Third Monitoring Report of the Medical Consent Decree

Mays et al. v. County of Sacramento

Case No. 2:18-cv--02081

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Introduction

On July 31, 2018, Plaintiffs Lorenzo Mays, Ricky Richardson, Jennifer Bothun, Leertese Beirge, and Cody Garland filed a federal class action complaint[1] alleging that Defendants failed to provide minimally adequate medical and mental health care to incarcerated persons in its jails; imposed harmful and excessive use of solitary confinement in violation of the Eighth and Fourteenth Amendments to the US Constitution; and discriminated against individuals with disabilities in violation of the American with Disabilities Act (ADA) and section 504 of the Rehabilitation Act.

On October 18, 2018 the parties entered into a Consent Decree, and Defendants agreed to implement measures set forth in a Remedial Plan, to be monitored by court-appointed Court Experts.[2] On January 13, 2020, the Consent Decree was approved by the federal court. Among other things, the Consent Decree requires Defendants to issue periodic status reports describing the steps taken to implement each provision set forth in the Remedial Plan and identifying provisions of the Remedial Plan which have not yet been implemented. With respect to the provisions of the Remedial Plan not yet implemented, Defendant's Status Reports must describe all steps taken toward implementation; set forth with as much specificity as possible those factors contributing to non-implementation; set forth a projected timeline for anticipated implementation based upon the best information available to Defendant.

We thank Sandy Damiano Ph.D., Deputy Director of the Department of Health Services, Primary Health Division, Stephanie Kelly, Health Services Administrator, Deputy Chief Santos Ramos, Sacramento Sheriff's Office, and their staffs for their assistance and cooperation in completing this review.

[1] Mays et al. v. County of Sacramento, Case No: 2:18-cv-02081-TLN-KJN (E.D. Cal.).

[2] Madeleine LaMarre MN, FNP-BC and Karen Saylor MD are the Medical Experts. Mary Perrien is the Mental Health Expert. Lindsay Hayes is the Suicide Prevention Expert.

Compliance Definitions

The Consent Decree offers limited guidance to the court-appointed experts regarding the measurement of compliance with the Remedial Plan, simply stating that the experts should determine whether the Defendants are in substantial compliance or not in "substantial compliance" with an individual provision. In an effort to more accurately measure compliance with the provisions of this Consent Decree, as well as to provide guidance to the parties, the court-appointed experts subsequently created a three-tier system for the measurement of compliance. Each of the experts have utilized such a system in prior federal court monitoring assignments. As such, the court-appointed experts agreed to the following definitions for compliance measurement for each of the provisions in this Remedial Plan:

Substantial Compliance: Defendants have achieved compliance with most or all components of the relevant provision of the Consent Decree for both the quantitative (e.g., 90% performance measure) and qualitative measures (e.g., consistent with the larger purpose of the Decree). If an individual compliance measure necessitates either a lower or higher percentage to achieve substantial compliance, it will be so noted by the expert. Compliance has been sustained for a period of at least 12 months.

Partial Compliance: Defendants have achieved compliance on some of the components of the relevant provision of the Consent Decree, but significant work remains. A minimum requirement is that for each provision, relevant policies and procedures must be compliant with Remedial Plan requirements, contain adequate operational detail for staff to implement the policy, staff are trained, and the County has begun implementation of the policy.

Non-Compliance: Defendants have not yet addressed the requirements of a provision of the Consent Decree or have not made substantive progress.

Facility Description

The Sacramento County Jail is comprised of two adult jails, the Main Jail (MJ) and Rio Cosumnes Correctional Center (RCCC), also known as "the Branch."

The Main Jail is a multistory building built in 1989 with an original rated capacity of 1,250 that was later increased to 2,380. It is the primary intake center for the jails and houses individuals of varying custody levels. Housing unit design is primarily single and double cells with solid doors. As of 8/31/2022, Main Jail population was 1,878 including 1661 males and 261 females, or 79% of the official rated capacity, but 101% of functional capacity.

RCCC is located in Elk Grove and was originally constructed as an Air Force base, which was deeded to the County in 1947 and converted to a jail around 1960. It is the primary custody facility for detainees sentenced to county jail by the Sacramento County Courts. An increasing percentage of the detainees housed at RCCC are pre-sentence detainees, in an effort to keep the population levels down at the Main Jail. Housing units are a combination of single and double cells, as well as open barracks or dormitories. It has a current rated capacity of 1,625 detainees. As of 9/1/2022 RCCC population was 1,396 including 1,294 males and 102 females, or 86% of rated capacity.

The Sacramento Sheriff's Office (SSO) has overall responsibility for management of the jails. Adult Correctional Health (ACH), a program in the Department of Health Services (DHS) Primary Health Division, provides health care services and physical/behavioral health services through county and contracted staff working in partnership with SSO.

Due to the age of the jails, they were not designed for health care and are not compliant with the American with Disabilities Act (ADA) or Health Insurance Portability and Accountability Act (HIPAA), which were enacted at later dates. Construction of an Annex facility was planned to facilitate compliance with ADA and HIPAA requirements, but the status of the previously proposed Annex is unclear.[3]

[3] Remedial Plan Status Report. Adult Correctional Health. July 10, 2020.

Executive Summary

For this report, the Medical Experts reviewed the following documents:

1. Patient medical records
2. Fifth Status Report: Mays Consent Decree, June 16, 2022
3. ACH documents supporting Consent Decree compliance
4. Main Jail Capacity to Meet the Consent Decree Report, Nacht & Lewis, March 31, 2022
5. Sacramento County Jail Study, Kevin O'Donnell, May 2022
6. Review of Nacht & Lewis and Sacramento Jail Study Reports, Wendy Still
7. Environment of Care Report-Sacramento County Jail, Diane Skipworth, June 21, 2022[4]

Our review shows that Adult Correctional Health (ACH), under the leadership of Deputy Director Sandy Damiano Ph.D., and Stephanie Kelly MS, LMFT continue to work toward building the structure necessary to achieve improvements in health care services.

Despite progress in some areas, this review showed continuing harm to patients as a result of population pressures, lack of medical and mental health beds, health care systems issues, and lapses in care. Staff work under extremely challenging conditions.

Currently, some factors impacting the delivery of health care are outside of the County's immediate control. However, others can and should be addressed directly and with urgency. In the intermediate term, the County needs to address the significant structural obstacles to progress as outlined in the recently commissioned space and population studies. The most significant issues negatively affecting medical Consent Decree requirements are described below.

The environment of care at the jail is inadequate to enable the jail to provide constitutional health care and meet Consent Decree Requirements.

The provision of constitutional health care in correctional institutions requires adequate clinical and treatment space to meet the serious medical, mental health, and disability needs of the incarcerated population. The Consent Decree outlines services the County is required to provide to meet constitutional care requirements, and there is no disagreement among the parties that the current space is completely inadequate for the population. Initially, the County planned to build an Annex adjacent to the jail to address space needs, but funding for design and construction of an Annex has not been approved. Given this, the County hired an architectural firm, Nacht & Lewis, to assess the population levels at which the Main Jail could meet Consent Decree requirements. The conclusions of the study included the following:

- Main Jail is overcrowded and houses double the population that it was designed for.

[4] The reports of the County consultants are available on the Disability Rights California website at https://www.disabilityrightsca.org/cases/mays-v-county-of-sacramento.

- 595 (25%) of 2,397 Main Jail capacity beds are dedicated to special populations.[5]
- Main Jail population would need to be reduced by more than 1,000 inmates to meet Consent Decree requirements for seriously mentally ill (SMI) patients.
- Reductions in population would not allow for treatment of long-term medical patients or permit the establishment of a detox unit.
- Even with modifications, Main Jail cannot be made ADA or HIPPA compliant.
- Main Jail requires far more staff than the building was designed to accommodate.
- The jail does not function safely at the current density and is challenging to manage; this is the cause of many operational and safety issues.
- The jail cannot provide the services that are now required by evolving needs and a paradigm shift in jail missions.

The overall conclusion of the study is as follows:

> *Achieving substantial compliance in all areas of the consent decree would require changes to jail operations, medical and behavioral health services, increased staffing, and improvement to the jail's physical plant. The Main Jail, built in 1990 prior to ADA, HIPPA and re-alignment was not designed to meet current standards or best practices for the inmate populations it houses. While progress toward compliance is being made in some areas, the jail's hardened construction and inflexible configuration is a barrier to achieving compliance that cannot be overcome.*

The Sacramento County Jail Study examined the extent to which the average daily population (ADP) could be reduced by a through a combination of strategies to decrease jail admissions, length of stay, and returns to custody.[6] The Report concludes that with intensive collaboration and partnership with justice and community services, an ADP reduction of 592 could be achieved. The report emphasized that reaching this goal would not be easy, but with practice and policy changes that could be quickly implemented, could generate near term reductions in jail population.[7]

Wendy Still, Conditions of Detention Expert, reviewed each of these studies and agrees with their methodology and conclusions. The Medical Experts reviewed these reports and concur with their findings and recommendations, with the caveat that establishing a detox unit to monitor and treat patients with substance use disorders remains critical to patient safety and achieving Consent Decree compliance.

The Environment of Care Report by Diane Skipworth showed that almost all areas of the jail, including medical treatment areas such as intake, dialysis, and 2P, were cluttered, dirty, and in many cases filthy. These findings are consistent with the findings in the Second Mays Medical Monitoring Report and are profoundly disturbing. Lack of sanitation and disinfection presents a

[5] Nacht & Lewis. Page 4.
[6] Sacramento County Jail Study. Page 7.
[7] Sacramento County Jail Study. Page 74.

risk of disease transmission within the jail. Ms. Skipworth finds that Sacramento Sheriff's Office (SSO) policies and procedures provide insufficient guidance regarding sanitation procedures at the jail. Moreover, reliance on inmate workers for terminal cleaning in jails and prisons is challenging due to high turnover and training issues. The findings also suggest a lack of accountability for sanitation at the jail.

There is no immediate solution to providing critically needed space, which threatens delivery of care and Consent Decree compliance. However, there are solutions for addressing the lack of clinic organization and cleanliness. We strongly recommend that health care and SSO leadership develop a plan for terminal cleaning, painting, decluttering, organization and ongoing sanitation and maintenance of all health-related space at the jail, especially in the booking area. We strongly recommend hiring commercial sanitation services for terminal cleaning, relying on inmate workers only for daily janitorial duties (e.g., emptying trash cans, mopping, etc.).

The COVID-19 pandemic continues to present challenges to Consent Decree implementation

Prevention and management of COVID-19 continues to impose intensive resource demands upon the County. In December 2021, Omicron, a more infectious COVID-19 variant, surged in the United States, resulting in outbreaks at Main Jail and/or RCCC in January, June, July, and August 2022.[8]

Adult Correctional Health (ACH) continues to update COVID-19 guidance documents.[9] However, the County's compliance with COVID-19 policies is threatened by population pressures and lack of adherence to ACH guidance. For example, although all newly arriving inmates are placed in intake quarantine, lack of bed space at Main Jail resulted in inmates remaining in Booking Loop tanks for up to 3 days, creating transmission opportunities. Miscalculation of close quarantine and medical isolation timeframe has resulted in patients being released prior to the 10-day period.[10] In one case, a patient in close contact quarantine developed COVID symptoms but was not moved to another housing unit and not tested for several days. When she was tested, her test was positive.

Vaccination programs for staff and inmates continues with high compliance among ACH and contract staff (93%-100%), but lower rates (25%) among inmates despite incentive programs.[11]

With respect to testing, counseling, monitoring and medical evaluation of patients in quarantine and isolation, concerns remain. Staff does not document that patients are informed of their COVID-19 test results and counseled about what symptoms to report. Health care staff do not consistently perform and document health checks. When staff performed health checks, they did

[8] ACH COVID-19 Data Weekly Status Report. 8/3/12022.
[9] ACH COVD-19 Staff Guidance. June 6, 2022
[10] Patients #25 and #41.
[11] Fifth Mays Status Report. Page 15.

not always identify patients that needed immediate medical attention, *whether or not it was related to COVID-19.* In one case, staff documented that a patient was asymptomatic for two consecutive days before he was found unresponsive and died. His health services requests prior to his death clearly showed his condition was deteriorating.[12] In addition, medical providers are not conducting medical evaluations for symptomatic COVID patients.[13]

Omicron is more infectious, but fortunately less virulent, than the original alpha and delta strains. As noted in the last report, early in the pandemic, practices to limit movement and defer non-urgent medical care were appropriate with the understanding that *patients need to receive timely and appropriate evaluation and treatment for their serious medical needs.* While quarantine remains an effective public health measure to prevent intramural transmission, the availability of vaccines and masking practices should allow routine health encounters to take place in appropriate clinical settings. This does not consistently take place.

There are still insufficient medical and nursing staff to meet Consent Decree requirements.

With respect to staffing, there is a multi-year staffing plan in process, but currently there are insufficient medical and nursing staff to meet Remedial Plan requirements.

The lack of permanent physicians continues to be one of the most serious staffing concerns.[14] As of June 2022, there were six "Physician 3" vacancies.[15] In addition, medical provider productivity has been low.[16] Patients do not have timely access to a medical provider to diagnose and treat their serious medical conditions. Intake history and physical examinations are being scheduled but not consistently taking place. Physicians are not timely monitoring patients with chronic diseases and specialty services, resulting in preventable harm.

The lack of physicians has delayed implementation of Consent Decree requirements. Given the challenges with hiring physicians, we recommend more intensive recruitment of nurse practitioners to conduct the full scope of clinical activities, including history and physical examinations, provider sick call, chronic disease management, and specialty services follow-up.

We found medical provider performance issues. Too often, physicians conduct remote medical record reviews and make changes to patient treatment plans or deny medical chronos requests without evaluation and discussion with the patient. Physicians do not timely inform patients of their lab and diagnostic tests results. When patients have not been informed, understand, or

[12] Patient #46.
[13] Patient #44.
[14] The County has renegotiated contracts to increase the competitiveness of physician salaries and will also renegotiate salaries for nurse practitioners and nurses.
[15] Mays Fifth Status Report. Page 18.
[16] ACH reports that the Medical Director monitors provider productivity which has increased from 7 patients per day, an extremely low number, to 12 patients per day. The Medical Director has a goal to increase productivity to 14 patients per day.

agree to treatment plan changes, compliance is not possible. As noted in our previous report, this practice leads to patient refusals of care and deterioration of their health status. We recommend that ACH develop a written notification system for informing patients of their lab and diagnostic test results.[17] Medical providers should not delegate notification of lab and diagnostic tests to nurses.

We also find that there is a lack of adequate nursing staff and custody escorts to timely administer medications in accordance with the medication schedule. ACH is in process of changing medication administration times to improve efficiency.[18]

The health care system does not provide inmates timely access to care for their serious medical needs

There is a systemic and pervasive lack of access to medical care involving multiple processes (e.g., nurse and provider sick call, substance use withdrawal monitoring and treatment, chronic disease management, and specialty services) that has resulted in preventable harm to patients.

Throughout the review period, patients with substance use disorder were not adequately evaluated, treated, and monitored. Nurses did not conduct adequate substance use histories and substance use withdrawal assessments in accordance with patient's clinical needs, Standardized Nurse Procedures (SNP) and Consent Decree requirements.

In one case, a patient reported drinking a gallon of hard liquor daily for two years but was not started on treatment for alcohol withdrawal. Nurses did not conduct an alcohol withdrawal assessment of the patient in booking and approximately 30 hours later the patient had a seizure and died.[19]

Similarly, a patient with opioid substance use disorder was housed in a booking loop tank for approximately 72 hours, experienced severe withdrawal, but was not monitored or treated. She reported that four of the seven women in the booking holding tank also experienced severe withdrawal without monitoring or treatment.

Following these events, ACH assigned more nursing resources in booking to monitor patients. ACH and SSO have explored establishing a detox unit to facilitate monitoring patients for substance use withdrawal. We strongly applaud and encourage the County to continue these efforts. However, given the findings of the past three reports, and until the County establishes a detox unit, the Medical Experts strongly recommend that ACH have intake nurses initiate treatment for *all patients with alcohol, benzodiazepine and opioid substance use disorders* (and

[17] In the California state prison system, physicians review labs and complete a patient notification slip that has one of three boxes: 1) Your test is normal; 2) Your test will be repeated and 2) A medical provider/chronic disease appointment is being scheduled for you. The form is placed in a sealed envelope and forwarded to the patient.
[18] Fifth Mays Report. Page 37.
[19] Patient #32

give the first dose in intake). The Medical Experts recommend that the County implement this practice until it demonstrates its ability to timely monitor patients with substance use disorders. Doing so will reduce withdrawal symptoms and increase patient safety.

Access to care is a fundamental and essential element to any correctional health care program. However, *the access to care program at Sacramento County Jail is broken. Patients do not receive timely access to care for their health serious medical needs, resulting in preventable harm to patients.* Record review shows that Health Services Requests are not timely collected and triaged, and patients are not seen in accordance with the acuity of their complaints. Nurses do not recognize red flag symptoms and schedule patients for an urgent sick call visit followed by an urgent medical provider visit. In one recent case, a patient submitted two health requests stating that he had “blood sepsis” and a “blood infection affecting my heart valves.” The triage of both requests was delayed; nurses then scheduled the patient for routine rather than urgent sick call but did not see the patient. Two weeks later the patient became unresponsive and died of septic and hypovolemic shock.[20] Nurse-to-provider referrals also often do not timely take place, if they occur at all. Patients then resubmit multiple health requests, creating additional workload for staff.

