
Degree of interaction and collaboration between the healthcare oversight body and prison health-care officials.
MEMBERS, STRUCTURE, AND FUNCTION
Composition, appointment, and removal of healthcare oversight body leadership.
Positioning of the healthcare oversight body in state government.
Funding of the healthcare oversight body.
REPORTS, FOLLOW UP, AND ENFORCEMENT
Healthcare oversight body reports, editorial control, topics, and frequency.
Role of the healthcare oversight body in enforcing any corrective measures in response to deficiencies in healthcare delivery.

We sent Panelists links to Survey 2 and Survey 3 with each member’s individual responses to the prior round survey shared in full so they could review their own responses simultaneously. Questions on the final survey (Round 3) were entirely quantitative but allowed additional comments following each question.

Round 2 and 3 survey questions were structured as follows:

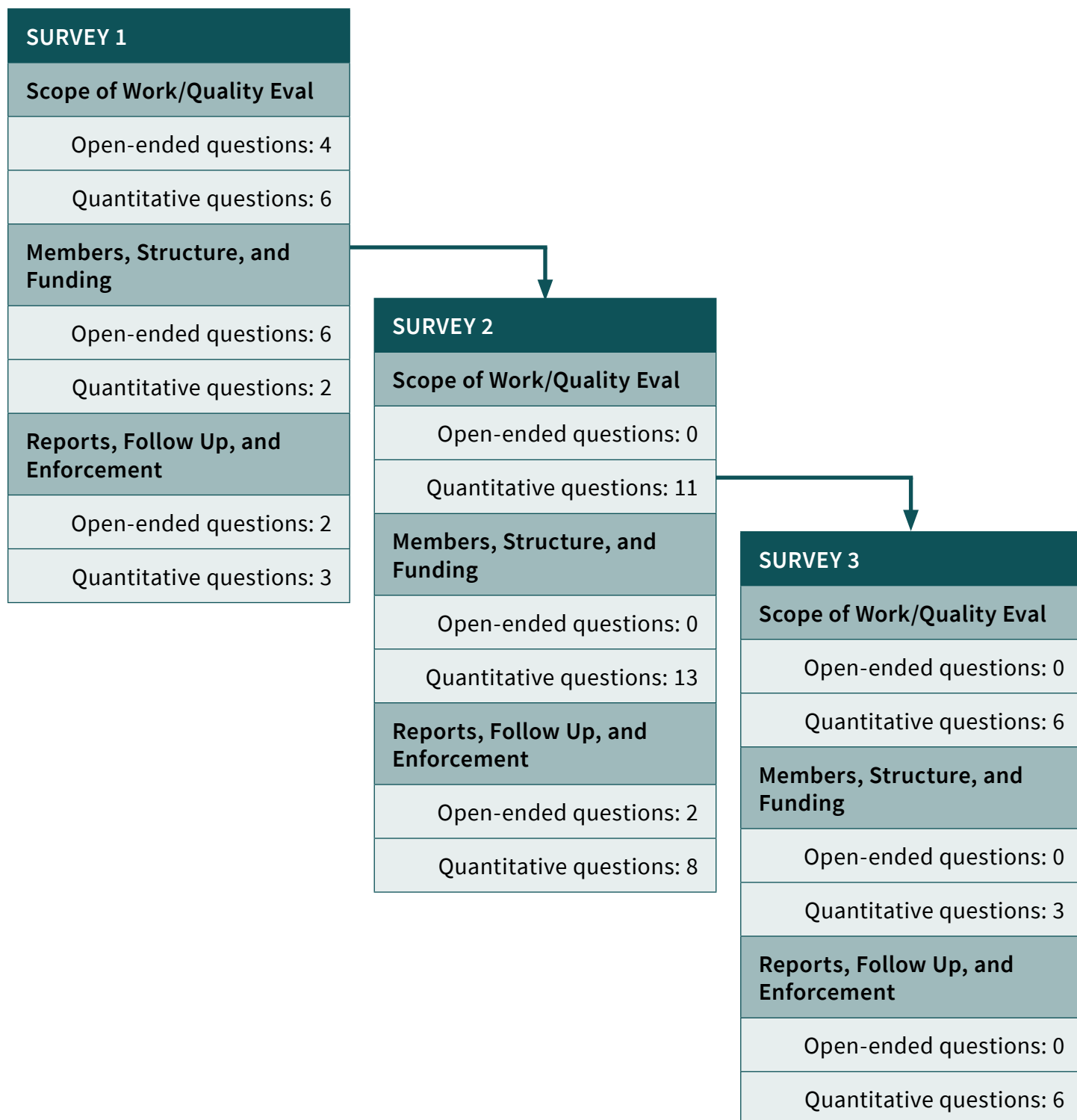
- 1. Prior survey question: original question from the prior round for reference**
- 2. Results: a brief, anonymous, quantitative or thematic analysis of the entire Delphi Panel’s responses to the prior round’s question**
- 3. Select anonymous quotations, demonstrating arguments for or against each possible response**

(these were abstracted from the thematic review of the prior round question, when applicable)

4. Current survey question(s)

The evolution of the survey through each round — moving from more open-ended to more quantitative questions — is portrayed in [Figure 2](#).

Figure 2. Survey evolution: Rounds 1 through 3.



4.4 Analysis

We evaluated qualitative responses using thematic analysis conducted independently by two reviewers who were blinded to each other’s coding and to the identities of survey respondents. We identified themes manually (without the use of artificial intelligence), using Atlas.ti (Lumivero, LLC; Berlin, Germany: 2025) to organize and analyze text.

Themes were identified and reconciled through discussion, and results were used to refine survey questions in subsequent rounds. This included converting convergent themes into structured response options, retaining open-ended questions where perspectives remained divergent, and introducing new survey items where needed.

Our quantitative analysis included determining which question met pre-specified criteria for consensus and identifying questions lacking consensus that needed to be repeated, in original or modified form (based on Panelist comments) in the subsequent round of surveys. Our goal was to reach “consensus recommendations” when possible and, when consensus was not possible, we reported “majority recommendations” (recommendations supported by a majority of Panelists that did not rise to the pre-specified definition of consensus). The definitions of consensus and majority recommendations, based on question type, are described in [Table 2](#).

Table 2. Definitions of consensus based on question type

QUESTION TYPE	CONSENSUS RECOMMENDATION	MAJORITY RECOMMENDATION
Dichotomous questions (typically yes/no)	≥75% agreement	>50% but <75% agreement
5-point Likert scale questions: points awarded from 1 point (“unnecessary recommendation”) to 5 points (an “essential recommendation”)	Mean score ≥4.0 points	Mean score >3.5 but <4.0 points
Multiple choice questions	≥75% of respondents selected any one choice	>50% but <75% of respondents selected any one choice
Ranking questions: ranked choice (“instant runoff”) approach, ²⁰ where the least common response was eliminated and the next choice from individuals with eliminated answers was re-distributed according to the next ranked preference until consensus or majority agreement reached	≥75% agreement reached	Only two responses remained with <75% agreement

5. RESULTS

5.1 Panel Confidence and Expertise

As a whole, Delphi Panelists reported a high degree of confidence in their ability to comment upon key domains relevant to the formation of a correctional healthcare oversight body. At least 50% of respondents reported they were “somewhat” or “very” confident on a 5-point Likert scale of confidence for each domain ([Table 3](#)).

