VIEWPOINT

# Establishing National Standards for Carceral Health Care—The Federal Prison Oversight Act

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**The US incarcerates** more of its population than any other nation, with prisons and jails serving as health care organizations for those detained.[1] The incarcerated population in the US is disproportionately composed of Black men and other people of color who enter carceral facilities with higher burdens of medical and psychiatric illness relative to the general public.[2] While imprisoned, unhealthy and unsafe conditions compound existing health disparities resulting in excess morbidity and a 2-year decrease in life expectancy for each year served.[3] Carceral conditions also negatively affect the health of facility staff, with correctional officers experiencing elevated rates of posttraumatic stress disorder, traumatic injury, and suicide.[4] With 95% of incarcerated individuals eventually returning to our communities and tens of thousands of employees cycling through carceral facilities daily, prison health is public health.

The Eighth Amendment to the US Constitution protects incarcerated individuals from deliberate indifference to their serious medical needs, including access to care, enactment of ordered care, and care without bias to status. Despite such protections, the US lacks uniform regulation and monitoring of carceral health care. Other societies, such as the United Kingdom, hold an explicit principle of equivalence that those detained receive equivalent care as the national population. This language is similar to that endorsed by the United Nations' Mandela Rules guiding the treatment of prisoners. The US, however, holds no stated goal of equivalent care to the general population, so the health care quality that individuals receive while incarcerated differs and is often deficient to that provided to patients who are not incarcerated.[5] With most incarcerated people eventually released, community health care systems often bear the brunt of these untreated medical conditions.

In the community, public insurance programs such as the Centers for Medicare and Medicaid (CMS) may withhold funds if care standards are not met. Overarching accreditation bodies, such as the Joint Commission, regulate standards across medical facilities along CMS guidelines. Those incarcerated, however, are excluded from public reimbursement programs under the Social Security Act's Inmate Exclusion Policy, meaning the requisite oversight that follows public reimbursement does not penetrate jail or prison walls.[6] Instead, carceral health care regulation often arises reactively through lawsuits following patient harm, a process curtailed in federal courts by the 1996 Prison Litigation Reform Act. The 2018 First Step Act introduced more protections for individuals in federal custody but still failed to require proactive monitoring or oversight.

But change is coming.

In late July 2024, President Biden signed into law the Federal Prison Oversight Act (H.R.3019/S.1401) with overwhelming bipartisan support. The legislation establishes transparent monitoring in all 122 Federal Bureau of Prisons (BOP) sites across the nation, including ensuring access to medical and psychiatric care for both incarcerated people and correctional staff. The Act creates an Inspector General to provide regular facility surveillance and an Ombudsman to investigate concerns from staff, incarcerated persons, or others. The bill also requires an inspection regime inclusive of community input by formerly incarcerated people, families, and community advocates and public reporting on facility conditions and corrective plans. Organizations including both the American Civil Liberties Union and correctional officer unions support the legislation.

With passage of the Federal Prison Oversight Act, the Inspector General will be required to create a tool for assessing conditions within BOP facilities, which will then guide monitoring and remediation. The quality metrics composing this assessment are not yet established but should include access to medical, psychiatric, and substance use treatment either not previously found or inconsistent across carceral centers, such as preventive services, trauma-informed care, violence interruption and de-escalation training for staff, and effective medications for opioid use disorder. With opioid-related overdose as the leading cause of death among people released from carceral facilities, Rhode Island state prisons instituted opioid use disorder screening, protocolized treatment, and community care linkages resulting in marked reduction in postrelease overdose deaths.[7] This example demonstrates how treatment within carceral facilities can improve outcomes for those detained and those returning to our communities. As such, creation of a novel assessment tool through the Federal Prison Oversight Act represents a critical opportunity to codify meaningful systems of care and monitoring within federal detention facilities, with public health implications for those detained, correctional staff, and the community.

Though the US correctional system is fragmented across federal, state, and municipal systems, the largest single correctional agency is the BOP, holding over 158 000 of the 2 million incarcerated individuals in the US. Policies and procedures established at the federal level can influence practices in state prisons and municipal jails, and vice versa. For example, the BOP's Residential Drug Abuse Program offers incarcerated individuals access to evidence-based substance use treatment in return for reduced sentences. Many states, recognizing the effectiveness of Residential Drug Abuse Program in reducing recidivism, now offer similar programs.[8] While the Federal Prison Oversight Act will not immediately affect all incarcerated individuals, it offers a blueprint for state prisons and county jails to follow, allowing beneficial practices to propagate across our various carceral systems.

Improving the health of those in federal prisons requires adapting community quality improvement and tracking methods to the carceral setting, while incorporating lessons learned from individual state correctional systems. For example, recent reforms within

the California State Prison system demonstrate the utility of implementing Healthcare Effectiveness Data and Information Set (HEDIS) measures in carceral facilities. The Partnership for Quality Management (PQM), a central repository for quality standards drawn from CMS, nongovernmental organizations, academic medical centers, and professional societies, also endorse many of these metrics.[9] While inexhaustive and requiring adaptation to the carceral health care setting, HEDIS and PQM metrics offer a starting point for organizing and tracking carceral health care structures and processes. Similarly, the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which measure care access and patient-reported health status, should be tested in correctional settings. Ideally, quality metrics should be refined that assess the clinical impact of carceral health care services following release, although the large flux of people cycling through carceral facilities makes tracking postrelease outcomes difficult. A larger quality and safety infrastructure requires financial costs that must be accounted for in the Act, since creating an unfunded mandate will only limit the Act's implementation or result in diverting of funds away from other programs.

The passage of the Federal Prison Oversight Act represents a unique opportunity to improve the health of those living and working in carceral facilities, as we currently have few standardized tools or systems to monitor, regulate, and publicly report on the quality of care provided within these sequestered environments. Yet this moment could easily pass us by. It is imperative that medical professionals partner with the Inspector General and advisory board when crafting metrics for judging the adequacy of medical and mental health care within our federal prison system and assessing balance measures. Aligning carceral care with evidence-based community standards, while accounting for the unique health care needs of incarcerated persons and correctional staff, will provide incarcerated people a chance of returning to their families and communities in better health than they left.

## ARTICLE INFORMATION

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