The chronic disease program has been partially implemented. The Medical Director has developed some chronic disease treatment guidelines for which the Medical Experts have provided input. However, there is no functional chronic disease tracking system. Physician staffing issues have negatively impacted the chronic disease management program, and lack of continuity is apparent in most of the charts we reviewed. Patients are commonly seen by a different provider each time. No single clinician seems to “own” the plan of care and be committed to following the patient to ensure clinical improvement. The quality of chronic disease evaluations is highly variable, and providers do not consistently monitor patients in accordance with their disease control. As noted above, medical providers make remote control changes to treatment plans without informing the patient, which should not occur.

In approximately 40% of cases, patients do not have timely access to specialty services and medical providers do not monitor patients to ensure that the treatment plan is implemented and the desired clinical outcome is achieved. There are delays in Utilization Management/Medical Director review and approval/denial of specialty services requests, sometimes for weeks or months. Record review shows a lack of coordination of care and some patients are lost to follow-up. Specialty services appointments are cancelled and rescheduled due to custody staffing or schedules. We believe that the Medical Director needs to provide greater oversight and supervision of specialty services.

We found cases in which medical providers did not document that pregnant patients were counseled about their reproductive options. In one case, a seriously mentally ill, homeless woman with ten previous pregnancies reported being raped in the camp where she lived. Yet there was no documentation that she was meaningfully counseled about her options for this

[20] Patient #46.

pregnancy and future birth control options. On several occasions, custody did not permit the obstetrician to evaluate the patient. After multiple admissions to the jail, the patient gave birth following her release. [21]

Lack of custody posts dedicated to essential health care functions and custody culture interferes with health care delivery

There continues to be lack of dedicated custody escorts to enable health care staff to timely conduct essential health care functions, including medical appointments and medication administration. We have been advised that additional custody positions have been funded for health care escorts, but due to SSO staff shortages, the positions are being utilized for COVID-19 escorts and other custody assignments. Record reviews show multiple instances in which medical appointments were not kept for custody reasons.

While many deputies are conscientious and collaborative with health care staff, as noted in previous reports, we found instances in which custody interfered with the delivery of health care. In one case, custody acknowledged withholding prenatal snacks from a pregnant patient because she "refused a pregnancy test."[22] This occurs because health care staff routinely leaves prenatal and other medically ordered snacks at control stations for deputies to distribute when they have time. Health care staff needs to personally deliver all medical treatment and document such in the record.

There were many instances in which custody informed providers and nurses that they were not permitted to see patients due to lack of escorts, "behavioral issues," or because unspecified activities were taking place in the housing unit. *This is obstructing access to care and should not occur*. While it is understood that custody is responsible for safety and security of the institution, it is the role of custody to facilitate appointments taking place, not prevent them. When behavioral issues are a factor, mental health staff need to be consulted.

There were frequent instances in which custody informed health care staff that the patient refused the visit, or would not come out of the cell, but health care staff did not independently verify, counsel the patient, and obtain a signed refusal. This practice violates the Consent Decree.

In collaboration with custody leadership, these issues need further study by the CQI committee to assess the scope of the issues and develop targeted strategies to address them.

[21] Patient #29.
[22] Patient #29.

The Mortality Review process fails to identify problems with health care systems and quality of care

At our last report, we found that mortality reviews were not timely, and consisted simply of the chronology of care with no meaningful analysis of the appropriateness of care. The reviews failed to identify lapses in care, systemic issues, or opportunities for improvement. There were extended delays in obtaining death certificates and autopsy reports, thus delaying the final mortality review.

For this review, we found that preliminary mortality reviews are conducted within 30 days and final mortality reviews are conducted generally in about six months. The Medical Director generates the preliminary and final reports.

With exceptions, both preliminary and final mortality reviews still lack identification and analysis of lapses in care, systemic issues, and opportunities for improvement. We reviewed mortality cases that transpired since our last report and compared our findings with that of the ACH mortality reviews. *We found that in several cases, significant lapses in care and system issues were unrecognized, glossed over, or ignored all together.*

Although relevant policy states that the clinical review process involves an interdisciplinary clinical review team, the participation of a clinical review team is not apparent in either the preliminary or final reports. We believe that the mortality review process would benefit from a more robust, collaborative process involving medicine, nursing, pharmacy, mental health, medical records and custody, to identify and study root causes of performance that does not meet expectations.

Conclusion

This review showed that inmates with serious medical needs continue to experience harm as a result of lack of an adequate infrastructure (e.g., space, staff), systems issues (e.g., intake screening and chronic care) and quality of care (e.g., chronic care, mortality review). Considerable work remains to achieve Consent Decree compliance.

Significant and timely effort needs to be made to bring health care in the Sacramento County Jails to minimally adequate levels. At present, there are substantial deficiencies and lapses that harm patients. Access to care falls below acceptable levels, and staffing is not sufficient to meet the needs of the population. While some of these changes require physical plant and other structural changes, many do not. This system urgently needs more active oversight and leadership.

We commend Sacramento County for commissioning studies that provide data-driven findings and recommendations regarding the limitations of space and programming at Main Jail and

exploring and developing strategies to safely reduce the population. These studies will enable County stakeholders to make informed decisions about next steps.

As noted above, we also commend ACH and SSO leadership for their work in laying the foundation for making progress: filling key positions, adding staff, increasing health care provider salaries, and policy development and implementation. However, as noted in the Nacht & Lewis report, compliance with the Consent Decree cannot be fully achieved with the current space limitations and population pressures.

As the County deliberates regarding immediate next steps, ACH and SSO need to focus on areas within their span of control. This includes the integrity and functionality of health care systems (e.g., intake, access to care, chronic care, etc.), timeliness and appropriateness of care, and sanitation and infection control. ACH and SSO needs to increase its daily oversight and supervision of these areas. We recommend the use of daily morning huddles by health care and SSO leadership to increase communication, collaboration, and immediate action to solve problems.

More detailed findings and recommendations are contained in the body of this report, as well as medical record reviews attached as an appendix providing supporting documentation for our findings and recommendations. We are available to assist the County and look forward to working with health care leadership and their staff to improve health care systems. Below is a summary of compliance for the Remedial Plan. A more detailed table of compliance is found at the end of this report.

Summary of Medical Remedial Plan Compliance

Substantive Area	Total Provisions	Substantial Compliance		Partial Compliance		Non-Compliance		Not Evaluated	
		17	%	29	%	44	%	9	%
Medical	75	13	#	22	#	33	#	7	#

Findings

A. Staffing

1. The County shall maintain sufficient medical, mental health and custody staffing to meet professional standards of care to execute the requirements of this remedial plan, including clinical staff, office and technological support, QA/QI units and custody staff for escorts and transportation.
2. Provider quality shall be evaluated regularly to ensure that relevant quality of care standards is maintained. This review shall be in addition to peer review and quality improvement processes described in this plan. The parties shall meet and confer regarding any deficiencies identified in the evaluation. Should the parties disagree regarding matters of provider quality, the Court Expert shall evaluate the quality of provider care and to complete a written report.

Findings:
To assess staffing, we reviewed staffing documents, the Fifth Mays Status Report, and patient medical records to assess the sufficiency of care provided. During this monitoring period, there were insufficient medical and custody staff to meet professional standards of care to execute the requirements of the remedial plan.

Areas of progress include the filling of all key ACH leadership and specialized positions, including the following:

- Health Services Administrator
- Training Coordinator
- Case Management Supervisor
- Electronic Health Record (EHR) Supervisor
- Mental Health Leadership Restructure[23]

Fiscal Year (FY) 2021/2022 staffing included an additional 29.0 Full Time Equivalent (FTE) positions totaling 186.5 FTEs. There are currently 27 clinical vacancies, including six physicians, one nurse practitioner, four registered nurses and 13 licensed vocational nurses.[24] There are four administrative vacancies. [25]

According to ACH leadership, maintaining filled positions is difficult due to recruitment challenges, staff retirements, and magnitude of changes required by the remedial plan. Salaries for selected positions (e.g., physicians, registered and licensed vocational nurses) have not been competitive, and labor agreement negotiations are in process or recently completed for multiple health disciplines.

[23] Fifth Mays Status Report. Page 8.
[24] The permanent positions do not include county on-call, registry, or contract positions. Fifth Status Report. Page 18.
[25] For FY 2022/2023 an additional 39.0 FTE's have been budgeted.

Of notable concern is that there are six "Physician 3" vacancies and one nurse practitioner vacancy. In the absence of permanent physicians, ACH utilizes registry physicians, which results in fragmentation of care, delayed diagnosis and treatment, and preventable harm to patients. Given the persistent issues hiring permanent physicians, we believe that greater effort needs to be invested in hiring nurse practitioners.

There are insufficient custody escorts to ensure access to health and mental health services. At this time, there are still no dedicated custody escorts to ensure access to health and mental health services, including medication administration.[26]

With respect to quality reviews, aside from mortality reviews, no documentation was provided to demonstrate that the Medical Director performs systematic reviews to evaluate the quality of medical care provided to the population, including document related to intake history and physicals reviews, chronic disease care reviews, specialty services reviews, or emergency care reviews.

Compliance Assessment:
A.1=Partial Compliance
A.2=Noncompliance

Recommendations:
1. Focus directed recruitment efforts toward hiring nurse practitioners.
2. Perform an analysis of essential health care functions requiring custody escorts and identify the numbers of deputies needed to provide timely and appropriate care.
3. Establish dedicated custody posts for essential health care processes, that cannot be redirected to non-health care functions.
4. The Medical Director should perform quality reviews to identify system and quality issues with a corresponding corrective action plan.

B. Intake

1. All prisoners who are to be housed shall be screened upon arrival in custody by Registered Nurses (RNs). RN screening shall take place prior to placement in jail housing.
2. Health Care intake screening shall take place in a setting that ensures confidentiality of communications between nurses and individual patients. Custody staff may maintain visual communication, unless security concerns based upon an individualized determination of risk that includes a consideration of requests by the health care staff that custody staff be closer at hand. There shall be visual and auditory privacy from other prisoners.

[26] Fifth Status Report. Page 9.

3. The County shall, in consultation with Plaintiffs, revise the content of its intake screening, medical intake screening, and special needs documentation to reflect community standards and ensure proper identification of medical and disability related concerns.
4. Nurses who perform intake screening shall consult any available electronic health care records from prior incarcerations or other county agencies. The form shall include a check box to confirm that such a review was done.
5. The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health records related to ongoing care needs. The policy shall ensure that any ongoing medication, or clinically appropriate alternative, shall be provided within 48 hours of verification or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple providers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.
6. The County shall follow a triage process in which intake nurses schedule patients for follow-up appointments based upon their medical needs and acuity at intake and shall not rely solely on patients to submit Health Services Requests once housed. The policy shall, in consultation with Plaintiff's counsel, establish clear protocols that include appropriate intervals of care based on clinical guidelines, and that intake nurses shall schedule follow-up appointments at the time of intake based upon those protocols.
7. All nurses who perform intake screenings will be trained annually on how to perform that function.

Findings:

The County continues to make improvements with respect to the Intake Screening process through changes in the intake screening protocols, electronic health record forms (B.3), and staff training (B.7).

A registered nurse conducts intake screening on all new arrivals (B.1). However, we found isolated examples that licensed vocational nurses (LVNs) performed intake screening. A Supervising Registered Nurse (SRN) needs to review all intake screenings performed by a LVN to ensure that the assessment is adequate.

The thoroughness and quality of intake screening is variable, particularly with respect to substance use histories. Nurses do not consistently review previous medical records to determine whether medical or mental health provider referrals are needed (B.4).

Intake Screening questions regarding testing for hepatitis C infection were posed in an Opt-In, rather than Opt-Out, methodology. This likely resulted in a decreased rate of testing. The Medical Experts notified ACH and changes to the electronic health record form were made to comply with

opt-out testing. However, even when ordered, hepatitis C testing is not timely being performed, if it is performed at all.

Due to ongoing space constraints, intake screening continues to be conducted in a non-confidential setting (B.2). The County plans to make changes in Main Jail booking including computer stations, larger interview cubicles with privacy barriers, sound machines, individual scanners for documents, and space for supplies, but these changes have not yet been implemented.[27] The space constraints are further discussed in the Clinic Space section of this report.

There has been improvement in continuity of essential medications from our last report, particularly for mental health patients. However, there are some delays in medical provider review of essential medications (B.5), including HIV medications.[28]

At the conclusion of intake screening, nurses order follow-up medical and mental health appointments according to intake protocols, but nurses do not always refer when clinically indicated and with respect to the urgency of the need. An April 2022 ACH Intake Referral Audit determined that nurses appropriately referred patients to a medical provider in 12 of 21 (57%) cases. In some cases, nurses should have referred patients directly from intake to a medical provider for evaluation but did not.[29]

There has been improvement in timely completion of initial mental health assessments, *but medical appointments, including the initial history and physical, are not timely performed, if they take place at all.*

Nurses do not conduct substance abuse withdrawal assessments in accordance with policy and standardized nurse procedures (B.6). This is discussed later in the report.

Performance of labs and tuberculin skin testing is inconsistent and untimely.

Compliance Assessment:

- B.1=Partial Compliance[30]
- B.2=Noncompliance
- B.3=Substantial Compliance[31]

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[27] Fifth Mays Report, page 10.
[28] Patient #39.
[29] Patient #46.
[30] This is a reduction in compliance rating due to LVN's performing some intake screenings.
[31] This provision addresses whether the content of the County's intake screening, medical intake screening, and special needs documentation reflect community standards and ensure proper identification of medical and disability related concerns. With respect to the disability component, there are separate Remedial Plan provisions that require that Jail staff, for example, "conduct adequate screening of prisoners to be housed in the Jail in order to identify disabilities and disability-related accommodation, housing, classification, and other needs." Remedial

- B.4=Partial Compliance
- B.5=Partial Compliance
- B.6=Partial Compliance
- B.7=Substantial Compliance

Recommendations:

1. Implement plans to provide adequate space, privacy, sanitation, and disinfection in the booking area.
2. A registered nurse needs to should conduct all intake screenings in accordance with the Consent Decree. If staffing issues result in LVNs conducting intake screening, a Supervising Registered Nurse (SRN) needs to timely review the intake screening to ensure that it is adequate.
3. The ACH leadership needs to implement the history and physical examination policy to ensure that medical providers conduct an H&P on all eligible patients within 14 days. The H&P needs to include a pelvic exam and pap smear for eligible women as this population is at increased risk for sexually transmitted infections and cervical cancer.
4. Medical providers should identify the H&P encounter in the EHR by selecting the provider H&P note.
5. ACH needs to perform a CQI study regarding the lack of timely performance of tuberculin skin tests and other laboratory tests.
6. Orders in Centricity should be modified to enable ACH to comply with policies, standardized nurse procedures, and provider referrals. This includes:
    a. Nurse-to-provider referrals based upon the acuity of the referral (Emergent, Urgent, or Routine).
    b. Substance use withdrawal monitoring (CIWA, COWS) to be initiated within 6 hours of arrival and be performed at least twice daily for 5 days.
    c. Provider essential medication review to occur in 12 hours for critical medications (e.g., insulin, anticoagulation, HIV, methadone) so that there are no lapses in doses.
    d. Create intake, substance use disorder, and chronic disease order sets to be implemented by the Intake Nurse based upon standardized procedures and clinical treatment guidelines.
7. Perform CQI studies related to compliance with the intake policy and related referrals to evaluate the timeliness and appropriateness of care. Include root cause analysis and action plan targeted to root causes.

Plan Section III.D. Compliance with these provisions are being assessed separately; our finding as to Provision B.3 addresses only the adequacy of screening tool and related methods of documentation themselves.

C. Access to Care

1. The County shall ensure that Health Service Requests (HSRs) are readily available to all prisoners, including those in segregation housing, from nurses and custody officers.
2. The County shall provide patients with a mechanism for submitting HSRs that does not require them to share confidential information with custody staff. The county shall install lockboxes or other secure physical or electronic mechanism for the submission of HSRs (as well as health care grievances) in every housing unit. Designated staff shall collect (if submitted physically) or review (if submitted electronically) HSRs at least two times per day in order to ensure that CHS receives critical health information in a timely manner. Designated health care staff shall also collect HSRs during pill call and go door to door in all restricted housing units at least once a day to collect HSRs. HSRs and health care grievances will be promptly date- and time stamped. The county may implement an accessible electronic solution for secure and confidential submission of HSRs and grievances.
3. The County shall establish clear time frames to respond to HSRs:
    a. All patients whose HSRs raise emergent concerns shall be seen by the RN immediately upon receipt of the HSR. For all others, a triage RN shall, within 24 hours of receipt of the form (for urgent concerns) or 72 hours of receipt of the form (for routine concerns).
        (i) Conduct a brief face-to-face visit with the patient in a confidential clinical setting.
        (ii) Take a full set of vital signs, if appropriate.
        (iii) Conduct a physical exam, if appropriate.
        (iv) Assign a triage level for a provider appointment of emergent, urgent, routine or written response only.
        (v) Inform the patient of his or her triage level and response time frames.
        (vi) Provide over-the-counter medications pursuant to protocols; and
        (vii) Consult with providers regarding patient care pursuant to protocols, as appropriate.
    b. If the triage nurse determines that the patient should be seen by a provider:
        (i) Patients with emergent conditions shall be treated or sent out for emergency treatment immediately.
        (ii) Patients with urgent conditions shall be seen within 24 hours of the RN face-to-face; and
        (iii) Patients with only routine concerns shall be seen within two weeks of the RN face-to-face.
    c. Patients whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication, within two weeks of receipt of the form.

d. The County shall permit patients, including those that are illiterate, non-English speaking, or otherwise unable to submit verbal or electronic HSR's to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified medical professional for response in the same priority as those HSRs received in writing.