Table 3. Delphi Panel: self-reported confidence in overarching topic areas

EITHER “SOMEWHAT” OR “VERY” CONFIDENT IN FOLLOWING DOMAINS	%
Identifying what is important to patients seeking healthcare in a prison.	68%
Understanding the challenges of providing healthcare in a prison.	91%
Describing regulatory and oversight mechanisms for healthcare delivery outside of carceral settings (in the U.S. or abroad).	50%
Describing regulatory and oversight mechanisms for healthcare delivery within carceral settings (in the U.S. or abroad).	53%
Defining how to measure and evaluate healthcare standards and quality.	71%
Recommending where a prison healthcare oversight body should be positioned in state government (e.g. reporting structures, funding).	53%
Identifying the legislative and/or legal considerations relevant to creating a charter for a prison healthcare oversight body (in the U.S. or abroad).	56%

FINDINGS

5.2 Healthcare Oversight Body: Scope of Work and Methods

FINDING 1

The healthcare oversight body should evaluate the full continuum of care (medical, dental, and mental health). While a healthcare oversight body would ideally have a unified mandate across adult and juvenile facilities, California’s governance structures make this infeasible.

RECOMMENDATIONS

- Integrate oversight of medical, dental, and mental health care: 94% (consensus)
- Ideally, the healthcare oversight body would oversee both adult and juvenile facilities [72% (majority)]. However, different loci of governance (county-run juvenile facilities versus state-run prisons) makes this ideal infeasible in California.

SUPPORTING QUOTE

“The body needs to have expertise in all (medical care, dental care, mental health care). The issues are too interrelated to separate into two [oversight] bodies.”

DISCUSSION

Panelists strongly agree (94%) that separating oversight of medical, dental, and mental health care would fragment evaluation and miss critical interdependencies across domains. Panelists view integrated oversight of all aspects of healthcare as essential for assessing quality and coordination of care.

A majority (72%) also favor a single healthcare oversight body spanning adult and juvenile facilities, citing potential gains in consistency and alignment across the correctional system. However, some Panelists raise concerns that differing governance structures (county-run juvenile facilities versus state-run prisons) make it too challenging for a single healthcare oversight body to monitor both effectively.

FINDING 2

Healthcare oversight should promote and positively incentivize quality and quality improvement, rather than solely identifying deficiencies.

RECOMMENDATIONS

- Introduce positive incentives for high quality care and gains in quality improvement (rather than only identifying problems or deficiencies): 88% (consensus)

SUPPORTING QUOTES

“Perhaps more important than identifying negative outliers that need correction, [the healthcare oversight body] should identify positive outliers that should be emulated.”

“Limiting the report to deficiencies only provides an imbalanced picture of the system...failing to identify where the institution is adequate or particularly where the institution excels does not provide the institution or the public with this important information that could be used to improve other less successful processes.”

“Bright spots should be noted. Whatever the healthcare system is excelling at should be celebrated... and if a system cannot improve due to reasons out of their control, it should be noted.”

DISCUSSION

Panelists emphasize that oversight focused only on deficiencies presents an incomplete view of system performance. Identifying and disseminating high-performing practices can drive improvement by offering models for replication, while also recognizing contextual constraints on performance that need to be addressed through policy. Panelists endorse a balanced approach that highlights both gaps and strengths as most conducive to quality improvement initiatives.

FINDING 3

The healthcare oversight body should review the state budget for prison healthcare expenditures prior to its finalization. Review may include non-binding feedback, but the healthcare oversight body should not have approval authority over the budget.

RECOMMENDATIONS

- The healthcare oversight body should review and provide non-binding feedback on the annual prison healthcare budget: 61% (majority)
- The healthcare oversight body should not have a role in approving the state budget for prison healthcare expenditures: 75% (consensus)

SUPPORTING QUOTES

“Approving the budget makes the oversight body part of the management structure and limits its independence. But having an opportunity to review and comment on the adequacy of the budget at the stage when the Legislature — made up of members who are NOT experts on these issues — is making decisions can provide important advice and guidance at a time when it can make a huge difference to the quality of health care that is eventually provided.”

“Given the inside knowledge and watchdog role of the oversight body, not allowing state officials and lawmakers to access that knowledge in evaluating budgets seems shortsighted and undermines the ability of the body to positively impact the system.”

DISCUSSION

A majority of Panelists (61%) agree that reviewing and providing non-binding feedback on the state budget for prison healthcare expenditures would help the legislature ensure that funding is commensurate with the needs and challenges of the system. Simultaneously, Panelists contend that having a role (beyond advisory) in the budget approval process would compromise the healthcare oversight body’s independence and encroach on the authority of the state legislature.

FINDING 4

The healthcare oversight body should review CCHCS strategic planning documents prior to their finalization. Review may include providing non-binding feedback, but the healthcare oversight body should not have approval authority over CCHCS’s strategic plans.

RECOMMENDATIONS

- The healthcare oversight body should review and provide non-binding feedback on CCHCS’s strategic planning documents before they are implemented: 88% (consensus)
- The healthcare oversight body should not maintain a role in approving CCHCS’s strategic planning documents: 76% (consensus)

SUPPORTING QUOTES

“This role should be advisory. All final decisions about strategic planning and management should be retained in the prison system. An oversight body has to remain independent and not become part of the prison agency’s management.”

“There should be a formal process for the oversight body to review and submit comments and concerns. Ideally these comments would be addressed in the final strategic plan (or a justification provided as to why not). This maintains a level of visibility, collaboration, and accountability without making the body the approver.”

DISCUSSION

Panelists agree that prospective review of key strategic documents (e.g., the CCHCS Performance Improvement Plan) would strengthen collaboration and improve alignment with quality goals by taking advantage of the healthcare oversight body's expertise. Panelists also emphasize that the healthcare oversight body's role should remain advisory. Maintaining non-binding feedback preserves the distinction between oversight and operations, avoiding encroachment on executive decision-making while still enabling useful input.

FINDING 5

The healthcare oversight body should be able to access individual patient records — with identifying information — in order to evaluate care quality.

RECOMMENDATIONS

- The healthcare oversight body should have access to individual patient health records: 91% (consensus)
- The healthcare oversight body should be able to review individual patient health records without additional privacy measures (e.g. individual consent or redaction) beyond what is required by law when handling protected health information: 62% (majority)

SUPPORTING QUOTES

“The policy creating a health care oversight body should explicitly say that it can access unredacted health care records without the prior consent of patients. I don’t see why the policy would create unnecessary barriers to records needed for oversight activities. The health oversight exception to the HIPAA privacy rule is clear.”

“It makes no sense to handicap the oversight body any more than any other oversight body in the community. If the body finds evidence of significant problems, they may even want to interview the patient and/or consider redress of some sort.”