4. The County shall designate and make available custody escorts for medical staff in order to facilitate timely and confidential clinical contacts or treatment-related events.
5. The County shall track and regularly review response times to ensure that the above timelines are met.
6. The County shall discontinue its policy of prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment.
7. When a patient refuses a medical evaluation or appointment, such refusal will not indicate a waiver of subsequent health care.
    a. When a patient refuses a service that was ordered by medical staff based on an identified clinical need, medical staff will follow-up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse a service.
    b. Any such refusal will be documented by medical staff and must include: (1) a description of the nature of the service being refused, (2) confirmation that the patient was made aware of and understands any adverse health consequences by medical staff, and (3) the signature of the patient, and (4) the signature of the medical staff. In the event the signature of the patient is not possible, the staff will document the circumstances.

Findings:
ACH revised the policy on Health Services Requests following feedback from the Medical Experts.[32] This revision included changing the Health Services Request (HSR) form to incorporate the date and time of receipt and adding an operational requirement that nurses perform in-person assessments within 24 hours for urgent complaints and 72 hours for routine complaints.

This review showed that the access to care system is broken and that detainees do not have timely access to care following submission of health requests, resulting in harm to patients.[33]

A key finding is that nurses do not timely collect and triage health requests and conduct in-person assessments. The following cases are examples:

- In July 2022, a patient submitted an HSR stating that he had intestinal cancer with weight loss to 106 lbs. "Cannot eat solid food without vomiting…Also blood sepsis infection." A

[32] The policy is pending review by Mental Health Experts.
[33] We reviewed 44 health service requests, from September 2021 to May 2022. Of these, 26 were submitted after January 1, 2022. Our review focuses primarily on requests submitted after January 1, 2022.

Registered Nurse (RN) scheduled the patient for routine nurse sick call the same day, but did not document this plan on the HSR itself. Nor did the RN recognize these red flag symptoms reported by the patient and arrange for the patient to be seen immediately. Four days later, a RN documented a triage disposition on the HSR as urgent provider sick call.[34] That day, the same patient submitted an HSR stating: "I have septic blood infection that gets to my heart valve. Also, intestinal cancer. Liver disease. Need blood work and hospital ASAP. I'm very weak and sick." The HSR was dated stamped the next day. Three days after that, a RN triaged the complaint as routine, and scheduled the patient for a routine sick call. Two days after the triage, the patient was found unresponsive and transported to the hospital where he died of septic and hemorrhagic shock.[35]

- On 4/14/2022, a patient submitted an HSR complaining of extreme pain in his neck, lower back, and eye. On 4/18/2022, a RN triaged the HSR and ordered a routine sick call appointment. On 4/26/2022, a RN saw the patient and referred him to a medical provider. Thus, the HSR was not timely triaged following receipt, and the patient was not timely seen following triage [36]
- On 3/10/2022, a patient submitted an HSR complaining of blurred vision. On 3/21/2022, a RN reviewed the HSR. A nurse did not see the patient for this complaint.[37]
- On 2/4/2022, a patient submitted an HSR complaining of (withdrawal) pain. On 2/12/2022, a RN reviewed the HSR and ordered a nurse sick call appointment. A RN did not see the patient for this complaint.[38]
- On 1/25/2022, a patient submitted an HSR complaining of an error with his mental health medication. On 2/9/2022, two weeks later, a Medical Assistant (MA) documented review of the HSR and ordered a mental health appointment.[39] The patient's HSR was not timely triaged.
- On 1/13/2022, a patient submitted an HSR requesting supplies for chronic diarrhea due to treatment with tamsulosin. Six days later on 1/19/2022, a RN reviewed the HSR. A RN did not see the patient for this complaint.[40]

These cases demonstrate that HSRs are not timely collected and triaged, and in some cases, nurses do not recognize alarm symptoms requiring immediate patient evaluation and notification of a medical provider. This is not compliant with the Consent Decree or ACH policy and creates an unacceptable risk of harm to patients. The review also showed that nurse-to-provider referrals did not take place timely, if at all (see Case Reviews in Chronic Disease Section).

In many correctional facilities, nurses initially see all patients who submit HSRs, including mental health and dental complaints, in order to conduct an assessment and determine the urgency of the referral. This practice results in patients being timely seen by a health care professional and

[34] Patient #46.
[35] Patient #46.
[36] Patient #34.
[37] Patient #30.
[38] Patient #34.
[39] Patient #34.
[40] Patient #25.

reduces duplicate HSRs. Conversely, ACH policy states that following RN triage for emergent complaints, the HSRs will be distributed to mental health staff and dental staff, who will then retriage the complaints and schedule patients to be seen in accordance with the acuity of the complaint which can be up to 2 weeks (e.g., routine MH visit). However, records show that many patients with mental health needs do not perceive their requests to be routine and submit multiple HSRs, creating patient dissatisfaction and additional work for staff.

ACH identified a lack of custody escorts as a factor in delaying or preventing access to care. This was supported by record reviews in which medical providers documented being unable to evaluate patients or having to perform non-confidential interviews due to lack of custody escorts.

For the majority of this review period, HSRs were not scanned into the electronic health record, which is a medical records systems issue. The lack of timely availability of HSRs and other medical records resulted in delays of sometimes critical information from being available to nurses and providers.

The Medical Experts forwarded concerns about access to care findings in advance of this report, and ACH developed a corrective action plan (CAP). The CAP indicated that nurse sick call would be conducted at RCCC from 1 pm until 11:30 at night. But that system does not prioritize access to care and is a barrier to participation, particularly for patients who are disabled and/or chronically ill.

Another concern is how nurses address calls from custody staff about patients requiring medical attention. We found instances in which custody called a nurse regarding a patient with urgent complaints. Instead of instructing custody to bring the patient to the clinic, nurses scheduled a 2M Walk-In Appointment, which sometimes took place days later. This practice is dangerous. When custody calls health care staff regarding a patient with urgent symptoms, the patient needs to be immediately brought to the clinic, and custody should escort patients when requested.

We found multiple instances in which unspecified custody issues did not permit health care staff to perform patient evaluations in a clinical and confidential setting. For example:

- On 9/8/2021, a medical provider had to see the patient in the dormitory due to lack of custody escort availability.[41]
- On 10/2/2021, a social worker saw a patient with auditory commands to harm herself cell side instead of a clinical setting due to lack of custody escort availability.[42]
- On 12/1/2021, a seriously mentally ill pregnant woman was sent to the emergency department, and the physician recommended obstetrical care ASAP. On 12/3/2021, an obstetrician (OB) documented that custody would not permit her to see the patient due to mental health concerns, but there was no documentation by mental health staff regarding this situation. On 12/10/2021, the OB saw the patient cell side due to custody

[41] Patient #23

[42] Patient #24.

not permitting her to come out of her cell due to behavioral issues. On 4/1/2022, the OB did not see the patient because custody reported that she was combative; the OB did not speak with the patient.[43]

- On 11/8/2021, a physician documented being unable to evaluate the patient because custody was unable to provide a location with sufficient privacy to evaluate the patient.[44]
- On 3/22/2022, custody cancelled the RCCC physical therapy clinic due to lack of custody escorts.[45]
- On 4/22/2022, a physician was unable to see the patient due to unspecified custody issues.[46]

In addition, medical record review showed that custody advised health care staff that patients refused substance withdrawal assessments or medical appointments, but health care staff did not independently determine if patients refused appointments, counsel the patient, or obtain a signed refusal of care as required by the Consent Decree. This is particularly concerning following intake, when detainees are at risk of harm from substance use withdrawal and undiagnosed COVID-19 infection.

Alarmingly, we found instances in which custody egregiously prevented patients from receiving ordered medical care. On 12/3/2021, a pregnant patient reported to a licensed clinical social worker (LCSW) that custody refused to provide her a prenatal snack. The patient also reported that custody locked her in the shower and searched her room. *The LCSW investigated and documented that 7W custody staff confirmed that they have not been providing the patient her snack due to her refusal to take a pregnancy test, although the pregnancy had been confirmed via ultrasound.* ***This is egregious and punitive action by custody staff; the incident needed to be escalated up the medical and custody chain of commands.***

In our last report, we expressed concern that health care staff dropped off prenatal snacks with custody and did not deliver the snack directly to the patient. This episode confirms our concern that involving custody in the delivery of medical care is not appropriate and should be immediately discontinued. Health care staff needs to deliver all medical treatment directly to the patient and document having done so in the medical record.[47]

In another concerning example, on 2/15/2022, a physician documented that the patient reported that custody staff did not respond when she complained of asthma symptoms requiring treatment with her inhaler. Custody not reporting a patient complaining of shortness of breath is a serious concern.[48]

[43] Patient #29.
[44] Patient #30.
[45] Patient #31.
[46] Patient #30.
[47] Patient #29.
[48] Patient #29.

Compliance Assessment:

- C.1=Not Evaluated
- C.2=Not Evaluated
- C.3.a=Noncompliance
- C.3.b=Noncompliance
- C.3.c=Noncompliance
- C.3.d=Not Evaluated
- C.4=Noncompliance
- C.5=Noncompliance
- C.6=Substantial Compliance
- C.7.a=Noncompliance
- C.7.b=Noncompliance

Recommendations:

1. ACH should implement the Health Services Request Corrective Action Plan to ensure that staff timely collect and triage HSRs and schedule patients to be seen in accordance with the urgency of the complaint, and that a RN sees all patients with medical complaints no later than 72 hours after the submission of the HSR.
2. In light of the ongoing major deficiencies, RNs should see all patients following submission of HSRs and then refer to mental health and dental staff in accordance with Consent Decree referral timeframes.
3. Prioritize and schedule nurse sick call to be conducted in an adequately equipped examination room at a designated time, 7 days a week.
4. Nurse sick call should be scheduled and conducted at times that do not present a barrier to care.
5. RNs must see patients with urgent complaints (e.g., chest pain, shortness of breath, nausea and vomiting, severe dental pain) when notified by custody staff. Custody staff must to escort the patients to a clinical setting for examination.
6. Establish custody posts for the purposes of health care escorts, not to be redirected for non-health care duties.
7. Perform CQI studies on the access to care process, including availability and collection of HSR forms, timely nurse triage and appointments, quality of nursing assessments and timeliness of medical, mental health and dental provider referrals.

D. Chronic Care

1. Within three months of the date the Remedial plan is issued by the Court, the County shall, in consultation with Plaintiffs' counsel, develop and implement a chronic disease management program that is consistent with national clinical practice guidelines. The chronic disease program will include procedure for the identification and monitoring of such patients and the establishment and implementation of individualized treatment plans consistent with national clinical practice guidelines.

a. The chronic disease management program shall ensure that patients with chronic illness shall be identified and seen after intake based upon acuity (on the day of arrival for patients with high acuity and not to exceed 30 days for all others). The County will timely provide clinically indicated diagnostic testing and treatment, including prior to this post-intake appointment. Follow-up appointments will be provided in intervals that do not exceed 90 days unless patients are clinically stable on at least two consecutive encounters, in which case, follow-up appointment intervals will not exceed 365 days (and sooner if clinically indicated), subject to a chart review every 6 months.
b. The chronic disease management program shall ensure patients are screened for hepatitis C at intake. If medical staff recommend Hepatitis testing based upon screening results, such testing shall be offered on an "opt-out" basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing the refusal shall be documented in the health record. Patients found to have hepatitis C shall be offered immunizations against hepatitis A and B.
c. The chronic disease management program shall include a comprehensive diabetic management program consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. The protocol shall be developed in coordination with custody administration to address normal circadian rhythms, food consumption times and insulin dosing times.
d. The chronic disease management program shall ensure that patients who take medications for their chronic conditions shall have the medications automatically renewed unless the provider determines that it is necessary to see the patient before renewing the medication. In that case, the patient shall be scheduled to be seen in a reasonable time period to ensure medication continuity.

2. The County shall track compliance with the chronic disease management program requirements for timely provision of appointments, procedures and medications. The County shall ensure that its electronic medical record system is adequate to support these critical functions.
3. The County shall review its infection control policies and procedures for dialysis treatment to ensure that appropriate precautions are taken to minimize the risk of transmission of blood-borne pathogens, given the proximity of HCV+ and HCV- patients receiving dialysis in the same room.

Findings:

The Chronic Disease Management policy was revised on 8/18/2021 and is compliant with Consent Decree requirements. ACH has a policy regarding treatment of hepatitis C infection that includes criteria for treatment, but not a hepatitis C treatment guideline. The Medical Director has developed Chronic Disease Treatment guidelines for HIV infection, Diabetes, Hypertension,

and asthma. The Medical Experts have provided comments on the diabetes and hypertension guidelines.[49] The Medical Director needs to develop clinical treatment guidelines for other common chronic diseases, including chronic obstructive pulmonary disease and thyroid disorders.

The Chronic Disease Management program has been partially implemented. Providers have been trained and have started managing chronic diseases in a more focused and structured way than during past reviews. Full implementation has been impeded by a number of factors including provider shortages, which limit continuity of care. For example, Patient #1 was seen by five different providers for his chronic diseases over the span of 4 months. We also noted inconsistent application of the chronic care policy guidelines across providers, particularly with regard to scheduling return visits for chronic care clinic.

Provider Chronic Care Follow-Up forms have recently been added in the EHR, but we did not observe them to be commonly used. Most encounters wherein chronic diseases were addressed were labeled as "MD Sick Call" visits. If the sick call visit occurs, it is as likely as not that some other issue will be addressed by the clinician who sees them, rather than the chronic disease requiring follow-up. In addition, mislabeling a chronic disease visit as a sick call visit makes tracking and data collection problematic.

Currently, there is no functional chronic disease tracking system. The current electronic health record does not have the capacity to produce reports with an associated tracking system. This is a major impediment to providing patients with timely chronic disease management. The tracking system would facilitate labs being ordered and drawn in advance of clinic visits.

Staffing issues that plague other aspects of health care delivery within the jail also negatively impact the chronic disease management program. Lack of continuity is apparent in most of the charts we reviewed; patients are commonly seen by a different provider each time. No single clinician seems to "own" the plan of care or be personally committed to following through to ensure that desired outcomes occur. Patients are typically referred back to provider sick call for follow-up.

Although a position has been budgeted for a chronic disease nurse, this position is currently not in place, which exacerbates the inefficiency of the program. It is evident that providers do not have ready access to all the information needed to perform a comprehensive chronic disease visit. This is especially true regarding outside consultation reports and test results, as well as information about medication adherence. The former issue is further discussed in the Specialty Services section of this report. The driver of the medication adherence issue is less clear. Providers presumably have access to the electronic medication administration report (MAR), yet often appear unaware of patients' patterns of medication nonadherence, which can be the main driver of poor disease control. This leads to orders for dose escalation when exploring the reasons

[49] The Medical Experts believed that they had previously provided comments regarding the HIV treatment protocol but will resend comments.

behind the lack of adherence would be the more appropriate response. The clinical and administrative support of a dedicated chronic disease nurse to compile these reports in an easily accessible way may help mitigate this problem. However, the medical provider is ultimately responsible for the care of the patient.

The quality of the providers' documentation is variable and often inadequate. Many of the providers use a templated review of systems but do not modify it to describe the individual patient. For example, Patient #13 was seen by a doctor for rectal bleeding and hand pain from rheumatoid arthritis, but in the review of systems the doctor's note says, "no blood in the stool" and "no joint pain or swelling." Contrary to that statement, the note goes on to describe the hands as "mildly swollen and tender" in the physical exam section.

In another example, Patient #7 was seen in October 2021 for a chronic disease visit. The NP documented an extensive physical exam, including visualization of the optic discs and retina, visualization of the nasal turbinates, a hernia exam, prostate exam, stool guaiac test, examination of the scrotum and penis, and describes the liver and spleen as having "no enlargement or nodularity." Based on the context, it is very unlikely that all these functions were actually undertaken.

A common practice among the providers is to include a statement at the end of their notes which reads: "Patient was counseled about medical conditions and management. Patient verbalize understanding and consents to current management." The presence of the same spelling and grammar mistakes in every instance makes it clear that this is an auto populated macro rather than an accurate description of exactly what aspects of the patient's condition and treatment plan were discussed. The practice of providers cutting and pasting notes risks documenting history and physical examinations and education that have not been conducted and, in some cases, simply amounts to falsification of medical records. The Medical Director needs to address this with providers as it is a patient safety issue.[50]

Record review shows multiple instances in which providers do not timely review laboratory and diagnostic reports and address abnormal findings, resulting in harm to patients. This is a serious issue that must be addressed by the Medical Director (see Patient Reviews).

A major concern is that medical providers too often practice remote control medicine. Providers commonly order tests and medications without seeing the patients to discuss the treatment plan and changes to their medical regimen. They often do not communicate test results with patients timely, if at all. For example, Patient #1 requested copies of his blood test results on several occasions, but there is no evidence that these were provided to him. On another occasion, one of the physicians increased this patient's thyroid medication dose fivefold without discussing this with him first. A dose increase of this magnitude carries a significant risk of side effects about which the patient should be forewarned.

[50] https://psnet.ahrq.gov/perspective/ehr-copy-and-paste-and-patient-safety

Medical providers need to timely schedule follow-up visits to discuss the treatment response, lab results and plan with the patient. Medical providers should not delegate informing patients of changes in their treatment plan to a nurse, who has no direct knowledge of the clinical rationale for the change, and does not provide the patient an opportunity to ask questions regarding changes in the treatment plan, particularly medications.

On a related but parenthetical note, we observed a degree of questionable judgment on the part of several of the health care staff, ranging from callousness to paternalism. For example, when Patient #1 developed a thyroid condition resulting in cold intolerance, he reported shivering and requested a long sleeve shirt and blanket. The medical provider denied this request without evaluating the patient. In another case, a physician decided not to work up a neck mass seen on CT in Patient #10 due to his advanced age and poor health status. This might well be a reasonable conclusion if that is what the patient decides, but there is no evidence that the doctor discussed this with him. Similar issues were observed in the care of Patient #5.

Regarding hepatitis C infection testing and treatment, opt-out testing is being offered at intake, but performance of the blood test is not timely occurring, and often does not take place at all, even for patients at the jail for months. This is not compliant with the Consent Decree.

With respect to dialysis services, medical record review shows that on several occasions, patients had to be sent out to UC Davis emergency department for dialysis due to “staffing issues” at the jail. The County is required to review its infection control policies and procedures for dialysis treatment to ensure that appropriate precautions are taken to minimize the risk of transmission of blood-borne pathogens, given the proximity of HCV+ and HCV- patients receiving dialysis in the same room. In March 2022, the inspection of Diane Skipworth, Environment of Care expert revealed that:

> *The dialysis room was cluttered and disorganized. Several cardboard boxes were stacked behind one of the patient chairs, boxes were stacked on the seat of the other patient chair, and* ***access to the handwashing sink was impeded by boxes and a trashcan.***[51] *The supplies in the room appeared to be arranged in a haphazard manner. The dialysis room should be organized so that essential supplies are readily available and accessing care does not interfere with patient care.*
>
> *Dialysis patients have weakened immune systems and are at increased risk of infections due to the insertion of catheters and needles to access the bloodstream during hemodialysis. Infection can spread from contaminated surfaces, such as dialysis stations and machines to the patient by health care workers hands. Therefore, health care workers must perform frequent hand*

[51] Bolded print added by Medical Experts.

> *hygiene during dialysis treatments; thus, access to the hand washing sink is an essential element of infection control.*[52]

These findings regarding the dialysis clinic are similar to the Medical Expert findings in the Second Mays Report, reflecting no change in the conditions in the dialysis treatment room, even though these findings were identified as serious issue one year ago. The lack of access to adequate hand washing in the room where dialysis is conducted presents an unacceptable risk of infection to medically compromised patients.

In summary, *the Chronic Disease Management Program is early in its development, hampered by lack of a tracking system, staffing issues, lack of adherence to policy guidelines, and poor continuity and quality of care*. The Medical Director needs to focus his attention on each of these factors.

The following case reviews of patients with chronic diseases illustrate the findings in our report. Many of these patients also needed specialty services that were not timely provided and, in many cases, the providers did not timely address consultant recommendations, educate, or monitor patients.

Patient #1

This is a man in his fifties with history of hepatitis C, gastritis, chronic obstructive pulmonary disease (COPD), substance use disorder (SUD) on methadone, pernicious anemia, subclinical hypothyroidism, and multifactorial mobility impairment. The patient was booked into the jail in November 2021, and was seen for an intake history and physical examination ten days later.

On 12/2/2021, his admission labs came showed mild anemia. Further workup revealed worsening iron deficiency anemia. He was started on iron and stool studies were ordered. At a subsequent visit, another physician ordered a GI consult for upper endoscopy (EGD), which was performed on 12/30/2021, and showed mild gastritis and esophagitis as well as a small tear in the esophagus.

On 12/22/2021, more blood tests were done. The report was signed off by a physician on 12/23/2021. No discussion with the patient is documented. The patient sent several health service requests asking for copies of his blood test results, but it does not appear that these were ever provided to him.

On 1/7/2022, the patient was seen for follow-up of the EGD. The doctor referenced the EGD report which revealed normal findings according to the doctor’s note. The pathology report was not yet available but was uploaded to the patient’s chart later that day.

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[52] Diane Skipworth Report. June 21, 2022. Page 11.

On 1/19/2022, he was seen by a different doctor for follow-up of the EGD results. The doctor wrote that the biopsy results were "pending" even though they had been uploaded to the chart on 1/7/2022. Follow-up was ordered in 2 weeks.

On 2/14/2022, the patient was seen for iron deficiency anemia by a third doctor, who ordered more blood tests. On 2/22/2022, the lab reports were reviewed by the physician, who ordered a stool test without seeing the patient.

On 2/28/2022, the patient saw yet another doctor for a chronic disease visit, the first to be labeled as such. She reviewed the pathology report, presumably with the patient.

On 3/16/2022, a physician saw the patient at MD sick call for follow-up of a leg wound and anemia. Labs were ordered and were signed by the physician two days later, but there is no evidence that the results were shared with the patient. On 4/14/2022, he was seen for MD sick call by yet another physician who addressed his chronic diseases thoroughly (though didn't use the chronic care form) and ordered follow-up in one month. On 5/10/2022, the physician saw him again and again did a thorough chronic disease visit, reviewed labs with patient but did not use the chronic are form. She did order a chronic care follow-up appointment.

In February 2022, the patient started to develop a thyroid problem. At first, he was asymptomatic, but as the condition progressed, he developed symptoms including low energy, constipation, weight gain, and feeling cold. In May 2022, a physician started the patient on medication. In early June, the patient sent at least two HSRs complaining of cold intolerance and asking for long sleeve clothing and a blanket. These went unanswered until ACH administration intervened to facilitate a nurse sick call visit, which occurred on 6/15/2022. The nurse conferred with a physician, who reviewed the chart but did not see the patient. He decided that a blanket and long sleeve shirt would not help and were therefore "not indicated," per the nurse's note. He increased the thyroid medication dose by five-fold without discussing this change with the patient. Ultimately, following concern expressed by the Medical Experts, the Medical Director got involved and ordered the patient an extra blanket.

The patient is mobility impaired due to neuropathy and scoliosis. He is also missing a thumb. On 5/10/2022, a physician saw the patient and decided that he was "minimally unstable" using a cane. She discontinued the cane and ordered a walker. Unfortunately, he was given a standard walker (metal frame with four legs) which he could not use due to his missing thumb. On 5/16/2022, when it was presented to him, he was told by custody that he had to choose one; either the cane or the walker. He chose to keep his cane. He saw the doctor later that morning and pointed out that while the walker is necessary for mobility around the facility, it would interfere with mobility inside his cell and in the shower as there is not enough space to accommodate a walker. He needed a cane for those tight spaces. She reiterated that he is not allowed to have both a walker and a cane at the same time. On 6/9/2022, after the patient's Power of Attorney raised concerns to class counsel, the patient was provided with a Rollator and has been allowed to keep his cane.

In January 2022, the patient developed a rash, which evolved into a chronic leg ulcer with recurring infection. He has been treated with multiple courses of antibiotics and local wound care but the ulcer persists. A dermatology consult was requested when he was housed at Main Jail, but he subsequently transferred to RCCC, then refused the consultation. The last visit that mentions the ulcer was dated 5/27/2022, at which time the doctor ordered a 10-day course of antibiotics, sick call follow-up in one week, and a provider chronic care visit in one month. Neither of those visits occurred.

On 7/19/2022, a physician saw the patient and sent him to the ED to rule out a blood clot (ultrasound was negative). The physician placed him on another course of antibiotics. The next day, the Medical Director placed an order for surgery clinic but did not see the patient. Chronic care follow-up was ordered on 7/26/2022 but as of 8/14/2022, the patient had not been seen.

Opinion:

1. In the span of four months, this patient was seen by five different doctors for chronic disease management. This does not reflect continuity of care.
2. It is not at all unusual for patients to require more than one assistive device to navigate different situations and circumstances (e.g., grab bars and a shower chair and a sock donner). It is medically inappropriate to restrict assistive devices from a patient who requires them. If there is a question regarding which device(s) might best serve the patient, a physical and/or occupational therapy consultation should be ordered.
3. Although an adjustment of the patient's thyroid medication may have been an appropriate intervention, medication changes should be discussed with the patient, not ordered on a "remote control" basis. Further, a dose increase of this magnitude is quite aggressive and risks overshooting the goal (and precipitating corresponding symptoms) in a patient whose free T4 was in the low normal range to begin with.
4. Refusing a blanket or long-sleeved shirt to a patient with a medical condition known to cause cold intolerance seems callous and punitive.
5. Local attempts to heal this patient's chronic ulcer have been inconsistent and unsuccessful. He should be referred to a wound specialist. Consider biopsy of the wound bed to aid in diagnosis.
6. We encourage the Medical Director to personally evaluate patients for whom he orders medical care.

Patient #4

This is a man in his early sixties with hypertension, hyperlipidemia, anxiety and arthritis, who on 1/2/2022 was seen for a chronic disease visit. His hypertension and hyperlipidemia were under fair control but assessed as good control.

During the month of February 2022, medical records show he refused his medications on a very frequent basis, but this went unaddressed by medical staff.

On 2/21/2022, he was seen at nurse sick call requesting to be seen by medical for back pain, thinking he might have kidney stones. The patient reported that his pain was 5 of 10 in severity.

The patient was told he would be seen the next day. Four days later, on 2/25/2022, a physician saw the patient and started him on prednisone 20 mg twice daily for 10 days with follow-up in one month. The patient was already taking meloxicam and aspirin.

On 3/21/2022, the NP saw the patient cell front for a chronic disease follow-up visit (labeled as a sick call visit). She rated his hypertension as under good control even though his blood pressure was 150/88 mm hg (BP goal=<130/80 mm Hg), similar to the readings of the past month. He had been refusing his medications on a very frequent basis but if the nurse practitioner was aware of this, she did not comment upon it. His back pain was not addressed.

On 4/19/2022, a provider saw the patient for chronic disease management and to review blood work drawn on 4/15/2022. The patient's blood pressure was still elevated at 152/86 mm Hg. His hypertension was judged to be under fair control and no medication changes were made. Blood pressure checks were ordered monthly. His cholesterol was also judged to be under fair control even though his triglycerides were severely elevated at 528 (normal=<150), which prevented his LDL cholesterol from being calculated. No changes were made to his medication regimen. A three-month chronic care follow-up was scheduled

At the next provider visit on 6/28/2022, the patient's blood pressure was at goal at 117/73 mm Hg. His cholesterol was rated as good control at this visit, even though no new labs had been performed. When his cholesterol panel was repeated in July 2022, the values had improved.

Opinion:

- Providers did not address this patient's frequent medication refusals.
- Chronic care visit notes are all labeled as MD sick call.
- The degree this patient's chronic disease control is not always assessed accurately.
- The provider did not change the patient's treatment plan for his hypertriglyceridemia.

Patient #5

This is man in his early thirties with chronic back pain, asthma/chronic obstructive pulmonary disease (COPD), Post Traumatic Stress Disorder (PTSD), borderline personality disorder, and "malingering," who has been challenging to care for due to his behavior. When opening his chart, there is a pop-up box which reads "argumentative/volatile behavior. Need chaperone when seeing patient." According to the records, he refuses medications and treatments frequently and becomes agitated easily. He has been placed on suicide watch multiple times.

His pulmonary disease is moderately severe, and he presents frequently with complaints of chest pain and tightness.

On 12/26/2021, he was seen by the RN for chest pain. The nurse elicited a history of excessive exercise (daily routine includes 250 push-ups, 100 dips, 100 sit ups, and 500 other ab exercises). He complained that he was "starved." She assessed "muscular strain," obtained an EKG which was normal, and gave him some Tylenol.

On 12/28/2021, he was seen by the nurse again for chest pain. An EKG was normal.

On 12/29/2021, he saw the MD for follow-up of chest pain. He reported a history of irregular heart rhythm and said he was supposed to see a cardiologist prior to his incarceration. His exam was benign. The physician considered referral to cardiology, but because the patient refused to have any blood work done, the referral was not placed. Instead, he was referred back to mental health to consider stopping Elavil, which can cause cardiac rhythm disturbances.

On 1/21/2022, he was seen cell side by a physician for COPD. The doctor reviewed his pulmonary function test from 2019, which revealed fairly severe obstructive lung disease. The patient was described as appearing to be in no distress with clear lungs, no wheezing, rambling speech "frequently deflects from answering questions and changes subject to avoid answering." A blood test for alpha-1 anti-trypsin deficiency was recommended, but the patient declined. Advair, an inhaled steroid, was added to him medication regimen.

On 1/21/2022, the patient saw a nurse for chest pain. The nurse noted no shortness of breath and normal vital signs. EKG was done and reportedly normal. He was returned to his unit. There was no mention of contact with a provider.

On 1/22/2022, the patient was seen at nurse sick call for chest pain, fever, difficulty breathing and generalized body pain rated 8/10. Temperature 100.0 F°, O2 sat= 99% on room air, pulse=101/minute, R=20/minute, and BP=131/78 mm Hg. The nurse noted clear lungs and no distress or difficulty breathing. He was given Tylenol and placed in COVID quarantine. He refused a COVID test and therefore it was not known whether he had COVID infection or not. Although this patient was symptomatic for COVID and had pulmonary comorbidity, a medical provider did not medically evaluate the patient throughout his isolation for COVID symptoms, which ended on 2/3/2022.

On 1/31/2022, a RN sent an alert to one of the physicians reportedly "per kite" though the kite is not attached. "Attention Dr. -- : I would like to speak to you more extensively about my COPD. I would like more medical information and print out regarding the medication's and tests you want to do on me...." Patient offered to release records from his pulmonologist. *There was no visit with the doctor following this alert.*

He was seen that day at nurse sick call for chest pain. He was noted to be wheezing and was given his inhaler and a dose of Tylenol. Lungs are described as clear after using the inhaler and he was sent back to his cell. *There was no order for follow-up with a provider.*

On 2/1/2022, he had a nurse visit to use his inhaler. However, the nurse refused to give him his inhaler after her evaluation revealed clear lungs, no signs of shortness of breath or distress, and normal vital signs. The patient became acutely agitated when the nurse refused to give him his inhaler and was physically escorted off the unit. The nurse did not measure the patient's peak expiratory flow rate (PEFR) to obtain objective data regarding the patient's airflow obstruction.

On 3/26/2022, he was seen by a nurse for complaints of chest pain. The nurse obtained an EKG, determined it was normal based on the automated reading, and sent him back to the unit without contacting a provider. *This exceeds the scope of practice for a nurse.*

On 3/29/2022, the NP saw the patient cell side for back pain. He requested to be seen in the exam room, so the appointment was rescheduled for the following day. However, the deputies on his unit requested that the NP reschedule the appointment again due to “behavior issues.” On 3/31/2022, she saw him but documented no history other than that the symptoms wax and wane, and no exam. She ordered duloxetine and follow-up in 3 months.

On 4/15/2022, he was seen by the nurse with chest pain. His vital signs were normal and exam was benign. He became irate when she refused to perform an EKG and was subsequently placed on watch for suicidal ideation. *Two days later, the unit deputy called 2M stating that the patient was reporting chest pain. The nurse scheduled him to be seen the next day. The next day, a different nurse called the unit and asked the deputy if the patient had reported any chest pain that day. When the deputy’s answer was no, she cancelled his appointment.*

On 5/3/2022, he was seen by the physician for left hand pain after punching a wall. X-rays were taken and were negative for fracture. He was treated with ice, Tylenol, and NSAIDs. At a follow-up visit two weeks later for ongoing pain and swelling of the left hand, a different physician obtained the additional history that he had injured that hand several years ago and had been using a brace on and off since then for chronic discomfort. She also addressed his low body weight and recent weight loss as a result of skipping meals. Her note is comprehensive and thorough, but his lung disease was not addressed. She ordered a chronic disease follow-up visit in three months.

On 5/22/2022, he presented to the nurse with chest pain and requested to use his inhaler. An ECG was performed and was essentially within normal limits. The pain resolved after using his inhaler. He was seen again by a nurse for wheezing on 6/10/2022, which improved with inhaler use, and again on 7/28 with chest pain, which resolved after using his inhaler.

Opinion:

- This patient’s mental illness makes providing medical care extremely challenging. However, he has significant lung disease which needs to be monitored on a regular basis. He has seen nursing staff regularly for inhaler use, but a provider has not addressed his lung disease since January 2022. This is not medically appropriate.
- The physician’s decision not to refer the patient to a cardiologist because he refused to have blood drawn appears to be retaliatory and inappropriate.
- A RN saw the patient with a history of COPD for complaints of chest pain, fever, difficulty breathing and generalized body pain. Independent of COVID-19 testing, a medical provider needed to evaluate this high-risk patient and discuss COVID-19 testing with the patient.
- On more than one occasion, nursing staff have made treatment decisions for chest pain based on their interpretation of the patient’s EKG, which is outside their scope of practice.

Not all chest pain is cardiac in nature (e.g., pulmonary embolism, pneumothorax). Nurses must contact a medical provider for all episodes of chest pain, independent of EKG results.

- Nursing staff should not refuse to give the patient his inhaler when he reports shortness of breath. Nurses and providers should perform PEFR measurements at each urgent and chronic disease encounter for patients with asthma and COPD to obtain objective data regarding airflow restriction and/or obstruction.

Patient #6

This is a man in his fifties with a history of morbid obesity, poorly controlled type 2 diabetes, advanced osteoarthritis, peripheral neuropathy, obstructive sleep apnea, coronary artery disease (CAD) with history of myocardial infarction (MI), chronic back pain, schizoaffective disorder, and antisocial personality disorder. His care has been complicated by noncompliance and challenging behavior.

Regarding his coronary artery disease: Beginning around September 2021, the patient began utilizing nitroglycerin at a high rate and presented to the clinic frequently complaining of chest pain. These visits intensified in December 2021 when he was either seen for chest pain or requested nitroglycerin *21 times,* including two trips to the emergency department. He was ultimately referred to cardiology and seen on 1/21/2022. A stress test and echo were recommended with a follow-up appointment in 2 to 3 months. *However, the tests were not completed until three months after this visit, and as of early August 2022, the patient had not had a return visit to the cardiologist.*

Regarding his diabetes: The patient's course has been marked by frequent, near daily, refusals of blood sugar checks and insulin administration. Unsurprisingly, his diabetes is poorly controlled. On only one occasion in the past year has a provider addressed the patient's noncompliance with him. On all other occasions, no mention is made and clinicians seem unaware of the magnitude of his nonadherence, as they continue to adjust his insulin dose and have discontinued oral medications (which he is typically more compliant with). During chronic disease visits (all of which are labeled as sick call), his diabetes is incorrectly assessed to be under fair control, and he has not been seen monthly as required by chronic disease policy.