DISCUSSION

Reaching near total consensus, Panelists agree that healthcare oversight body members should be able to review individual patient health records. We informed Delphi Panelists that HIPAA privacy laws allow disclosure of identifiable protected health information — without explicit consent or redaction — to healthcare oversight agencies for oversight activities authorized by law.²¹ Based on prior comments, we then asked Panelists if additional measures should be implemented for the handling of protected health information by the healthcare oversight body, specifically redaction of patient identifiers or a process of opt out or informed consent. A majority (62%) do not think additional measures are needed and clarify that this could also hinder the investigative capacity of the healthcare oversight body unnecessarily.

FINDING 6

The healthcare oversight body should have the authority to make unannounced inspections/visits to prisons and be able to visit any part of a prison and talk to any patient or staff member.

FINDING 7

The healthcare oversight body should have the authority to review any relevant documents held by the state prison system.

RECOMMENDATIONS

- The healthcare oversight body should have the authority to make unannounced inspections/visit to prisons: 97% (consensus). This includes the authority to:
 - Visit any part of a prison and talk to any patient or staff member: 94% (consensus)
 - Review any relevant documents held by the state prison system: 100% (consensus)

DISCUSSION

Panelists reached broad consensus and engaged in little debate around granting the healthcare oversight body the authority to visit any part of any prison and speak to any staff member or patient. Panelists view this as a foundational authority granted to the healthcare oversight body even if information gathered from inspections is only a small part of the overall assessment of healthcare quality. Some Panelists acknowledge that unannounced inspections can be disruptive to operations and thus recommend limiting such visits in frequency or conducting them within pre-determined timeframes. Panelists also agree that any internal CCHCS documents should be made available to the healthcare oversight body upon request.

FINDING 8

The healthcare oversight body should oversee health-related programming, nutrition, and exercise as it relates to the physical and mental health of patients.

RECOMMENDATIONS

- The healthcare oversight body should oversee the following health and wellness-related domains:
 - Health-related programing: 91% (consensus)
 - Nutrition: 81% (consensus)
 - Exercise and out of yard time: 66% (majority)

SUPPORTING QUOTES

“Out-of-cell time and exercise are ABSOLUTELY health concerns, not custody concerns. I don’t think the oversight body’s mandate should be restricted a priori – if the body thinks it relates to health, or a person says this is affecting health, go look at it. Maybe denial of religious worship is having a major psychological effect? Maybe the education programs address addiction? If the body thinks something affects health (physical or psychological), then investigate.”

“This is a good example of why integrated oversight makes sense – due to overlapping expertise and the impact of multidisciplinary systems on incarcerated people.”

DISCUSSION

Panelists emphasize that nutrition, particularly for those with medically focused needs, and structured health or mental health programming are core components of effective healthcare, reflecting their direct and immediate impact on the health and well-being of incarcerated individuals. There is also support (though more variable), for the body to provide oversight of exercise and “out-of-cell” time, with many Panelists noting these to be critical contributors to both physical and psychological health. Yet, several respondents also caution against an overly expansive mandate, suggesting that the healthcare oversight body should remain focused on healthcare delivery while collaborating with other entities on broader issues.

FINDING 9

An assessment of population level health should be a primary focus for evaluating the quality of healthcare in the prison system. In addition, the healthcare oversight body should evaluate quality through a random sampling of individual medical records among complex and medically vulnerable patients, a review of healthcare appeals data, and the administration of confidential surveys to individual patients and staff members. The healthcare oversight body should also review internal policies/procedures related to healthcare, perform on-site inspections, and evaluate incident report data in its assessment of health system performance.

RECOMMENDATIONS

- Based on mean scores from a 5-point Likert scale (from “unnecessary” to “essential”), the Delphi Panel asserts that a healthcare oversight body should prioritize — in descending order — the following strategies to assess healthcare quality:
 - Evaluation of population level data: 4.3 (consensus)
 - Record review from a random sampling of individual records of complex and medically vulnerable patients: 4.2 (consensus)
 - Review of patient healthcare appeals data: 4.2 (consensus)
 - Confidential surveys/interviews of individual patients: 4.2 (consensus)
 - Confidential surveys/interviews of individual healthcare staff: 4.1 (consensus)
 - Review of internal policies/procedures related to healthcare delivery: 4.1 (consensus)
 - On-site inspections: 4.1 (consensus)
 - Incident report data and how it is handled: 4.0 (consensus)
 - Review of random sampling of individuals medical records from the whole population: 3.8 (majority)
 - Confidential surveys or interviews with custody staff: 3.7 (majority)

SUPPORTING QUOTES

“I think all of these things are absolutely basic requirements. Within them, I would rank patient

experience and population level data on outcomes the highest.”

“Aggregate data is necessary to identify trends. Reviewing medical records of more complex or vulnerable patients yields a deeper look at how the institution is able to handle tougher and more complex medical issues. Understanding, and holding institutions accountable to their own internal policies and procedures is vital in ensuring quality patient care at scale.”

“Prioritize speaking to residents to get qualitative data that can’t be obtained anywhere else.”

DISCUSSION

Panelists emphasize that population-level health data is essential for identifying system-wide trends, distributions, and areas where problems are concentrated, making it the cornerstone of effective oversight. They highlight the importance of complementing these data with in-depth review of a statistically significant number of medical records of patients (with an oversampling of patients with medical complexity or medically vulnerabilities), direct engagement with patients to capture experiences that are not reflected in quantitative data, and review of internal quality assurance processes and policies. Panelists also support the use of healthcare appeals data, incident report data, and corrective action plans to assess healthcare quality. Panelists’ comments support the use of these modalities both to assess healthcare quality and to determine how responsive the healthcare system is to complaints, adverse events, and other challenges that require corrective action.

FINDING 10

The healthcare oversight body should create a mechanism to allow both staff and patients to anonymously share concerns about healthcare delivery in the prison system. Other parties should be able to share concerns confidentially.

RECOMMENDATIONS

- The healthcare oversight body should create and manage a portal for anyone to share confidential complaints or concerns around healthcare delivery with the healthcare oversight body: 100% (consensus)
- Those who should be allowed to anonymously share concerns include patients 86% (consensus) and staff 88% (consensus)

SUPPORTING QUOTES

“I appreciate the trade-offs between having complaints be or not be anonymous. I believe more data is better than less (i.e., allowing people to remain anonymous if they so choose). Not every single complaint needs to be investigated. Sometimes just the nature of the complaints and their trends is sufficient information to lead to an analysis of a potential problem. I am most supportive of a complaint portal that invites all input, allowing the reporter to decide how much self-identifying information they want to provide. They are therefore also controlling whether or not their specific complaint can be investigated.”

“If complaints are anonymous, it would be almost impossible for the oversight body to look into or verify the legitimacy or accuracy of any of the complaints. So as long as the complaints are confidential, I think that is sufficient. I make an exception for prison employees, though, since there is such tremendous disincentive for employees to be ‘whistleblowers’ of sorts, and the fear of

exposure would lead many to avoid bringing issues to the attention of the oversight body even if the complaints are described as confidential.”

DISCUSSION

Panelists emphasize that anonymous and confidential reporting mechanisms are essential to encourage individuals to share their concerns about healthcare quality. Panelists note that fear of retaliation may deter reporting unless anonymity is permitted, particularly for patients and employees who are more vulnerable to reprisal. Several respondents acknowledge that anonymous complaints may limit the ability to investigate or verify individual concerns, suggesting that complainants should be informed of these limitations while still being allowed to control how much identifying information they provide.

FINDING 11

Data from complaints or concerns regarding healthcare delivery shared with the healthcare oversight body may be used to 1) identify trends and assess performance from aggregate data and 2) evaluate urgent and serious threats to the health of the prison population or the health of an individual. The healthcare oversight body should not be tasked with evaluating or responding to every complaint.

RECOMMENDATIONS

- Use complaint data to (mean scores from a 5-point Likert scale from “unnecessary” to “essential”):
 - Identify trends and assess performance: 4.5 (consensus)
 - Evaluate urgent and serious threats to the health of the prison population or a group of people: 4.2 (consensus)
 - Evaluate urgent and serious threats to the health of an individual: 3.9 (majority)

SUPPORTING QUOTES

“The oversight body is by definition not to be ‘in the weeds’ regarding day-to-day operations of the correctional health facilities. What the oversight body should do though is ensure that complaints/concerns are monitored, aggregated to determine areas of concern, and require correctional health staff to review and provide plans to mitigate/address select complaints/concerns.”

“It depends on whether the healthcare oversight body is set up as a complaints body or as an entity designed to identify systemic issues. I would argue that the latter is most critical, since it will potentially have the greatest impact. Complaints should mainly be used as a source of data to help identify the critical issues. And realistically, given the number of complaints about medical care, it seems unlikely that every complaint could be fully investigated or addressed. That said, if someone presents an urgent complaint with life-threatening implications or a complaint that is easily addressed, these complaints should be addressed.”

DISCUSSION

Panelists emphasize that complaint data are most valuable when used to identify systemic trends, recurring problems, and areas requiring focused oversight, rather than as a mechanism for investigating

every individual grievance. Panelists support the use of complaints to flag potential urgent or serious threats to the health of individuals or the broader prison population, while noting that many complaints should be referred to prison healthcare authorities with follow up, as needed, from the healthcare oversight body. Several respondents caution that requiring the healthcare oversight body to investigate every complaint would be impractical and would overwhelm limited resources, potentially undermining the body's broader oversight mission. Panelists also note the importance of maintaining a broadly accessible complaint process. Overall, Panelists favor a structured triage model in which complaint data inform the healthcare oversight body's subsequent evaluations, help them to prioritize special investigations, trigger escalation of serious concerns, and complement broader assessments of healthcare quality and safety.

FINDING 12

The healthcare oversight body should (whenever possible) align quality standards in the prison system with standards used in evaluations of community healthcare systems.

RECOMMENDATIONS

- The healthcare oversight body should align healthcare quality standards to the extent possible with the following (mean scores from a 5-point Likert scale from “unnecessary” to “essential”):
 - Measures used in the community (e.g. HEDIS measures, Medi-Cal/CalAIM standards, PCMHC recognition standards, etc.): 4.1 (consensus)

SUPPORTING QUOTES

“The ultimate goal should be meeting standard of care in the community. Incarcerated patients should not have worse outcomes than community dwellers.”

“NCCHC/ACA accreditation standards just look at the existence of policies and don't look at actual outcomes or medical practice. They are less useful than the quality treatment standards used in the community or that are disease/condition specific.”

DISCUSSION

Panelists emphasize that correctional healthcare quality should be benchmarked against community standards of care, with the goal of achieving health outcomes equivalent to those in non-correctional settings. Panelists frequently cite community-based quality measures, including disease-specific standards and HEDIS metrics, as more meaningful indicators of quality than correctional accreditation frameworks alone. Many experts express skepticism about relying heavily on correctional standards — such as those promoted by the National Commission on Correctional Healthcare (NCCHC)²² and the American Correctional Association (ACA)²³ — arguing that while there may be some limited utility to adopting some of these standards, both frameworks often focus on the existence of policies (and whether the system follows its own policies) rather than actual clinical outcomes or quality of healthcare delivery.

5.3 Healthcare Oversight Body: Structure, Members, and Funding

FINDING 13

The healthcare oversight body should be positioned within state government in a manner that insulates it from external political pressures. To the extent that the healthcare oversight body needs to be positioned within state government, housing it within the Health and Human Services Agency (HHS) is preferable.

RECOMMENDATIONS

- The healthcare oversight body should report to the Health and Human Services Agency (HHS): 57% (majority)

DISCUSSION

There is near universal agreement that the healthcare oversight body should be positioned within state government in a manner that insulates it from external political pressures. Furthermore, Panelists agree that the findings of the healthcare oversight body should be released to the public and not solely within a state government reporting structure. As described in the quote below, there is uncertainty whether the body should be housed within another entity of the state government bureaucracy or if it should report directly to the Governor's office. Ultimately, in the final round of ranked choice voting, a majority (57%) of respondents favor HHS over the Governor's office (43%). Other entities such as the Office of Inspector General (where the Medical Inspections Unit currently resides) and the State Auditor were eliminated in earlier rounds.

"You don't want to trap the oversight body within a bureaucratic org chart. You want its reports to go to the public and to the Governor. If the oversight body needs subject matter expertise from HHS, they should seek it out, and they could even do some inspections together. But the oversight body will be better able to create transparency and leverage that transparency for accountability if they're not layers below an auditor or HHS Secretary for purposes of publishing their reports, making budget and hiring requests, etc.."

FINDING 14

The healthcare oversight body should receive a mandated amount of funding that is independent of the CDCR population and not renegotiated yearly in the state budgeting process. The amount of funding should be adjusted for inflation on a regular basis.

RECOMMENDATIONS

- The healthcare oversight body's funding should be a mandated amount independent of the population size (following 3 rounds of ranked-choice voting): 52% (majority)
- A sizeable minority (48%) suggested that funding may be drawn as a percentage of CDCR's budget

SUPPORTING QUOTES

"I tend to think the oversight body will be more stably funded if it's structured as a percentage of CDCR's budget."

“This is a difficult decision but at the end of the day the body needs to be sufficiently funded and for the funds to not be competitive with funds for custody or healthcare -- how to accomplish that is complicated.”

DISCUSSION

There is a near-even split regarding how best to fund the healthcare oversight body. Overall, following three rounds of ranked choice voting, 52% of Panelists support funding the healthcare oversight body at a mandated amount that is independent of the CDCR population and not renegotiated yearly in the state budgeting process, while 48% favor funding the healthcare oversight body at a mandated percentage of the annual CDCR budget. There is little support for tying the budget to the CDCR population or subjecting the budget to renegotiation each year as a separate line item, although funding should be increased to keep pace with inflation on a regular basis.

FINDING 15

The leader of the healthcare oversight body should be a full-time employee who is appointed by the Governor’s office with the advice and consent of the legislature.