Opinion:

- This patient has not been seen timely according to the degree of his disease control.
- The patient was not returned to see cardiology as recommended.
- Providers are not addressing the barriers to compliance with regard to blood sugar checks and insulin administration. The frequency with which the patient refuses insulin is certainly contributing to his poor disease control. Other options to enhance compliance should be explored (e.g., enhanced use of oral medications).

Patient #7

This is a man in his early fifties with kidney failure, diastolic heart failure, diet-controlled type II diabetes, and hypertension. Despite the fact that his renal function is teetering on the edge of

dialysis and his blood pressure is rarely at goal, these diseases are judged to be under "good" or "fair" control at most of his visits.

On 8/30/2021, hematology recommended that the patient take Procrit (Epogen) 20,000 units every two weeks for hemoglobin less than 10 grams with a complete blood count every two weeks. A RN saw the patient upon return, noted the recommendations, and contacted the on call medical provider for orders. However, the nurse wrote the medication order to *hold* the medication if the patient's hemoglobin was less than 10 grams, instead of to *give* the medication when the hemoglobin was less than 10 grams. This was a medication transcription error. However, despite the transcription error, staff did not adhere to the direction to hold the medication if the patient's hemoglobin was less than 10 grams. In this case, the two errors resulted in the patient receiving his medication as recommended. It does not appear that this error was ever recognized.

After transfer from Main Jail to RCCC in September 2022, the patient sent an HSR stating that he is supposed to be taking Procrit (Epogen) once every two weeks for anemia related to his kidney disease but had not received it. On 9/3/2022, the physician saw the patient for Epogen concern and noted that the medication was ordered on 8/30/201 *but not seen on the Medication Administration Record (MAR).* The provider planned to reorder the medication. On 9/7/2022, the Fusion MAR showed the patient was administered a dose of Epogen, but it does not appear on the eMAR list of medications given on that date. Thereafter the medication was listed on the eMAR to be administered every two weeks.

By late December 2021, the patient had developed severe anemia (hemoglobin 5.8) and required hospitalization. He was also found to be in acute diastolic heart failure with 25 lbs. weight gain following discontinuation of his diuretics at the jail. He was treated with blood transfusions and diuretics.

On 12/25/2021, the patient was discharged from the hospital back to the jail. Hospital physicians recommended to switch his diuretic to bumetanide 2 mg, 3 times a day; to continue his nitrate and hydralazine; and to hold Lisinopril due to renal function. *Upon return to the jail, Bumetanide was added to the regimen rather than switching the patient from Furosemide to Bumetanide. The result is that he received excessive and redundant diuresis. Moreover, Lisinopril was not discontinued upon his return to the jail as recommended. He then ended up back in the hospital a week later with overdiuresis and resulting acute kidney injury.*

Multiple references are made in the health record that the patient was not able to be safely managed at the jail due to staffing issues interfering with medication continuity. This included comment by the hospital physician that the patient's PCP was unable to adequately monitor him due to staffing and inability to receive daily labs in the prison.

In January 2022, the patient returned to the jail. The discharge summary outlined very specific recommendations for management of the patient going forward including holding his diuretic, stopping his calcium supplement, and ensuring that he get a potassium lowering medication. It

was suggested that he be allowed to keep the latter medication on person given its importance. *Instead, the MAR reflects that the patient continued to receive his diuretic and calcium supplement, and the potassium lowering medication was only administered sporadically.*

Similarly, Epogen has not been given consistently. It is ordered for every other week, but he got it only once in January and once in February. By 3/11/2022, he was back in the emergency department for severe anemia and needing another blood transfusion. At his follow-up visit with hematology on 3/28/2022, it was recommended that his Epogen dose be increased. However, the note was not uploaded to the patient's chart until 4/13/2022 and was implemented on 4/18/2022.

Opinion:

- *This patient has been subject to multiple medication errors which have resulted in actual harm and precipitated avoidable ER visits and hospitalizations.*
- The Medical Director should review the record of this very high-risk patient to further identify and address systemic issues or individual provider performance issues.[53]

Patient #8

This is patient in his early fifties with type 2 diabetes, peripheral vascular disease with history of right below knee and left toe amputations, coronary artery disease (CAD) status post triple bypass surgery in 2018 and stent placement June 2021, chronic kidney disease, diabetic neuropathy, anemia of chronic disease and congestive heart failure (CHF).

In mid-December 2021, the patient was seen at MD sick call for confusion. He was described as unable to make any coherent sentences or follow commands, "confused and dazed." Temp= 98.1 F. BP=86/55 mm Hg, pulse= 96/minute and oxygen saturation=99% RA. He was sent to the emergency department and admitted with severe sepsis from suspected pyelonephritis with toxic encephalopathy. Two days later, he was discharged back to jail. There are multiple references in the discharge summary of the hospital doctor not having access to the patient's medical history or medication list.

At a provider visit in January 2022, most of his chronic diseases were addressed. *It was documented that the patient has a history of a nodule in his right lung for which a follow-up CT is pending for 6/1/2022 – this did not occur.*

[53] The response from the Medical Director regarding this patient review was as follows: *The discharge medication list from the hospital clearly instructs the patient to take both diuretic medications (bumetanide and furosemide), which were ordered precisely as recommended by the discharge hospitalist. Furthermore, in the discharge instructions, the hospitalist instructed the patient to take furosemide. While the second hospitalization was unfortunate, it was not caused by failing to follow discharge orders*. We strongly disagree with the Medical Director's interpretation. We find this statement to be unsupported by hospital documentation, which clearly states that the patient was to be switched to Bumetanide (not added to Furosemide), and when the patient was hospital a week later, that hospital physicians noted that the patient was over-diuresed. The Medical Director also fails to note that ACH provider did not discontinue the patient's Lisinopril as recommended by the hospital and likely contributed to his acute kidney injury.

In early March, the patient went out for cardiology follow-up visit. No note was returned with the patient, and he was not seen by a provider to address the cardiology visit.

Later that month, the patient was seen at MD sick call for a severe headache and elevated blood pressure (176/100 mm Hg). Under the review of systems section of the note, it states, “no headache.” There is no physical exam of the patient. He was given 30 mg of IM Toradol and 50 mg of metoprolol. There was no follow-up documentation as to whether this was effective; there was also no repeat blood pressure checks or nurse assessment. He was not seen again by a provider prior to his release in June 2022.

Opinion:

- This patient has a high burden of chronic disease, but was seen only once in six months for chronic disease management.
- No follow-up occurred after the patient’s cardiology appointment, and the note was never received by the facility.
- There was no follow-up of this patient’s hypertensive urgency.
- The patient was not timely scheduled and did not receive a chest CT for follow-up of a lung nodule for evaluation of malignancy.
- Given the inadequacy of care and inaccuracies of clinical documentation, the Medical Director needs to conduct peer review of this provider.

Compliance Assessment:

- D.1=Noncompliance
- D.1.a=Noncompliance
- D.1.b=Partial Compliance
- D.1.c=Noncompliance
- D.1.d=Partial Compliance
- D.2=Noncompliance
- D.3=Noncompliance

Recommendations:

1. Ensure that intake nurses refer chronic disease patients to a medical provider to be seen based upon their medical acuity.
2. Conduct a CQI study regarding why intake labs, including hepatitis C and sexually transmitted disease and tuberculin testing is not taking place timely, if at all. Intake labs should be drawn in time for the 14-day history and physical exam.
3. Immediately implement the 14-day history and physical program to serve as a baseline assessment and to order chronic disease labs to be performed prior to the first chronic disease visit.
4. Develop an electronic tracking system for chronic disease patients to include:
    a. Date of arrival
    b. Date of initial history and physical examination

   c. Date of initial labs
   d. Date of initial chronic disease visit
   e. Dates of labs to be performed prior to the next chronic disease visit
   f. Dates of follow-up visits
5. The Medical Director needs to finalize hepatitis C infection, hypertension, and clinical treatment guidelines and develop guidelines for other chronic diseases.
6. Providers need to timely review and inform patients of lab and diagnostic test results and changes to the treatment plan and document education and counseling in the medical record. This is a provider responsibility that should not be delegated to nurses.
7. The Medical Director needs to conduct formal reviews of patients with chronic diseases to determine if medical providers meet the standard of care.
8. ACH needs to assess access to dialysis services at the jail and address staffing issues that result in patients being sent to the hospital for dialysis.
9. Perform CQI studies to assess timeliness of referral from intake to a medical provider and medical provider compliance with nationally recognized clinical practice guideline for treatment of chronic diseases.

E. Specialty Services

1. The County shall develop and implement policies regarding specialty referrals using an algorithm with evidence-based referral criteria and guidelines.
2. Within 3 months of the date the Remedial plan is issued by the Court, the County shall develop and implement policies and procedures to ensure that emergency consultations and diagnostic treatment procedures, as determined by the medical provider; are provided immediately; high priority consultations and procedures, as determined by the medical provider are seen within 14 days of the date of the referral; and routine consultations and procedures, as determined by the provider are seen within 90 days of the date of the referral.
3. Patients whose routine specialty consultation or procedure do not take place within 90 calendar days from the date of the referral shall be examined by a clinician monthly and evaluated to determine if urgent specialty care is indicated.
4. Within 5 days of the completion of a high priority specialty consultation or procedure, or within 14 days of a routine specialty consultation or procedure, patients returning to the Sacramento County Jail shall have their specialty reports and follow-up recommendations reviewed by a jail nurse practitioner, physician assistant or physician.
5. Specialty care consultations and outside diagnostic and treatment procedures shall be tracked in a log that identifies:
   a. The date of the referral request
   b. The date the request is sent to UM
   c. The date of UM notification of approval or denial
   d. The date the referral was sent to the specialty care provider
   e. The date of the consultation or procedure appointment

    f. The date the consultation or procedure took place
    g. If cancelled or rescheduled, the reason for the cancellation/rescheduling
    h. The date the appointment was rescheduled.

6. Requests for specialty consultations and outside diagnostic and treatment procedures shall be tracked to determine the length of time it takes to grant or deny requests and the circumstances or reasons for denials (Note: date of approval should be on specialty services tracking log, see above).
7. At least twice a year, the County shall conduct an audit of specialty care referral logs described in subsections (5) and (6), above, and complete a report as to whether each category of specialty care is completed in a reasonable time frame, consistent with established time frames. If any specialty care area has a record of untimely appointments as determined by the Correctional Health Service Continuous Quality Improvement (CQI) Committee, the County shall report to Plaintiffs and the parties shall meet and confer to take prompt steps to address the issue. The County will provide Plaintiff's access to the specialty care referral logs and audit reports periodically and upon written request. The parties will work to resolve issues with untimely specialty care in individual patient cases and with respect to systemic trends, including through the dispute resolution process.
8. The County shall consider implementing an e-referral system to reduce delays and facilitate communication between specialists and primary care providers, as well as reducing unnecessary transportation costs and unnecessary specialist appointments by ensuring that the specialist has all the information he or she needs before an appointment takes place.
9. The County shall ensure that utilization management and/or scheduling staff provides notification of whether a patient's specialty care appointment is scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, including as follows:
    a. Medical staff may request and obtain information as to whether any patient's specialty care appointment is scheduled, and as to the general timing of the appointment (e.g., within a one-week date range).
    b. If a specialty care appointment is denied or is not scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.
    c. If a previously scheduled specialty care appointment is postponed to a date that is outside the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.
    d. The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the demand for service at the jail.

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Findings:
ACH revised the Specialty Referrals policy and procedure (revised 8/6/2021). The policy referral time frames meet Consent Decree Requirements (E.1.). ACH reports that it conducts quarterly audits of specialty care referral logs and produces reports as to whether each category of specialty care is completed in a reasonable time frame, consistent with established time frames (E.7.). The most recent audit provided for this report was from July to December 2021(E.7.).[54]

Since our last review, the county has added onsite specialty services including physical therapy, nephrology, ophthalmology, and a GI/Hepatitis C clinic. Also, one of the primary care providers with additional training in HIV conducts a weekly HIV clinic. This represents an improvement as compared with our last review with respect to onsite services.

In June 2022, the County produced the Specialty Services Tracking Log that included the time frame from July 2021 to March 2022. The tracking log was not compliant with tracking key items required by the Consent Decree. (E.5). The following columns need to be included: whether the specialty request was approved or *denied*; the scheduled date of the appointment and the date the appointment took place; the date the appointment was rescheduled; the date the report was received. *The tracking log contained a column for scheduled date for medical provider follow-up, but not for the date the provider actually saw the patient.* This is an important indicator as record review showed that medical providers did not timely see patients for follow-up, and in some cases, patients were lost to follow-up for months, or completely. The Medical Experts provided feedback on missing elements of the log and in August 2022, the log was revised. However, for the majority of the period of review, the tracking log did not meet Consent Decree requirements.

Although not required by the Consent Decree, we recommend a column for whether the consultant recommends follow-up care (e.g., procedures or follow-up appointments). This would facilitate Consent Decree compliance by cueing Utilization Management staff to review the consultant's report and coordinate follow-up care if not already initiated by medical providers.

With respect to the Utilization Management (UM) process, following submission of a specialty services request by a provider, the UM policy states that:

> *"Case Management will make determinations for urgent referrals and notify provider (sic) within 24 hours and make determinations for routine referrals and notify providers in 3 business days."*

Review of the UM tracking log shows many instances in which Case Management did not make a UM decision within policy time frames. In some cases, delays in specialty service approval also resulted in delays in requesting appointments and lack of compliance with Consent Decree time frames. Examples of delays in review and approval of specialty services requests are noted below:

- On 1/18/2022, a cardiology consult was submitted and not approved until 2/2/2022.[55]

[54] Fifth Mays Status Report. Page 36.
[55] 2021-2022 First Three Quarters Data QI Monitoring Sheet.

- On 1/25/2022, a gastroenterology consult was submitted and not approved until 2/17/2022.[56]
- On 1/14/2022, a surgery consult was submitted and not approved until 4/12/2022.[57]
- On 1/1/2022, an optometry consult was submitted and not approved until 6/27/2022, noting "limited resources."[58] The lack of availability of resources should not have a bearing on the timeliness of approval.
- On 2/4/2022, a surgery consult was submitted that was not approved until 4/18/2022, 11 weeks later. The consult was not completed within the required 90-day time frame.
- On 1/20/2022, an orthopedic consult was submitted, but not approved until 3/1/2022. The appointment was scheduled for 5/20/2022, but cancelled due to pre-ops and COVID testing not being performed. The consult was completed 6/10/2022.
- On 3/11/2022, an ENT consult was submitted, but it was not approved until 7/16/2022, over 18 weeks later and well beyond the 90 days by which the appointment should have been completed.

In some cases, delays in the approval process did not adversely affect timely completion of the consultation. However, in several cases, delayed approval did delay access to the service, sometimes significantly. *Record reviews showed that delays in access to specialty services caused significant harm.*

It is important that each step of the Utilization Management process is timely, from provider submission, UM review, appointment scheduling, and communication with providers. Consent Decree time frames for completion of specialty services appointments are from the date that the medical provider requested the service, not the date approved by Case Management/Medical Director. While in some cases, the consultant may request certain lab tests or imaging be performed prior to the appointment, this should not delay approval of the appointment. Case Management needs to timely communicate to providers any labs and imaging required by consultants, so that they can be *expedited* and the specialty service appointment can be timely requested and scheduled in order to complete services within Consent Decree time frames and/or as clinically warranted.

With respect to the timelines of services, the facility continues to struggle with providing timely access to external specialty care services. In the second half of 2021, 37% of routine referrals were not seen timely, i.e., within 90 days. Only three of the 12 urgent referrals (25%) were seen timely (within 2 weeks) during that same period.[59]

Record review showed several cases in which specialty services were not completed for more than six months, and in some cases, patients were lost to follow-up (E.2). Medical providers do not monitor patients monthly when specialty services cannot be provided within required time

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[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Mays Fifth Status Report. Page 36.

frames (E.3). When appointments are denied or delayed, medical records do not reflect that providers and patients are timely notified (9.b and 9.c).

The following cases are examples of unacceptable delays in medical evaluation and treatment:

A patient with ocular melanoma was under the care of ophthalmology and receiving monthly Avastin injections for macular edema.[60] In mid-March 2022, ophthalmology saw the patient and requested monthly follow-up, but the patient was not seen until mid-June 2022. Ophthalmology expressed deep concern when the patient was not brought to the clinic for treatment as scheduled, due to the patient's risk of losing his right eye. According to ACH response, there apparently was a problem with custody rescheduling consultation appointments due to staffing issues. There is no documentation in the EHR of the reason the appointment(s) did not take place as scheduled.

In another case, a woman in her mid-forties had a breast mass for which a specialist recommended ductography in early June 2022. Twenty days later, a provider saw the patient but did not appear to see the report, and the recommendations were not addressed. The Medical Experts advised ACH who confirmed that no action had been taken to address consultant recommendations. According to the Medical Director, the jail was required to obtain preapproval for specialty services, but no action had been taken to obtain preapproval, thus delaying evaluation for breast cancer.[61]

Upon return to the jail following completion of a specialty services, a nurse usually, but not always sees the patient to review information provided by the consultant. During this review period, medical providers typically did not see patients within five days of return from a high priority and 14 days of a routine specialty service to discuss findings and recommendations, and to develop a treatment plan with the patient, in violation of the express requirements of the Consent Decree (E.4). [62]

In late 2021, providers were given access to Hospital Connect,[63] allowing them real-time access to clinical data from external health care organizations. However, we found no documented instances of providers using this system. In every chart we reviewed where an outside service was provided, clinicians were waiting for results of tests, consults, or procedures for extended periods of time, further delaying care. For example, Patient #1 underwent an upper endoscopy for anemia on in late December 2021, and the pathology report was uploaded to the patient's chart a week later, but when the patient was seen two weeks later, the doctor noted that the report was "unavailable." The results were finally discussed with the patient *two months after*

[60] Patient #34.
[61] Patient #47.
[62] ACH has made recent changes to the process of tracking and monitoring these time frames, including an automatic provider order placed by case management after the Specialty Appointment. The Case Management SRN is to monitor compliance. The Medical Experts were not able to assess the impact of these recent changes.
[63] Hospital Connect is a program that allows users of electronic health records to share information.

the procedure, in late February 2022. Delays of this nature and others were also noted in the care of patients #6, #8, #9 and #13.