RECOMMENDATIONS

- The leader of the healthcare oversight body should be a full-time employee: 96% (consensus)
- The leader of the healthcare oversight body should be appointed by the Governor’s office: 72% (majority)
- The legislature should advise the Governor’s office and consent to the nomination of the healthcare oversight body leader: 81% (consensus)

DISCUSSION

After two rounds of ranked choice voting, 72% of Panelists favor the leader of the healthcare oversight body being appointed by the Governor’s office (with 81% of these respondents also recommending the advice and consent of the legislature in making this appointment). The HHS secretary and representatives from a California state university each received 14% of the vote. Ultimately, the Delphi Panel recommends that the healthcare oversight body leader should have the approval of the HHS secretary and should be selected based on their expertise at the intersection of healthcare quality, operations, healthcare oversight, and corrections.

FINDING 16

The healthcare oversight body leader should be subject to term limits of approximately 5 years, although reappointment should be permitted. The leader may be removed by the appointing authority prior to the conclusion of their term due to undisclosed conflicts of interest, unethical behavior, and/or failure to perform the duties of their job.

RECOMMENDATIONS

- The healthcare oversight body leader should be subject to term limits (allowing for reappointment): 86% (consensus)
- Term limits for the healthcare oversight body leader should last 3 to 5 years: 79% (consensus)

- The healthcare oversight body leader may be removed prior to the conclusion of their term due to undisclosed conflicts of interest, unethical behavior, and/or a failure to perform the duties of their job: 91% (consensus)

SUPPORTING QUOTES

“The most important reason for term limits would be to avoid complacency that might grow out of familiarity. However, this downside is overshadowed by the value of having an oversight body that gains expertise over time. The only other reason for short term limits would be poor performance, but for this problem, short term limits are too blunt (slow) an instrument. Thus, the appointing authority needs to be able to terminate for cause.”

“This sort of work isn’t easy. It takes years to carry out the vision in a piece of oversight legislation. A good leader should want to stay in the role for 10+ years to create an effective oversight body. The idea that the selection is political and should get very brief term-limits is overblown.”

“It is important to have people with interest and expertise, which often means there is a real or perceived conflict of interest. Strict rules for disclosure and recusal should be in place but an undisclosed conflict of interest (or failure to recuse oneself) could lead to removal.”

DISCUSSION

Most Panelists (86%) favor subjecting the leader of the healthcare oversight body to term limits that may be renewed through reappointment. Panelists caution against introducing short term limits (1 to 2 years), stressing the importance of allowing the healthcare oversight body leader time to gain experience and expertise. A majority of Panelists (79%) agree that term limits should be 3 to 5 years, the remaining Panelists are in favor of 6-to-7-year term limits (11%) or term limits of 8 years or longer (11%). Most Panelists agree (91%) that the risks of longer-term limits could be mitigated by providing a clear mechanism for the appointing authority to remove the healthcare oversight body leader for cause.

FINDING 17

The healthcare oversight body should consider assembling a volunteer advisory board made up of diverse stakeholders.

RECOMMENDATIONS

- An advisory board to the healthcare oversight body should be appointed and made up of diverse stakeholders: 65% (majority)

SUPPORTING QUOTES

“I see the advisory board as both a critical source of expertise for the body, a way to ensure community engagement, and a means to ensure that politics does not undermine the role of the oversight body.”

DISCUSSION

Delphi surveys included a few questions exploring the utility of an advisory board to the healthcare oversight body, the ideal composition and compensation of such an advisory board, and who should appoint members if an advisory board were created. Overall, 65% of Panelists favor assembling

an advisory board to the healthcare oversight body, although several respondents remarked that an advisory board would be an unnecessary and redundant layer of bureaucracy. If created, Panelists favor this board being comprised of a diverse group of volunteers including formerly incarcerated people, former prison healthcare employees, community healthcare professionals, experts in healthcare quality evaluation, and experts in healthcare compliance and oversight. The official duties of the board and how it would best advise and support the healthcare oversight body were beyond the scope of this project and should be determined by the healthcare oversight body itself.

5.4 Healthcare Oversight Body: Reports, Follow-Up, and Enforcement

FINDING 18

The healthcare oversight body should issue reports on healthcare delivery across the entire state prison system at least annually. Additional reports on healthcare delivery at individual prisons or on topics selected by the healthcare oversight body should be issued at intervals determined by need and the levels of staffing and funding provided to the healthcare oversight body.

RECOMMENDATIONS

- The healthcare oversight body should issue reports on the following scope and schedule:
 - Report on healthcare delivery across the entire state prison system at least annually: 94% (consensus)
 - Report on healthcare delivery at individual prisons at an interval TBD (dependent on staffing and budget): 80% (consensus)
 - Report on topics/themes of interest that span multiple prisons: 90% (consensus)

SUPPORTING QUOTES

“The oversight body should release reports based on appropriateness/need. It’s that simple. In other words, they should release a report when they have something to say. Otherwise, they’re wasting taxpayer money to do non-value-added work. If we can’t trust the oversight body to make that determination, then we have the wrong oversight body.”

“I suspect thematic reports (chronic care, sick call, end-of-life care, med pass, continuous quality improvement, etc.) will be more valuable than reports on individual facilities.”

DISCUSSION

There is broad consensus (94%) in the value of an annual healthcare oversight report on the whole system. Beyond this, however, Panelists do not endorse pre-specifying a rigid reporting schedule for thematic reports or reports on individual prisons (especially as the quality and frequency of these reports would be highly dependent on staffing and funding). While Panelists stress that evaluations at each prison should occur with regularity, their comments in the survey clarify that the healthcare oversight body should have the freedom and flexibility to evaluate each prison and generate thematic reports based on its expertise and perceived need, as opposed to being subject to a prescribed reporting frequency and a preselected range of topics at the outset.

FINDING 19

Reports issued by the healthcare oversight body should avoid pass/fail scoring or the reliance on graded or scaled scoring of healthcare quality. Instead, reports should highlight successes and identify problems that need to be fixed and a timeline for corrective action.

RECOMMENDATIONS

- In the evaluation of healthcare quality, healthcare oversight body reports should:
 - Avoid pass/fail scoring: 91% (consensus)
 - Avoid relying on any graded or scaled scores in reports: 58% (majority)

SUPPORTING QUOTES

“I think grades make no sense. The oversight body should identify problems that need to be fixed. Period. For a given problem, it may make sense to assign an urgency or timeframe for remediation.”

“There is too much nuance in any given report for a grade to make sense. They could be doing well in some areas but awful in others. A grade just averages those things out, and most agencies will be happy with even low (but passing) grades. Far better for the report to clearly outline the problems and successes observed by the oversight body.”

“An overall performance grade has the potential for being overly provocative — which is good to get a headline — but not helpful in trying to solve the problem. I think ok to have ratings for specific performance metrics. But an overall grade is ultimately counterproductive.”

DISCUSSION

There is consensus (91%) that giving pass/fail grades to institutions or the state as a whole is too simplistic and counterproductive. However, Panelists are split on the utility of assigning grades or scaled scores to the major findings in a report (42% in support). Many Panelists express concern that grades oversimplify the complex nature of prison healthcare oversight findings. Many Panelists instead argue that reports should focus on identifying specific strengths, deficiencies, and areas requiring remediation (with urgency ratings or timelines for corrective action). While several Panelists note that grades could become counterproductive by reducing complex findings to a single label, a minority of Panelists argue that grading systems may carry greater public and political impact than lengthy narrative reports alone, particularly when accountability is needed:

“A grade means something more actionable to the public, the media, and the institution. If a report basically concludes the institution is ‘so-so’ after 50 pages, nothing will happen. But if an institution is given a ‘C,’ then the public, political leaders, and the institution itself will strive for at least a ‘B.’ Such practices may lack the nuance we would like as experts, but they recognize the way humans are wired to respond.”

FINDING 20

CDCR/CCHCS and the Governor’s office should be able to comment on reports before they are released to the public, but neither should have editorial control over the report.

RECOMMENDATIONS

- Allow CDCR and CCHCS to comment on healthcare oversight body reports before they are released to the public: 76% (consensus)
- Prohibit the Governor’s Office from having editorial control over the report: 91% (consensus)

SUPPORTING QUOTES

“Comments from CDCR/CCHCS are necessary to ensure the accuracy of the findings and recommendations in the report because it allows the institution the opportunity to review the report for any factual errors, call the oversight body’s attention to those errors, and allow the oversight body the opportunity to investigate and reach an independent determination as to whether the issues the institution raised are legitimate and the report should be amended.”

“The Governor’s office should have a meaningful opportunity to review a draft, ask questions, suggest changes, challenge findings that don’t appear to be supported by data, and offer guidance on tone/ even-handedness. They could even participate in or mediate discussions of the draft report with CDCR. But the final editorial control, including whether/when to publish, should lie with the oversight body independently.”

DISCUSSION

Panelists emphasize that healthcare oversight reports must remain fully independent and free from editorial control by CDCR/CCHCS or the Governor’s Office, arguing that such independence is essential to the credibility and integrity of the healthcare oversight body. At the same time, many Panelists support allowing correctional agencies and executive officials to review draft reports for factual accuracy, provide contextual feedback, and submit non-binding comments for the healthcare oversight body to consider prior to finalization and publication of the report. Overall, Panelists favor a pre-release review process, but emphasize that final authority over report content, timing, and publication must remain exclusively within the healthcare oversight body.

FINDING 21

The healthcare oversight body’s methodology must be clearly described and publicly available.

RECOMMENDATIONS

- Make the methodology used by the healthcare oversight body publicly available and clearly described: 100% (consensus)

SUPPORTING QUOTES

“It is critical for oversight processes and methods to be transparent to maintain the integrity and neutrality of the oversight.”

DISCUSSION

Panelists were asked to identify ways to ensure the integrity of the healthcare oversight body’s findings. While much of this deliberation centered around structuring the healthcare oversight body in a way that maintains its independence, a few additional ideas emerged through the Delphi process. One such idea — the publication and dissemination of healthcare oversight body methodology — garners consensus support (100%). The suggestion that reports be subjected to

peer review prior to their publication was also debated but ultimately most (71%) of Panelists are not in favor of this approach.

FINDING 22

Healthcare oversight body reports may both identify deficiencies in care and also suggest corrective actions to address these deficiencies. Reports should aim to disseminate best practices by highlighting successes across institutions.

RECOMMENDATIONS

- Healthcare oversight body reports may suggest corrective actions when deficiencies in care are identified at the institutions or statewide: 96% (consensus)

SUPPORTING QUOTES

“The oversight body should not itself become involved in implementing any corrective actions otherwise it compromises its status as an independent body. It should however be available to explain to prison healthcare leadership why it is important to pursue the corrective actions proposed.”

“The oversight body should make recommendations on how it believes the health care system can improve its deficiencies, but the health care system should have the responsibility for determining how to incorporate and implement those recommendations.”

DISCUSSION

The vast majority of Panelists (96%) support a model in which the healthcare oversight body identifies deficiencies and may recommend corrective actions, while leaving responsibility for implementation of any corrective action to the prison healthcare system. Panelists emphasize that direct involvement in operational decision-making could compromise the independence of the healthcare oversight body and blur the distinction between oversight and management.

FINDING 23

When the healthcare oversight body identifies significant deficiencies in care, the enforcement of corrective actions should not fall to the healthcare oversight body itself. Instead, CCHCS/CDCR should develop a corrective action plan, and a separate government entity (e.g. the Governor’s office or legislature) should be authorized to enforce the satisfactory implementation of the corrective action plan and to deploy additional resources (such as funding) or punitive measures, if needed, in consultation with the healthcare oversight body.

RECOMMENDATIONS

The healthcare oversight body should not act as an enforcement entity when deficiencies in care are not responded to in an appropriate and timely manner; instead the healthcare oversight body should make recommendations to another government entity (e.g. Governor’s office or legislature) that is authorized to act: 83% (consensus).

SUPPORTING QUOTES

“The oversight body should not be penalizing anyone. It is for the executive to ensure that the recommendations of the oversight body are implemented. The oversight body should receive a response from the executive as to the measures taken to implement the recommendations and based upon the

response or other information it receives, it may decide to undertake a follow up visit sooner than scheduled. The aim should be to avoid litigation but if no action is taken to address the oversight body's concerns, then litigation is the last resort."

"It is hard to imagine who could actually hold the accountability aspect of this oversight. Giving the body the authority to levy fines or remove people from their roles, feels like an overreach and potentially could delve into operations. Giving it to the Governor's office or a third entity would probably be resisted. Since the prison system is technically part of the executive branch, the Governor already has some authority to enforce recommendations and standards set forth by the body."

DISCUSSION

Most Panelists (83%) believe that enforcement of corrective action plans and decisions regarding punitive measures should remain outside the healthcare oversight body's authority and instead rest with the Governor's Office or legislature. Panelists emphasize that the healthcare oversight body's primary role should be independent assessment, monitoring, and public reporting, warning that direct enforcement powers could blur the distinction between oversight and operational management, while compromising productive collaboration. Many respondents support a model in which the healthcare oversight body monitors compliance, conducts follow-up reviews, identifies noncompliance publicly, and recommends enforcement actions, while leaving implementation of penalties to other governmental actors. Simultaneously, a minority of Panelists argue passionately that oversight without enforcement authority risks becoming "toothless," citing concerns that political leaders may fail to act on even damning findings when there are few political consequences for inaction. These respondents draw comparisons to public health regulatory systems, arguing that oversight bodies in other sectors routinely possess enforcement authority and that similar powers may be necessary to ensure meaningful accountability in correctional healthcare.

FINDING 24

Corrective measures — whether enforced by the Governor's office or another entity — may be enacted if the prison healthcare system (as a whole or individual prisons) fails to adequately address significant deficiencies in care. Corrective measures may include appointment of new healthcare leadership, mandated population reduction, or a loss of local control over prison healthcare delivery. If a prison is eventually stripped of its authority to deliver healthcare services, it must either close or be subject to the appointment of a temporary healthcare overseer with broad powers to implement change.