In addition to lack of a functional tracking system that encompasses the entirety of the referral process from the time of the initial request, through the approval process, scheduling, completion of the test or consult, receipt of report, and follow-up with the patient and specialist where recommended, our record review revealed breakdowns at each stage of this process.

In summary, this review showed major delays in access to specialty services. Providers do not timely review and address consultant findings with the patient and develop an appropriate treatment plan that addresses all consultant recommendations. In addition, medical providers do not monitor patients to ensure that the treatment plan has been implemented and the desired clinical outcomes are achieved. Lack of coordination of care has resulted in appointment delays or wasted appointments when requested information was not available to the consultant. *All these factors have resulted in preventable suffering and harm to patients.*

When cases are forwarded to ACH, the response from the Medical Director is that he counsels medical providers. However, this is an oversimplistic response to the multiple factors that contribute to delays in specialty care and requires a comprehensive CQI approach to identify and resolve root causes.

Other cases that illustrate identified issues are described below in greater detail:

Patient #3

This is a man in his early forties with a history of morbid obesity, chronic knee and shoulder pain, past lower extremity deep vein thrombosis (DVT), and chronic venous stasis. His care has been complicated by challenging behaviors described as confrontational, demanding, and verbally abusive to staff. The patient submits HSRs nearly daily, sometimes more than once per day. He often expresses displeasure with the advice he has been given, even when it is medically appropriate. He has been seen frequently at nurse sick call and by providers at least monthly on average, *but many MD sick call referrals by nursing staff were not completed.* His specialty care has been substantially delayed.

For example, in September 2021, he went out for a vascular surgery clinic appointment due to a history of DVT with chronic pain and swelling of the left leg. The surgeon recommended arterial and venous duplex studies bilaterally, hematology consult for hypercoagulable work up and compression stockings, as well as a follow-up appointment after completing these. This consult report appears to have gone unnoticed by the onsite clinicians as none of the recommendations was acted upon and the report was not signed by a clinician until early January 2022.

In mid-September 2022, he was seen at MD sick call for great toe pain, left leg swelling, and right knee pain. The physician described encounter as difficult because of patient's aggressive behavior, "near yelling, acting upset, and often on unsubstantiated and exaggerated claims." This notwithstanding, the provider obtained a thorough history and sorted through the patient's

complaints and seemed to do a thorough and objective evaluation and documented a comprehensive set of recommendations.

The next day he was seen at nurse sick call for left shoulder numbness and pain as well as bilateral knee pain. MD sick call was ordered but patient was not seen.

Five days later, he was seen at nurse sick call for severe pain on the bottoms of both feet. Nurse offered Tylenol but the patient refused. Nurse ordered provider sick call but the patient was not seen.

Two days after that, he was seen at nurse sick call for chronic left shoulder pain, requesting pain medicine. He refused Tylenol or Naprosyn. The nurse contacted the onsite physician, who reiterated that Tylenol and Naprosyn are his only choices. The nurse ordered provider sick call. He was not seen.

Approximately one week later, he saw an outside orthopedic surgeon for left shoulder pain. The doctor ordered an MRI of the left shoulder, activity modification, ice, and “appropriate oral medications for pain control.” The patient was next seen by a provider during sick call five days later. The note indicates that the doctor was not able to locate the ortho consult. He ordered another ortho consult, physical therapy, and provider chronic care follow-up. Though his assessment and plan mentions topical lidocaine, it was not ordered.

On 10/15/2021, the ortho consult note was uploaded to the patient’s chart. Three days later, the patient was seen at MD sick call, but no mention was made of the recent ortho visit or recommendations. Finally, six days later, the MRI was ordered by the NP during a sick call visit.

Although the provider submitted the ortho consult request in October, Case Management did not request an appointment with San Joaquin General Hospital until 11/29/2021 and were advised the soonest appointment was in early February. The patient was transported to the hospital but once there it was determined the patient was too large for the machine. A new appointment was made for Sutter Imagining for mid-June, but was cancelled due to their machine being inoperable*. The MRI was not performed for eight months, on 6/22/2022.*

On 11/2/2021, the patient was seen at nurse sick call for leg pain. His legs were noted to be swollen, discolored, tender, and hot to touch. The nurse ordered urgent MD sick call. *The patient was not seen.*

He sent multiple HSRs, and on 11/12/2021, a medical provider finally saw the patient for left lower extremity cellulitis, ingrown toenail and paronychia of toe. The doctor ordered antibiotics and added Tylenol to the naproxen already ordered.

Six days later, the patient was seen at nurse sick call for right knee pain. The nurse ordered MD sick call. *The patient was not seen.* The next day, he was seen again at nurse sick call for bilateral leg pain. The nurse ordered MD sick call. *The patient was not seen.*

On 11/26/2021, he was seen at nurse sick call for left shoulder pain. The nurse referred him to provider sick call and he was seen three days later. The doctor investigated the MRI and ortho requests and was told that because it is elective, scheduling has been impacted by the COVID surge. He went on to appropriately address all the patient's complaints during this visit

On 12/23/2021, a physician saw the patient for a physical examination. The physician noted that his right leg was getting more swollen and painful. She obtained a history of prior DVT and that he had been taken off Xarelto "a long time ago." She suspected new DVT, ordered arterial and venous duplex studies of lower extremities and put him back on Xarelto. She ordered a hematology consult for history of unexplained DVTs. *This consult was never completed.* A week later, the Doppler ultrasound of lower extremities was negative

On 1/2/2022, he was seen at nurse sick call for lower extremity pain and swelling. The nurse noted swelling, warmth, and discoloration of the left lower extremity. The nurse contacted the on-call provider who ordered antibiotics. The next day, he was referred to MD sick call but was scheduled for another appointment at the same time and was not seen. He continued to send HSRs reporting pain and swelling and was seen on 1/9/2022 at nurse sick call. The nurse spoke with physician, who ordered that he be sent out but the patient refused because he did not want to be quarantined upon return. He was seen at MD sick call the next day for left lower extremity venous stasis dermatitis question possible mild cellulitis as a complication of stasis. Care was appropriate.

In mid-January, he was seen for a chronic care visit for mild cellulitis of the left lower extremity with chronic pain. Medications were adjusted for better pain control.

In mid-February, he was seen by a physician for chronic bilateral leg swelling due to venous stasis from varicosities. There was no documented exam of the lower extremities aside from "can ambulate." Compression stockings were ordered along with referral to vascular surgery for venous stripping. Weight loss was advised as well as elevation of the lower extremities. *The vascular referral was denied on 2/17/2022 for failing to meet criteria, but this information was evidently not shared with the patient or the physician.* At a follow-up visit on 3/2/2022, the doctor noted that the vascular surgery consult was in progress. *On 3/21/2022 another doctor reviewing the case determined that a Rubicon consult would be required before the patient would be considered for an offsite vascular surgery consult. However, this was never arranged and has not been completed.*

Over the course of this problem, the patient has had multiple ultrasounds (all negative), received several courses of antibiotics (without improvement), has been tried on a variety of pain medications (to minimal effect), and has been referred to vascular surgery, hematology, general surgery and the emergency department by the various providers who have seen him.

Opinion:

- This patient has experienced dramatic delays in access to specialty care.

- The clinicians caring for this patient seem unaware of the status of his specialty referrals and fail to access reports and recommendations.
- This patient's care has been fragmented across providers at the facility with lack of continuity which has resulted in redundant and disorganized treatment.
- Nurse to provider referrals repeatedly did not timely take place, if the referrals took place at all.

Patient #8
This is a man in his mid-fifties with type 2 diabetes, peripheral vascular disease with history of right below knee and left toe amputations, coronary artery disease (CAD) status post triple bypass surgery in 2018 and stent placement June 2021, chronic kidney disease, diabetic neuropathy, and anemia of chronic disease and congestive heart failure (CHF).

In mid-December 2021, the patient was seen at MD sick call for confusion. He was escribed as unable to make any coherent sentences or follow commands, "confused and dazed." Temp= 98.1 F. BP=86/55 mm Hg, HR= 96/minute and oxygen saturation=99% RA. He was sent to the emergency department and admitted with severe sepsis from suspected pyelonephritis with toxic encephalopathy. He was discharged back to jail two days later. There are multiple references in the discharge summary of the hospital doctor not having access to the patient's medical history or medication list.

At a mid-January 2022 provider visit, most of his chronic diseases were addressed. *It was documented that the patient has a history of a nodule in his right lung for which a follow-up CT is pending for 6/1/2022 – this did not occur.*

In early March, the patient went out for cardiology follow-up visit. No note was returned with the patient, and he was not seen by a provider to address the cardiology visit.

In late March, the patient was seen at MD sick call for a severe headache and elevated blood pressure (176/100 mm Hg). Under the review of systems section of the note, it states, "no headache." There is no physical exam of the patient. He was given 30 mg of IM Toradol and 50 mg of metoprolol. There was no follow-up documentation as to whether this was effective, no repeat blood pressure check or nurse assessment. He was not seen again by a provider prior to his release in mid-June.

Opinion:
- This patient has a high burden of chronic disease but was seen only once in six months for chronic disease management.
- No follow-up occurred after the patient's cardiology appointment and the note was never received by the facility.
- There was no follow-up of this patient's hypertensive urgency.
- Given the inadequacy of care and inaccuracies of clinical documentation, the Medical Director needs to conduct peer review of this provider.

Patient #9
This is a patient in his seventies with end-stage renal disease on dialysis, chronic systolic and diastolic heart failure, coronary artery disease, type II diabetes, hypertension, obstructive sleep apnea (OSA) on C-PAP, right knee hardware infection on chronic antibiotic suppression, and anemia of chronic disease. This patient's care was discussed in the chronic disease section of this report but is included here because of the issues related to specialty services.

In mid-December 2021, a physician saw him for "follow up multiple medical problems." The patient was seen while undergoing dialysis. *The degree of disease control was not commented upon for any of the patient's chronic conditions.* The patient's blood pressure noted to be above goal and his medication was adjusted. His diabetes was treated with Lantus and metformin, which is contraindicated in this stage of renal disease. Glucometer checks were noted to be between 61 and 135 and his fasting blood sugar readings had been consistently less than 100, often in the 60s and 70s, but this was not commented upon by the physician. Hemoglobin A1c not mentioned. No changes were ordered, and no follow-up visit was mentioned.

Four days later, the patient submitted an HSR "need to see Dr. to lower my insulin from 10 units to 7 units. My sugar numbers are dropping. Have been in 37 to 67 Range (illegible) morning." The nurse triaged this HSR on 12/2021 for an urgent nurse sick call, but he was not seen. Four days after that, his fasting blood sugar was 34. The nurse gave him three glucose tabs and arranged sick call with the provider for that morning who reduced his Lantus dose to 5 units. However, his blood sugars continued to run low.

In early January, a provider saw the patient. *It was a sick call visit following a missed dialysis appointment on New Year's Day due to a staffing issue at the jail.* The patient had been sent to UC Davis Emergency Department (ED) for the missed dialysis session, where he was found to be hyperkalemic with peaked T waves on his EKG which was treated. The physician discussed this, his anemia, and his blood pressure, but not his low blood sugar readings. Chart review shows that his blood sugars were still running low, and in fact the very next morning his blood sugar was 65 before breakfast and he was given glucose tabs.,

The next day, the patient sent an HSR stating, "my whole body is weak. It is hard to stand up and walking I keep falling down because legs give out. Need to see doctor ASAP." He was scheduled for urgent sick call two days later, but was sent to the ED again for dialysis the day after his HSR due to staffing issues at the jail. That morning he had a fasting blood sugar of 48 and was given 2 glucose tabs. *When he got to the hospital, they admitted him and noted that they would not be discharging him back until the jail could confirm a stable hemodialysis plan. He did not return to the jail for six days.*

Three days after that, he was sent back to the ED for hypoglycemia (38 mg/dL), which did not respond to glucose tabs and food (44 mg/dL). He was given a sandwich and returned to jail. He was seen by a physician upon his return, who stopped his insulin. The following day he was seen by a different physician who realized that the patient had, for inexplicable reasons, been on metformin for months despite the degree of his kidney disease and discontinued it.

On 2/3/2022, CBC showed a critically low hemoglobin at 4.9 g/dL. It was not signed by the doctor for five days. Meanwhile, he went out to the ED for dialysis as it was not available at the jail. A CBC done at the time of dialysis showed a hemoglobin of 8 g/dL, though dialysis notes do not mention transfusion. A few days later, repeat CBC showed a hemoglobin of 6.8 g/dL. Later in the month, it was down to 5.4 g/dL and he was sent back to the ED for transfusion. Again, his hemoglobin was measured as 8 g/dL once he got to the ED.

In late March, the patient began reporting hematuria. He was treated empirically with antibiotics which did not help. An ultrasound was performed in early April, showing enlargement (hydronephrosis) of both kidneys and a possible mass in the bladder. *The report was signed by the ordering doctor more than two weeks later, but he ordered additional imaging prior to this. There was no visit with the patient.* A repeat ultrasound was performed on 4/12/2022 again showing bilateral hydronephrosis and an abnormal appearing bladder. A CT scan was ordered. The patient was seen for knee pain three days later, but there is no mention of his ultrasound findings and no indication that the patient knows what is going on.

Later that month, urology saw the patient and opined that he was experiencing overflow incontinence. The doctor sent the patient to the ED for Foley insertion. The catheter was removed the next day after draining very little urine.

In late April, the patient saw the onsite nephrologist who mentioned the ultrasound but could not locate the report. *He described the inconsistencies and delays with the patient's dialysis regimen.*

At the end of May, the CT scan was performed. It showed tumor in the bladder, with extension into the mid ureters bilaterally causing the obstructive hydronephrosis seen on ultrasound. Multiple metastatic lesions were seen in the abdominal cavity, retroperitoneum and in the left 11th rib. The nephrologist presumably reviewed the result, as he ordered an expedited hematology/oncology consult in early June. *No discussion with the patient is documented.*

Shortly thereafter, the patient was seen by a different doctor, who reviewed the CT scan with the patient. He was seen by oncology the next day via telemedicine with recommendations for cystoscopy, PET scan and labs to be done within the next three weeks along with a follow-up visit. The following day, the nephrologist saw him and ordered the tests. The blood was done timely. The urology appointment took place at the end of June, and a cystoscopy was scheduled.

Neither the cystoscopy nor the PET scan was done prior to his transfer to prison in July 2022.

Opinion:

- There were multiple lapses in care for this high-risk dialysis patient.
- This patient had severely low blood sugar on multiple occasions before it was adequately addressed. The inappropriate prescribing of metformin went unnoticed for months.
- Critical imaging findings such as a possible mass in the bladder, should be called immediately to the ordering provider. This is the standard of care in the community.

- There is no evidence that this patient's abnormal ultrasound results were discussed with him.
- Placement of a Foley catheter is well within the scope of a urologist; sending the patient out for this simple procedure should not be necessary.
- The jail has been unable to meet the dialysis needs of this patient.
- There appears to be a discrepancy between the accuracy of labs obtained at the jail and those performed at the hospital.
- Although the patient was seen timely by oncology, the additional required testing was not completed. There is no clear communication documented from the jail to the prison regarding these urgently needed tests.

Patient #13
This is man in his early forties with a history of latent TB infection, inflammatory bowel disease, rheumatoid arthritis (RA), and immunosuppression secondary to medications including sulfasalazine, Methotrexate, and Humira.

Regarding his rheumatoid arthritis: The patient's arthritic symptoms were evaluated by a rheumatologist through Rubicon MD in late October 2021. At that time, the rheumatologist's opinion was that the patient had active rheumatoid arthritis and should be seen by a rheumatologist "sooner rather than later to get his disease under control and to prevent joint damage." He opined that given the patient's young age, he should be treated with TNF inhibitors or other biologic medications and gave recommendations for additional tests to obtain to expedite treatment.

The patient was seen in December 2021 for bilateral elbow and hand pain and swelling. His sulfasalazine was increased but at his next chronic care visit in early January 2022, he reported that he was still only given one tab twice a day instead of two tabs twice a day as ordered. He had just been approved for the KOP program and so started taking the higher dose just days before this visit.

The patient then saw a rheumatologist at SFGH via telehealth in early February, *more than three months after he was referred.* The doctor recommended injectable biologic therapy and a prednisone taper in the meantime, as well as labs and a follow-up appointment in three months. *He was seen in follow-up of this consult five days later by the onsite doctor, who ordered prednisone but ignored the recommendation for disease-modifying therapy.*

On 1/11/2022, the patient tested positive for COVID, was placed in isolation on 1/12/2022, and released on 1/21/2022. A physician wrote a note in the chart on 1/19/2022, stating that he had "completed CDC recommendations" and was "OK to release from isolation" which, at that time, was not compliant with the 10-day Medical Isolation period recommended by CDC, although he was ultimately released 10 days after testing positive. Regarding this and other cases, the County reported that they had been mistakenly releasing patients from isolation too soon. This situation was remedied in early June 2022.

In early March, he was seen in MD sick call complaining of an RA flare. The physician added naproxen 500 mg twice a day to his regimen which included prednisone, despite well documented ongoing rectal bleeding. Adding Naproxen to the patient's medication regimen increased the risk of worsening gastrointestinal (GI) bleeding. Six days later, a NP discontinued the medication.

In mid-May, the NP saw the patient for follow-up of the rheumatology appointment from three months prior and started the patient on adalimumab despite the fact that he had a history of a positive tuberculin skin test (TST). The same NP signed off on a positive QuantiFERON gold test the very next day, confirming latent TB infection. Later in May, a physician saw the patient for follow-up of the LTBI and ordered a chest x-ray, but did not stop adalimumab or indicate that he was aware of the risk of reactivation of TB. Treatment for TB infection is required before starting adalimumab.[64]

Regarding rectal bleeding: A physician saw the patient in late November for ongoing and frequent painless blood in the stool. She did a rectal exam and anoscopy showing blood in the rectum with a few small nonbleeding internal hemorrhoids. Six days later, the onsite GI doctor saw the patient for a four-month history of rectal bleeding. The doctor's assessment was "suspect hemorrhoids," but the doctor did not perform a rectal exam. The GI recommended labs, medications, and an EGD (esophagogastroduodenoscopy) to be possibly followed by colonoscopy. On 12/17/2021, labs were drawn, but the other recommendations were not acted upon until 12/23/2021. On 2/3/2022, he was seen at MD sick call complaining of rectal bleeding. The doctor noted that he had a GI consult pending for endoscopy and ordered follow-up in two months. The doctor stated in his note that the patient was no longer bleeding but did not do a rectal exam, order a CBC, or do orthostatic vital signs.

In late February 2022, the onsite gastroenterologist saw the patient, who had ongoing rectal bleeding and had still not had an EGD or colonoscopy which were reordered on this date. He continued to be seen intermittently for bloody stool until finally in mid-April, he underwent EGD, which showed mild gastritis and no evidence of upper GI bleeding. He was not seen for follow-up of these results for nearly a month, when he saw the NP who focused primarily on his RA and did not address the need for colonoscopy.

Over a month later, he saw the onsite GI doctor again, who inaccurately described the patient as having a history of vomiting blood despite the fact that the chief complaint is listed as "blood per rectum." The note states "patient now reporting blood per rectum," as if this was a new problem when in fact it had been ongoing for at least eight months. The doctor ordered an x-ray, blood tests and a stool test and follow-up in one month. No colonoscopy was ordered.

[64] Adalimumab. UpToDate. August 2022.

Opinion:

- Adalimumab should not be prescribed to patients with untreated latent TB infection. TB infection needs to be treated first to minimize the risk of reactivation of TB, and possible tuberculosis.
- NSAIDs should be used with caution, if at all, in patients on prednisone who have active GI bleeding.
- Upper endoscopy is not the appropriate initial test for a patient with red blood in the stool. He should have had a colonoscopy initially.
- The patient's EGD was not performed timely and the more appropriate test (colonoscopy) has not been performed at all.
- This patient has not been seen timely after specialty appointments and recommendations have not been implemented timely, if at all, in some cases.
- Care for this patient has been fragmented and delayed.

Compliance Assessment:
E.1=Substantial Compliance
E.2=Noncompliance
E.3=Noncompliance
E.4=Noncompliance
E.5=Partial Compliance
E.6=Noncompliance
E.7=Noncompliance
E.8=Substantial Compliance
E.9=Noncompliance
E.10=Substantial Compliance

Recommendations:

1. The Medical Director needs to provide closer oversight of all aspects of the UM process to identify system and provider performance issues.
2. Ensure timely UM/Medical Director review and approval and/or denial of specialty services requests following medical provider determination that the service is medically indicated (i.e., 24 hours for urgent requests and 3 business days for routine requests).
3. Ensure that following approval, UM timely requests specialty services appointments, even when the consultant requests pre-appointment labs/imaging. Expedite labs and imaging if necessary.
4. If the specialty service is denied, providers need to timely inform patients and develop an alternate treatment plan.
5. UM needs to notify medical providers of when the appointment date exceeds required time frames and schedule patients to see the provider. Providers need to monitor patients monthly until the appointment takes place.
6. Ensure that a registered nurse sees all patients upon return to the jail following a specialty services appointment. The registered nurse should notify a provider of urgent orders and

schedule the patient to see the provider in accordance with the urgency of the consultant recommendations.

7. UM needs to track receipt of specialty services and diagnostic imaging reports, and contact specialists if reports are not timely received.
8. Medical records should notify medical providers when consultant reports are uploaded to the electronic health record.
9. Medical providers need to timely meet with the patient to discuss consultant findings and recommendations, develop a treatment plan, and monitor the patient to ensure that the treatment plan is implemented and the desired clinical outcome has been achieved.
10. To the extent possible and appropriate, telemedicine services should be implemented at the jails to enhance access to specialty services.
11. Perform CQI studies to assess timeliness of care by specialty and identify barriers to access so these can be addressed.

F. Medication Administration and Monitoring

1. The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws through the following:
    a. Ensuring that initial doses of prescribed medications are delivered to patients within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner.
    b. Ensure that medical staff who administer medications to patients document in the patient's Medication Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, (3) the date and time for any refusal of medication, and (4) in the event of patient refusal, documentation that the prisoner was made aware of and understands any adverse health consequences by medical staff.
2. The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication.
3. The County shall provide pill call twice a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility security concerns. The County shall develop and implement policies and procedures to ensure that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician. Any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician.
4. The County shall develop and implement policies and procedures to ensure that patients are provided medications at therapeutically appropriate times when out to court, in transit to and from any outside appointment, or being transferred between facilities. If administration times occurs when a patient is in court, in transit, or at an outside appointment, medication will be administered as close as possible to the regular administration time.

5. The County shall develop policies and procedures to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate levels.
6. The County shall explore the expansion of its Keep-on-Person medication program, (especially for inhalers and medications that are available over-the-counter in the community) and to facilitate provision of medications for people who are out to court, in transit, or at an outside appointment.

Findings:

The County has revised pharmacy and medication policies and procedures, including for patients that are to go out to court (F.1.a, F.1.b and F.4). In December 2021, the County implemented a Keep-On-Person (KOP) Medication Administration program that includes nitroglycerin, inhalers, chronic disease and Over-The-Counter (OTC) medications (F.6). With respect to implementation, we were not able to determine from this review if patients were provided medications when going out to court (F.4).

Review of intake records show improvement with nurses referring patients to providers for essential medication review. Once referred, medical and mental health providers more timely reviewed medication histories and ordered medications as appropriate.

However, we did find cases in which medication continuity was not provided:

- On 2/10/2022, a transgendered patient in their late forties with HIV infection transferred from another county jail. The RN ordered a referral to a medical provider and essential medication review. Four days later, the HIV provider ordered HIV medication. On 2/15/2022, the first dose was received.[65] In this case, a provider did not timely review and order HIV medication, increasing the risk of viral resistance to the medication.
- On 12/21/2021, a 35-year-old man with HIV infection arrived at the jail. The patient had a history of antiretroviral treatment. The HIV provider did not assess the patient's need for resumption of HIV therapy until 12/30/2021.[66] In this case, a provider did not timely conduct an essential medication review to determine if it was appropriate to delay restarting HIV medication until the initial visit.
- On 11/22/2021, a pregnant patient with asthma was readmitted the jail after being released the prior week. A medical provider ordered albuterol inhaler but not her controller medication.[67] In this case, a provider did not order medication needed to prevent exacerbation of asthma symptoms.

ACH CQI conducted a point in time audit for 2/2/2022 to determine if new medications were timely administered (within 48 hours) and whether existing medication orders were renewed without interruption. The audit showed that 100% (N=65) of new medication orders were timely,

[65] Patient #39.
[66] Patient #28.
[67] Patient #29.

and 64% (N=7) of patients with medication renewals were provided continuity of medications. The study did not include root cause analysis for lack of timely medication order renewal or an action plan to improve performance. It would also be useful to conduct a study over time (e.g., two-week period) rather than a single point of time in order to identify issues that may be unique to certain shifts or days of the week.

At the time of our last report, medications were scheduled to be given twice daily, at 7 am and 7 pm (F.3). Standards of nursing practice permit medications to be given one hour before and one hour after a designated medication time. With respect to the current medication schedule, this would permit nurses to administer medications from 6 am to 8 am and 6 pm to 8 pm and meet standards of nursing practice. Previously, nursing leadership reported that nursing staff schedules that begin at 7 am do not allow nurses to take full advantage of the window of time permitted to administer the 7 am dose (6 am to 8 am). This could be addressed by changing the times of morning medication to 8 or 9 am to permit nurses to administer medications during the two-hour window. ACH is in process of changing medication administration times to improve efficiency.[68]

Medication administration records show that nurses continue to document giving medications at time frames far exceeding a two-hour window. Nurses frequently document giving the 7 pm dose of medication after midnight. Factors that appear to contribute to this extended time frame are insufficient dedicated custody escorts for medication administration, and nurse and custody staffing issues (F.2). ACH reports that COVID-19 operations significantly impact medication administration at Main Jail, and that ACH has been meeting with Custody to resume prior medication administration practices.

In addition, technology issues have prevented nurses from documenting medication administration in real time. ACH is in process of purchasing handheld tablets that will enable nurses to document in real time.[69] This will facilitate more accurate documentation. Accurate documentation of medication administration times will also facilitate ACH and custody leadership's ability to more accurately measure the amount of time it takes to administer medications to assess staffing needed to timely administer medications.

Review of medication efficacy and side effects is to be primarily performed by providers in the context of the chronic disease program. This program has not been fully implemented, and providers do not routinely document assessment of medications adherence, efficacy, and side effects. (F.5) [70] Nurses do not routinely notify providers of patients that are non-adherent to medications. This needs to be done so that providers can discuss and address the reasons for non-adherence, counsel the patient regarding the consequences of non-adherence, and/or change medications. At chronic disease visits, providers need to review MARs to assess medication adherence.

[68] Fifth Mays Report. Page 37.
[69] Fifth Mays Report. Page 38.
[70] Fifth Mays Report. Page 33.

Compliance Assessment:

- F.1.a=Substantial Compliance
- F.1.b=Partial Compliance
- F.2=Noncompliance
- F.3=Partial Compliance
- F.4=Not Evaluated
- F.5=Noncompliance
- F.6=Partial Compliance

Recommendations:

1. The County needs to ensure adequate nurse and custody staff assigned to medication administration to ensure that medications are administered within a two-hour time frame (one hour before and one hour after a designated time).
2. The County should purchase handheld tablets to enable nurses to document medication administration in real time.
3. The County should continue to perform CQI studies to assess the following areas:
    a. Nurse to provider referrals for essential medication review
    b. Timeliness of provider essential medication review and time from order to first dose.
    c. Continuity of chronic disease and psychotropic medications.
    d. Time studies to assess duration of medication administration
4. At chronic disease and other encounters, providers need to document assessment of medication adherence and address patient reasons for non-adherence, which may include: lack of understanding of the purpose of the medication, side effects, barriers to compliance (e.g., medications being administered at 1 am when the patient is asleep, etc.).
5. The County needs to provide documentation that inmates going out to court are provided medications.

G. Clinic Space and Medical Placements

1. The County shall provide adequate space in every facility to support clinical operations while also securing appropriate privacy for patients. Adequate clinical space includes visual and auditory privacy from prisoners, and auditory privacy from staff, the space needed reasonably to perform clinical functions as well as an examination table, sink, proper lighting, proper equipment, and access to health records.
2. The County shall ensure that any negative pressure isolation rooms meet community standards, including an antechamber to ensure that the room remains airtight, appropriate pressure gauges, and regular documented checks of the pressure gauges.
3. The County shall ensure that absent individualized, documented safety and security concerns, patients in acute medical or quarantine placements shall be allowed property and privileges equivalent to what they would receive in general population based upon their classification levels. The County shall ensure that patients in medical placements are not forced to sleep on the floor, including providing beds with rails or other features appropriate for patients' clinical needs and any risk of falling.
4. The County shall not discriminate against patients in medical placements solely because of their need for C-Pap machines, but instead shall provide access to programs and services in accordance with their classification level, as set forth in the ADA remedial plan.

Findings:

The County acknowledges that space limitations continue to negatively impact service provision and patient confidentiality.[71] As noted earlier in our report, we did not conduct a site visit for this monitoring report. For this section of the report, we relied on the Fifth Mays Status Report, medical record reviews that demonstrate space and privacy issues, the report of Diane Skipworth, the Nacht & Lewis Report examining Main Jail's capacity to meet Consent Decree requirements, the Sacramento County Jail Population Study, and the Review of the Nacht & Lewis and Sacramento County Jail Study Reports by Wendy Still.

Structural space issues identified *in our last report* include the following findings:

- There is no auditory privacy for detainees as they go through the medical screening process. This includes:
  - COVID-19 symptom screening (it is performed while the officer does property management, right next to the nurse)
  - Nurse Intake Screening
  - Mental Health Assessments

[71] Fifth Mays Report. Page 4.

- The Nurse Intake Screening room is too small for its intended purpose, is cluttered, dirty and unsanitary. Desks and counters are in disrepair, in some cases falling apart, and cannot be adequately disinfected.
- A room off the Nurse Intake Screening room is used to store supplies and has an exam table. The room is dirty and cluttered. The cabinets are disorganized and in disrepair. There is food in the medication refrigerator. The refrigerator contained expired insulin.
- Detainees requiring monitoring for alcohol and drug withdrawal are placed in a "Sobering Cell," a large room that is used to monitor a person for withdrawal symptoms. The floor was dirty and the foundation crumbling. It is dehumanizing and no place for any type of therapeutic monitoring.
- There is no space dedicated for an alcohol and drug withdrawal monitoring unit. Instead, detainees at risk of withdrawal are dispersed in quarantine housing units throughout Main Jail. Record review shows that nurses do not timely perform monitoring assessments for detainees undergoing alcohol/drug withdrawal. *The failure to timely monitor and treat inmates for withdrawal results in preventable hospitalizations and deaths*, which was identified in the First Mays Monitoring Report.
- It was pointed out to us that there were previously plans to establish a detox unit on 2 East, and we observed six beds set aside for this purpose. However, it was also reported that due to COVID-19 the unit was never opened. It is likely that six beds will not meet the demand for the number of inmates that need to be monitored for withdrawal.
- 2 Medical is the Main Jail medical treatment area with clinic rooms, dialysis and ten medical beds. There is insufficient space to store medical equipment and supplies, and the hallways are filled with wheelchairs, dialysis dialysate solution, etc.
- 2M Nurses station counters are in disrepair. Cabinet drawers have fallen off.
- Clinic room desks and carts are in disrepair.
- A 2M Medical room door had dried fluids on the outside of the food port.
- Clinic rooms are cluttered with carts and supplies. The floors and surfaces are dirty. They are not cleaned and disinfected on a routine basis.
- There is a negative pressure room used to house tuberculosis suspects on 2M that does not have an anteroom. *This violates an express requirement of the Consent Decree*. It was reported that the room was tested daily, but medical does not receive these reports. This is unusual, as it is the responsibility of health care staff to know if the room's ventilation is working properly when placing TB suspects or other patients requiring respiratory isolation in the room.
- 2 East 100 is designated for disabled inmates in wheelchairs. It has five cells and, according to staff is always full.
- 2 East 200 is designated for inmates with C-PAP machines because there is no other housing at Main Jail with electrical outlets. We did not assess whether these inmates have access to programming as required by the Consent Decree.

- On each floor of Main Jail, there is an examination room. We toured the clinics on Floors 7 and 8 and found them to be relatively clean, organized, and adequately equipped and supplied. However, there is only one clinic on each floor that is currently occupied by a physician from 7 am to 3:30 pm. This is insufficient space to conduct other activities, such as nurse sick call, and mental health and psychiatric assessments. As a result, nurses and mental health staff conduct assessments cell-side. Even obstetricians conduct OB visits at the patient's cell, which is not a clinical setting and does not provide privacy.

Based upon review of the materials available to us, we find that the findings in our previous report are substantially unchanged (G.1).

In addition, over the course of the COVID-19 pandemic, increases in the average daily population (ADP) combined with lack of medical, psychiatric and even general population beds has resulted in inmates remaining in booking for up to three days, in conditions that expose them to COVID-19. It has also resulted in patients with substance use disorders not being properly monitored and treated for withdrawal, resulting in harm, including a death. Suicidal inmates are placed in extremely punitive safety cells in booking because there are no other appropriate beds.

As noted in Ms. Skipworth's report, sanitation in the jail is extremely poor, including the booking area, medical, mental health clinics, medical and mental health beds, and dialysis. On 2 East, extension cords for C-PAP machines posed a trip and fall hazard as well as a fire hazard. It seems that there was virtually no area of the jail occupied by inmates that was clean (see Skipworth Report).

The Nacht & Lewis report noted that the respiratory isolation rooms on 2M were nonfunctional and without an anteroom (G.2). Therefore, it is unsafe to house a tuberculosis suspect or confirmed case at the jail.

In April 2021, the County engaged the services of Nacht & Lewis to study the question: How many inmates would have to be removed from the Main Jail in order to achieve compliance with the Mays Consent Decree? Following a comprehensive study, the response to the question was that: "Even reducing the population very substantially, the Main Jail cannot achieve meaningful compliance with the Consent Decree." The consultants found:

> *Achieving substantial compliance in all areas of the Consent Decree would require changes to jail operations, medical and behavioral health services, increased staffing, and improvements to the jails physical plant. The Main Jail, built in 1990 prior to ADA, HIPPA, and re-alignment, was not designed to meet current standards or best practices for the inmate population it houses. While progress toward compliance is being made in some areas, the jail's hardened*

construction and inflexible configuration is a barrier to achieve compliance that cannot be overcome.[72]

Although the consultants concluded that even with modifications to the Main Jail, Consent Decree compliance cannot be achieved at Main Jail, the County has already made, or plans to make, changes to space that include the following:

- New Nurses Station at Main Jail 2 East
- Nurse interview cubicles across from Nurses Station on 2 East
- Converted Medical Records Room to a Medical Provider Exam Room on 2 East
- A Provider Charting Room on 2 East
- Specialty Clinics-Installed new cabinets and optometry/ophthalmology equipment
- Removed excess medical supplies
- Nurse Intake in Main Jail Booking will undergo major changes in the near future.