RECOMMENDATIONS

- If the state prison healthcare system (as a whole, or an individual prison) fails to adequately address significant deficiencies in care, the enforcement entity may:
 - Remove prison healthcare leadership: 76% (consensus)
 - Take away local control over healthcare delivery in the prison, followed by closure or the appointment of a temporary overseer with broad powers to implement change: 81% (consensus)

- The enforcement entity should avoid:
 - Decreasing prison healthcare funding at the level of the state or individual prison in response to significant deficiencies in care (although population reduction may be considered): 96% (consensus)
 - Fining leadership at the prison or state level based on findings from the healthcare oversight body: 66% (majority)

SUPPORTING QUOTES

“Most of the sticks are unlikely to make the situation better. It’s not that easy to recruit staff and fining or lowering funding rarely leads to efficiencies that improve quality. Outsourcing local control of the prison to a (temporary) external entity is expensive, but I believe this could address deficiencies.”

“The most important ‘teeth’ is closure/reduction in population of the prison, analogous to a health department being able to close a restaurant. Of course, there should be a defined progression of events leading up to a potential closure.”

“Ultimately, it depends on why the care is inadequate. Is it poor leadership? Inadequate funding? Red tape? Headquarters maintains a great deal of control over individual prisons – should HQ prison health-care leadership be removed? I would keep options open. I think we have learned from the prison system itself that punitive measures without addressing the ‘why’ get us nowhere.”

DISCUSSION

Panelists support a clear roadmap of escalating corrective interventions starting with increased monitoring and initial efforts to advocate for additional resources to address deficiencies, followed by an eventual move toward punitive and/or corrective measures such as removal of prison healthcare leadership (if poor leadership was a root cause of the institution’s failures), mandated population reduction, and a loss of local control over healthcare delivery. If a prison were eventually stripped of its authority to deliver healthcare services, it would be forced to either close or be subject to the appointment of a temporary overseer with broad powers to implement change.

Many Panelists express skepticism about the effectiveness of punitive financial approaches such as fines of leadership or reductions in funding, noting that these measures may discourage qualified leaders from taking correctional healthcare positions and exacerbate underlying structural causes of poor care. Most importantly, Panelists emphasize that corrective measures should be proportional, guided by clear standards from the enforcement entity, and tailored to the underlying causes of healthcare failures rather than relying solely on one-size-fits-all punitive or corrective measures. It is important to note that many Panelists argue that oversight systems must have meaningful enforcement powers (“teeth”) to ensure accountability when deficiencies persist or corrective actions are not undertaken.

6. DISCUSSION AND NEXT STEPS

6.1 Discussion

Following nearly two decades of federal oversight under the *Plata* Receivership, California is approaching a pivotal moment in its prison healthcare system. While the *Plata* Receivership was born out of a constitutional crisis in healthcare delivery, it has produced substantial improvements in infrastructure, care delivery, and patient outcomes. As responsibility for healthcare oversight transitions back to state control, the challenge is no longer how to emerge from crisis, but how to preserve the gains made and create a framework capable of preventing future failures while driving ongoing quality improvement.

The stakes are considerable. A well-designed healthcare oversight body can proactively identify emerging risks and encourage corrective action before deficiencies become systemic failures. In doing so, oversight can serve as an early warning system that protects patients and reduces the risk of litigation. Equally important, an effective oversight framework can facilitate the dissemination of best practices and promote system-wide learning. Because the vast majority of incarcerated individuals ultimately return to the community, improvements in correctional healthcare also have important implications for public health, continuity of care, and community well-being throughout California.

In this report, we used a novel application of the Delphi process — an evidence-based, consensus-building methodology — to develop an expert-informed roadmap for the creation of a robust post-*Receivership* model of healthcare oversight in California prisons. The study assembled a Delphi Panel with extraordinary breadth and depth of expertise spanning correctional healthcare delivery, healthcare quality improvement, prison oversight, healthcare regulation, constitutional litigation, public policy, public health, patient advocacy, and lived experience of incarceration. This diversity of perspectives was a major asset and ensured the recommendations in this report reflect insights from multiple disciplines and stakeholder groups.

The Delphi process facilitated productive discussion around several particularly challenging issues that have the potential to undermine the effectiveness of future healthcare oversight if not addressed directly. Questions regarding the healthcare oversight body's independence, access to confidential information, enforcement authority, organizational structure, funding, and the relationship between oversight and operational management often generate disagreement among healthcare oversight stakeholders. Despite this, our Delphi Panelists achieved consensus or majority agreement on many of these topics, demonstrating that common ground can exist even on issues that have historically proved challenging. **Our resulting recommendations represent more than a collection of individual opinions; they reflect the collective judgment of a multidisciplinary expert group engaged in an iterative process of anonymous deliberation.**

Several overarching themes emerged from this study. First, **Panelists consistently emphasize the importance of independence.** The healthcare oversight body must possess sufficient independence from political pressures and the entities it oversees to maintain credibility and objectivity. Second, **Panelists advocate for a proactive approach to oversight that identifies emerging problems**

before they result in widespread harm, rather than relying solely on complaints, crises, or litigation. Third, Panelists emphasize that **oversight should focus on healthcare quality and patient outcomes rather than existence of, and compliance with, policies or procedures**. Population-level health measures, patient experiences, and close review of care provided to medically vulnerable individuals, were all viewed as central to evaluating performance. Whenever possible, performance should also be aligned with community standards of healthcare quality (and not a siloed and separate standard for corrections). Fourth, transparency emerged as a recurring theme. **Panelists consistently support public reporting, transparent methodologies, and clear communication regarding oversight findings and recommendations**.

Finally, **Panelists favor a model that distinguishes oversight from operational management**. Throughout the Delphi Panel process, there was broad agreement that the healthcare oversight body should function primarily as an independent evaluator and expert source of information rather than as a policymaking, budgetary, or enforcement entity.

Several limitations should be considered when interpreting our findings. First, Delphi studies are inherently influenced by Panel composition. While we made a substantial effort to recruit a diverse group of experts and stakeholders, different Delphi Panelists could have produced somewhat different recommendations. Second, while the number of Panelists was modest, it was larger than many published Delphi studies addressing complex policy questions. Third, the evidence base informing prison healthcare oversight remains relatively limited. Consequently, many recommendations necessarily reflect expert judgment informed by experience and available evidence rather than direct scientific evaluation of alternative oversight models.

6.2 Next Steps

The most important conclusion emerging from this Delphi Panel is that the creation of a new healthcare oversight body in California will require extensive planning and must begin immediately. Although the exact timing of the conclusion of the *Plata* Receivership remains uncertain, establishing a new healthcare oversight body will require legislation, funding, staff recruitment, organizational development, and development of the methodology and standard operating procedures, as described in this study. This is a complex undertaking that will take time.

For this reason, **California should pursue a transition strategy that includes meaningful overlap between the Receivership and the successor healthcare oversight body**. Such overlap will allow the new healthcare oversight body to develop institutional knowledge, establish operational capacity, understand existing quality monitoring systems, and build working relationships while the Receivership remains active. Achieving this transition requires immediate engagement by all parties to the underlying class-action lawsuit, including representatives of the state, plaintiffs' counsel, the Receivership, and the federal court. Additional engagement from policymakers, correctional healthcare leaders, healthcare professionals, advocates, researchers, and individuals with lived experience will also be critical.

California stands at a consequential moment in its history of correctional healthcare delivery. The state has an opportunity to both preserve the gains achieved under the *Plata* Receivership and

establish a new standard for healthcare oversight that promotes accountability, transparency, and continuous quality improvement. Given the size and influence of California’s prison system, the model it ultimately adopts may also inform correctional healthcare oversight efforts far beyond the state. The findings from this study should serve as a roadmap for policymakers and stakeholders as they undertake the vital work of designing a durable and effective post-Receivership healthcare oversight framework.

7. APPENDICES

7.1 Delphi Panelists

The following is a list of individuals who completed at least one of the study's surveys. Participation in the Delphi Panel does *not* indicate that these individuals endorse any specific finding in this study (including findings with 100% consensus as not all Panelists may have replied). Furthermore, Panelists were asked to answer questions based on their individual experience and expertise, *not* on behalf of their employers. Their responses and the study's conclusions *should not* be assumed to reflect the views or opinions of their employers.

Table 4. Delphi Panelists and their Affiliations

PANELIST	AFFILIATIONS	EXPERTISE
Noha Aboelata	Physician, Founding CEO of Roots Community Health; <i>Plata</i> Advisory Board Member to Judge Jon Tigar	Community health leadership and carceral healthcare
Stefano Bertozzi	Physician, Professor at the University of California Berkeley School of Public Health; <i>Plata</i> Advisory Board Member to Judge Jon Tigar	Health policy and healthcare program evaluation
Matt Cate	Consultant/Partner, Mosaic Solutions and Advocacy ; Focus on healthcare policy and corrections	Carceral healthcare management, integrated care models, and policy
Alice Hm Chen	Physician, Chief Health Officer, Centene Corporation	Population health, healthcare equity, and delivery system transformation
Hugh Chetwynd	Human Rights Attorney Executive Secretary, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment	International prison reform, human rights, and the treatment of detained individuals
Barbara Crawford	Senior Vice President of National Health Plan and Hospital Quality, Kaiser Permanente; <i>Plata</i> Advisory Board Member to Judge Jon Tigar	Nursing leadership, clinical performance improvement, and patient-centered care
Michele Deitch	Attorney, Professor of Law at University of Texas, Austin; Director, Prison and Jail Innovation Lab	Carceral oversight, prison and jail conditions, and juvenile justice reform

PANELIST	AFFILIATIONS	EXPERTISE
Jane Dorotik	Former Practicing Nurse Community Leader, Prison Reform Advocate, and exoneree after 20 years following a wrongful conviction	Criminal justice reform, healthcare delivery, and post-incarceration reintegration
Amy Fettig	Attorney; Focus on Eighth Amendment litigation	Incarcerated individual rights law, Eighth Amendment litigation, and advocacy for humane prison conditions
Rachel Gibbs	Physical Therapist, Director of Adult Services & Healthcare in Prison South Eastern Health & Social Care Trust (Northern Ireland)	Correctional healthcare delivery, and correctional healthcare oversight
Marta Green	Consultant	Healthcare delivery reform, public policy, and health equity
Corene Kendrick	Attorney, Deputy Director ACLU National Prison Project	Prison law, Eighth Amendment rights, and the impact of prison conditions on health
Darby Kernan	Consultant/Partner, Mosaic Solutions and Advocacy; Focus on healthcare policy and corrections	Community healthcare management and funding, state government financing, and carceral healthcare services
James King	Director of Programs, Ella Baker Center; First-hand knowledge of healthcare in prisons	Criminal legal system reform, decarceration, and advocating for the rights and dignity of incarcerated individuals
Daniel Landsman	Vice President of Policy, FAMM	Criminal justice reform, second look sentencing, and compassionate release legislation
Amy Lerman	Professor, University of California Berkeley School of Public Policy <i>Plata</i> Advisory Board Member to Judge Jon Tigar	Criminal justice reform, health policy, social inequality research, and public perceptions of government
Phuong Luu	Physician; Lead executive for CalAIM Justice-Involved Reentry Care Initiative, Yuba County Jail and Tri-County Detention Center	Medi-Cal and healthcare delivery for justice-involved individuals during incarceration and at reentry

PANELIST	AFFILIATIONS	EXPERTISE
Phil Melendez	Director of Special Projects, Smart Justice California; First-hand knowledge of healthcare in prisons	Criminal justice reform, the systems for policy making in California, and advocacy for people who are incarcerated
Marko Mijic	Vice President Community Health, Kaiser Permanente; Former Undersecretary, California Health and Human Services Agency (CalHHS)	Government operations, health policy, and expanding access to safety-net programs
Jens Modvig	Director, Health Department, Dignity – Danish Institute Against Torture Chair, United Nations Committee Against Torture	Torture prevention, forensic medicine, prison oversight, and the health rights of detained individuals
Amika Mota	Executive Director of Sister Warriors Freedom Coalition; First-hand knowledge of healthcare in prisons	Reproductive justice, criminal legal system reform, and advocacy for incarcerated women
Lola Ogunnubi	Doctor of Nursing Practice; Nursing Consultant, New Jersey Office of the Corrections Ombudsperson	Carceral healthcare oversight, nursing practice, and healthcare delivery
Alison Pachynski	Physician, Chief Medical Executive at San Quentin State Prison, CDCR	The provision of healthcare delivery to people who are incarcerated, quality improvement in prisons, and prison healthcare system-level change
David Panush	President, California Health Policy Strategies	Health policy, state budgeting, and legislative processes
Heather Pool	Chief Assistant Inspector General Medical Inspection Unit, Office of the Inspector General (California)	Correctional healthcare oversight
Mary Rogan	Professor, Trinity College Dublin’s School of Law; Focus on international human rights and detention	Prison law, human rights in imprisonment, and penal policy reform
Radha Sadacharan	Physician, Statewide Medical Director for the Idaho Department of Corrections	Healthcare delivery, quality assessment, and quality improvement in carceral settings
Stephen Saltzburg	Professor of Law, George Washington University; Former chair of the ABA Criminal Justice Section	Carceral healthcare oversight and litigation

PANELIST	AFFILIATIONS	EXPERTISE
Terry Schuster	Corrections Ombudsperson, New Jersey	Correctional oversight
Shira Shavit	Physician, Executive Director and Co-Founder of the Transitions Clinic Network	Healthcare for formerly incarcerated individuals, community health system transformation and financing
Monica Soni	Physician, Chief Medical Officer of Covered California	Value-based healthcare strategies, clinical informatics, and health equity
Marc Stern	Physician, Former Assistant Secretary for Health Services/Health Services at the Washington State Department of Corrections	Correctional healthcare delivery
Jim Wood	Dentist, Former Speaker pro tempore of the California State Assembly	State government and healthcare access
Ivan Zinger	Attorney, Retired Correctional Investigator of Canada	Correctional oversight and human rights law in corrections

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