ACH and SSO are meeting to review plans to move the Acute Psychiatric Unit (APU) from 2P to the third floor, as well as relocating the Intensive Outpatient Unit to another unit so that each would have confidential space. These interim changes would increase mental health bed space and enable ACH to establish a detoxification unit for monitoring and treatment of patients experiencing substance use withdrawal.

In conclusion, the findings of the Nacht & Lewis report demonstrate that serious space issues at the jail prevent the County from meeting many Consent Decree requirements. On the other hand, the findings of the Environment of Care expert Diane Skipworth reflect a profound lack of focus and commitment to sanitation and disinfection, which is under the control of the County. Immediate action needs to be taken to address unsanitary conditions in the jails.

Compliance Assessment:

- G.1=Noncompliance
- G.2=Noncompliance
- G.3=Not Evaluated
- G.4=Not Evaluated

Recommendations:

1. Implement the recommendations of the Environment of Care expert Diane Skipworth.
2. The County needs to develop an action plan to allow compliance with the Consent Decree, including reducing the jail population and construction of new space.

[72] https://agendanet.saccounty.gov/BoardOfSupervisors/Documents/ViewDocument/BOARD_OF_SUPERVISORS_7624_Agenda_Packet_9_14_2022_2_00_00_PM.pdf?meetingId=7624&documentType=AgendaPacket&itemId=0&publishId=0&isSection=false

H. Patient Privacy

1. The County shall develop and implement policies and procedures to ensure that appropriate confidentiality is maintained for health care services. The policies shall ensure confidentiality for clinical encounters, including health care screening, pill call, nursing and provider appointments, and mental health treatment. The policies shall also ensure confidentiality for written health care documents, such as health care needs requests and grievances raising medical care or mental health concerns, which shall not be collected by custody staff.
2. The County shall provide adequate clinical space in each jail to support clinical operations while securing appropriate privacy for patients, including visual and auditory privacy from prisoners and auditory privacy from staff.
3. All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such a determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be made based upon housing placement or custodial classification. The issuance of pills does not constitute a clinical interaction.
    a. For any determination that a clinician interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.
    b. If the presence of a correctional officer is determined to be necessary to ensure the safety of staff for any clinical encounter, steps shall be taken to ensure auditory privacy of the encounter.
    c. The County's patient privacy policies, as described in this section, shall apply to contacts between patients and all staff who provide health-related services on site at the jail.
4. Jail policies that mandate custody staff to be present for any medical treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and medical staff shall be trained accordingly.

Findings:
ACH has revised policies involving patient privacy but has not implemented these policies in a manner that provides privacy and confidentiality of medical information.

Record review shows that a significant number of clinical encounters are performed cell side and without patient privacy or confidentiality. These include clinical encounters in the booking area as well as housing units. Documentation reflects that the lack of privacy is due both to lack of adequate clinical space and lack of custody escorts to a room where privacy can be provided.

Patient privacy is a cornerstone of the patient-provider relationship. Lack of privacy deters patients from sharing clinically relevant information needed for providers to timely diagnose and

treat patients. Patients being unable to freely communicate with providers results in delayed or missed diagnoses and preventable harm. Lack of privacy also limits what providers share with patients, inhibiting provider-patient communication.

The critical importance of privacy was addressed in the Nacht & Lewis Report:

> *In short, there is no acoustic or visual privacy between intake stations, nor is there acoustic or visual privacy between the nursing intake office and the general booking area. The effect of these shortcomings on healthcare operations cannot be overstated; people entering jail have no reasonable expectation of privacy during a medical encounter occurring at one of the most stressful moments of their lives. Combined with the astronomical rates of chronic medical conditions, acute injury in the process of arrest and detention, and risk for suicide, overdose, and other adverse events, the expectation of confidentiality is not only a legal right but an absolute medical necessity.*[73]

In our two previous reports we noted that when patients are transported to a hospital or an outside specialist, medical transportation deputies are given an Intent to Incarcerate (ITI) form containing Health Protected Information (HPI) that the officer signs and is therefore able to see HPI for which there is no need to know. This is not compliant with the Consent Decree (H.1) and Medical Transportation policy, which requires that the case management and/or nurses prepare health care information for the outside provider and place it in a sealed envelope to maintain confidentiality. This is not happening. [74]

Compliance Assessment:

- H.1=Noncompliance
- H.2=Noncompliance
- H.3=Noncompliance
- H.4=Substantial Compliance

Recommendations:

1. Enforce Patient Privacy, Safeguarding Protected Health Information, and Medical Transportation policies by separating HPI from any transportation forms that require officer review and signature.
2. Case Management and/or nursing staff needs to place protected health information in a sealed envelope and advise the hospital or specialist to also return HPI in a sealed envelope.
3. Implement plans to reconfigure clinical spaces to enhance patient privacy.

[73] Nacht & Lewis Report. Page 8.

[74] ACH responded that this statement was inaccurate and that transporting deputies are only given basic health information and that only information necessary to transport the patient to the appointment is given. However, review of Intent to Treat forms of patients transported to the hospital show that Health Protected Information (HPI) is documented on the form by the ACH medical provider with medical symptoms or diagnoses that the hospital physician is to evaluate. This form is signed by the transporting officer.

4. Establish dedicated health care custody posts so that patients are escorted to a clinical examination or mental health interview where privacy may be provided.

I. Health Care Records

1. The County shall develop and implement a fully integrated electronic health care record system that includes medical, psychiatric, and dental records and allows mental health and medical staff to view the medical and mental health information about each patient in a single record. This shall be accomplished within 12 months of the date the Remedial plan is issued by the Court.
2. Until such a system is implemented, the County shall develop and implement policies and procedures to ensure that medical staff have access to mental health information and mental health staff have access to medical information, as needed to perform their clinical duties. This information shall include all intake records. Medical and mental health staff shall be trained in these policies and procedures within one month of the date the Remedial plan is issued by the Court.
3. The County shall develop and implement policies and procedures to monitor the deployment of the CHS Electronic Health Record (EHR) to ensure the records system is modified, maintained and improved as needed on an ongoing basis, including ongoing information technology support for the network infrastructure and end users.

Findings:
As noted in previous reports, the current electronic health record (EHR) is challenging and does not meet workforce needs for data and tracking.[75] A new EHR administrator was onboarded in April 2022. He began working on the procurement plan at the end of September 2022. The County anticipates having an update for an EHR timeline in November 2022.

The current Centricity provides access to medical, mental health and dental information that is accessible to medical, mental health and dental users (I.1 and I.2.). The EHR has been modified to incorporate inmate photos for patient identification. EHR templates (e.g., nurse intake, chronic disease, etc.) have been modified as new policies and protocols are rolled out.

The County has developed health record policies and procedures including Release of Protected Health Information, Safeguarding Protected Health Information, Standard Abbreviations and Records Retention. When the County implements a new EHR, the County will need to establish new policies specific to the EHR and information technology support for the network infrastructure end users (I.3)

Centricity workflows have been modified with respect to intake orders that are more specific to the work task. Intake nurses can order substance use disorder (SUD) monitoring appointments instead of the generic Priority Flex Nurse (PFN) appointments.

[75] Fifth Mays Status Report. Page 22.

Other workflows such as nurse sick call have been modified to facilitate compliance with HSR policy and the Consent Decree, however record review shows lack of timely access to care (see Access to Care Section). We were informed that Centricity scheduling has the capacity to order priority appointments, but health care staff do not consistently schedule patients for appointments in accordance with their medical acuity.

We note that providers have begun selecting EHR clinical encounter templates targeted to the type of encounter (e.g., chronic disease), but they often fail to utilize key features. For example, providers do not select the history and physical encounter template for 14-day history and physicals. Obstetricians do not use the obstetrical flowsheets in Centricity which would enable better tracking of the progress of the pregnancy and permit ACH to monitor the timeliness and appropriateness of care.

Record reviews shows that health service request forms are not scanned into the EHR. Outside hospital records are also not timely retrieved and scanned into the EHR, preventing medical providers and other health care staff access to medical information needed to provide timely and appropriate care to the patient. In addition, health documents are sometimes misfiled in the EHR.

This review showed that medical record staff did not always notify a medical provider of the availability of outside medical records and need to perform chart review, particularly following hospitalizations. *In some cases, the lack of timely clinical information resulted in delayed diagnosis and treatment, and preventable harm.*

Compliance Assessment:

- I.1=Substantial Compliance
- I.2=Partial Compliance e
- I.3=Not Evaluated

Recommendations:

1. Ensure that all health documents (e.g., Health Services Requests, hospitalizations and specialty services, etc.,) are timely scanned, and when indicated, health information staff notify medical and mental health providers of the need for chart review.
2. Procure and implement a new electronic health record that can be reconfigured to align with ACH workflows, provide patient tracking, and produce needed reports.

J. Utilization Management

1. The County shall revise its utilization management (UM) system to ensure that critical health decisions about patients' access to care are made with sufficient input from providers and a thorough review of health care records.

2. The County shall ensure that decisions about a patient's access to, timing of or need for health care are made by a physician, with documented reference to the patient's medical record. Nurses may gather information and coordinate the UM process, so long as it does not interfere with that requirement. All decisions by the UM committee shall be documented, including the clinical justification for the decision.
3. The UM system shall ensure that providers and patients are promptly informed about decisions made by the UM committee, including denial of a specialist referral request.
4. The UM system shall include an appeal process to enable patients and providers to appeal a decision denying a referral request.

Findings:
ACH has developed Specialty Services and Utilization Management policies that were revised following feedback from Plaintiffs and medical monitors (J.1.) The policies include an appeals process (J.4.).

Review of the Specialty Services Tracking Log showed that it did not contain elements required by the Consent Decree. The Medical Experts provided feedback to ACH and the tracking log has recently been revised.

Review of the tracking log showed some significant delays in UM/Medical Director review and approval of specialty services requests following determination by a medical provider that it was clinically indicated.

Review of medical records show that many patients did not have timely specialty services appointments and some patients were lost to follow-up (See Specialty Services Section).

The UM policy include an appeal process. We were unable to determine if the appeal process is utilized. We will evaluate this at our next site visit.

Compliance Assessments:
- J.1=Substantial Compliance
- J.2=Partial Compliance
- J.3=Noncompliance
- J.4=Not Evaluated

Recommendations:
1. Ensure that UM/Medical Director timely review and approve or deny specialty services requests.
2. Ensure that UM staff monitor tracking logs to ensure that patients are scheduled for timely initial and follow-up specialty appointments.
3. UM/Medical Director need to document notification of the medical provider that a specialty services appointment was approved or denied, and the date the appointment is scheduled.

4. Medical providers need to timely communicate with patients if the specialty services request was denied and/or significantly delayed.

K. Sanitation

1. The County shall consult with an Environment of Care expert to evaluate facilities where patients are housed and/or receive clinical treatment, and to make written recommendations to address issues of cleanliness and sanitation that may adversely impact health.

Findings:
In 2022, the County contracted with Diane Skipworth, MCJ, RDN, LD, RS, CCHP, an Environment of Care expert, to conduct and evaluation of facilities where patients are housed and/or receive clinical treatment. On March 7-9, 2022 Ms. Skipworth conducted a tour of the facilities and, on 6/21/2022, published her report with recommendations. Her findings were that sanitation, including in health care units, was very poor. The Medical Experts will follow-up on implementation of recommendations at our next site visit.

Compliance Assessment:
- K.1=Substantial Compliance

Recommendations:
1. The County needs to institute a sanitation and disinfection program in all areas of the jails, but with particular attention to the booking and intake area, sobering cell, safety cells and all health care areas of the jails.
2. The program should include a schedule of terminal cleaning of floors, walls, doors with repairs and repainting as needed.
3. There should be sanitation schedules posted with designated persons responsible for ensuring that daily, weekly and monthly sanitation activities are implemented and documented.

L. Reproductive and Pregnancy Related Care

1. The County shall ensure that pregnant patients receive timely and appropriate pre-natal care, specialized obstetric services when indicated, and post-partum care (including mental health services).
2. The County will provide pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or have an abortion.
3. The County will provide non-directive counseling about contraception to female prisoners, shall allow female prisoners to continue an appropriate method of birth control, shall provide access to emergency or other contraception when appropriate.

Findings:
ACH revised the Female Reproductive Services policy on 7/21/2021; it is compliant with Consent Decree requirements.

We note that nurses and providers do not utilize Centricity EHR obstetric related flow sheets to document care and facilitate monitoring the progression of the pregnancy.

We found that pregnant patients are referred to obstetrics upon arrival to the jail, however there are barriers to care. We do not find documentation that patients are timely counseled regarding their reproductive options, if at all.

We also found that medically ordered snacks for pregnancy are delivered by health care staff to housing unit control stations, for distribution by deputies, instead of personally delivering the snacks to the patient. Health record documentation shows that custody staff intentionally withheld the snacks from patients, or placed them outside their cell door where patients could not access them. The following is a case in point.

Patient #29
This woman in her late twenties was admitted to Sacramento County Jail 6 times between 9/3/2021 to 5/5/2022.The patient has an extensive mental health history with bipolar disorder, schizoaffective disorder, depression and multiple mental health hospitalizations. She also had a history of 11 pregnancies, two live births, six therapeutic abortions, and two spontaneous abortions.

At her admission in late October, she reported that she was pregnant as a result of sexual assault in the homeless camp that she lived. There is no documentation that she was ever counseled about reproductive options, including abortion nor future birth control. She was diagnosed with syphilis, chlamydia and trichomonas. About two weeks later, on 11/12/2021 an obstetrician reviewed the medical record but did not see the patient to counsel the patient regarding her pregnancy options. On 11/15/2021, the patient was released not having been seen by the OB.

A week later, the patient was readmitted to SCJ. On 12/1/2021, the patient reported that she had been recently sexually assaulted and, on 12/3/2021, told the a LCSW that her pregnancy was due to being raped multiple times in the tent camp that she lived. *The patient also told the LCSW that custody was not giving her ordered pregnancy snacks which 7W custody confirmed to the LCSW stating that they withheld the snacks because the patient would not agree to take a pregnancy test, when her pregnancy had long been confirmed.* The patient also reported that custody locked her in the shower in order to search her room.

On 11/27/2021, the patient was prescribed Zyprexa but did not receive it until 11/30/2021. It was noted to be a live order in provider notes, but did not appear on the eMAR for several weeks. She had a prescription for ferrous sulfate that was not continued after 12/2/2021.

On 12/10/2021, 18 days after arrival, the OB saw the patient outside of her cell because custody would not let the patient out of her cell due to behavioral issues. This did not permit the OB to have a confidential interview with the patient. There was no documentation that mental health was consulted about her behavioral issues to determine whether it was safe for OB to see the patient. On 12/17/2021, the OB wrote a note about OB ultrasound results, but it is unclear from the note whether the OB performed record review only or saw the patient in person. The OB wrote VSS (vital signs stable) and no complaints today, but no review of systems (ROS) is documented.

The patient did not receive adequate evaluation and treatment of her asthma. She was not permitted to keep her asthma inhalers on her person.

On 1/23/2022, the patient was admitted to UC Davis for monitoring of uterine contractions. The transporting deputy signed the form with confidential medical information.

On 1/24/2022, following her discharge from the hospital for uterine contractions, the physician saw the patient at cell side *in the booking tank through the window.* The physician was unable to perform an HPI and ROS because she conducted the encounter through the window in booking with multiple inmates present.

On 2/10/2022, a mental health nurse practitioner saw the patient at cell side and requested the deputy to open the cell door for rapport building with the patient. Patient was known to provider and calm and cooperative during the evaluation. She reported frustration with her prenatal care. She wanted have more out of cell time. The provider discussed her behavior and how it will not be tolerated. Her medication was switched from Zyprexa to Seroquel. The patient was scheduled to RTC (return to clinic) in two weeks.

In late March 2022, the patient was released. She was subsequently readmitted twice, the last admission was in May 2022, four days after delivery of her child.

Opinion:

- This seriously mentally ill, homeless patient who was diagnosed with syphilis reported being pregnant as a result of sexual assault, but there is no documentation that she was counseled about her reproductive options for her pregnancy and desire for birth control in the future.
- There is no documentation to reflect awareness of this patient's life situation and the importance of counseling her about her reproductive options. This patient would have benefited from a case management approach to her multiple medical, mental health and social issues, but this did not occur.
- Several OB visits were not conducted as scheduled, with custody informing OB that she could not see the patient due to behavioral issues, yet mental health was not consulted

on the decision. These situations need to elevated up the chain of command and not simply allowed to lapse.

- In January 2022, after the patient returned from the hospital, the physician saw the patient at the booking tank through the window with other inmates standing around and therefore could not conduct an adequate evaluation due to lack of access to an examination room with privacy and access to the medical record. This is shocking and illustrates that the conditions of confinement are completely unacceptable.

Patient #35

In another case, a woman was in her early thirties admitted to the jail in early September and released in early December 2021. The patient had a history of heroin substance abuse disorder. Upon admission, she tested positive for pregnancy. She gave a history of opioid substance use, and a urine drug screen was positive for substance use, including morphine. The nurse did not make an urgent referral to a medical provider for a pregnant patient with heroin SUD. Nurses did not conduct COWS assessments or COVID 19 health checks. There was no substantive documentation counseling of her pregnancy options by the obstetrician. She had timely access to a physician following complaints of lower abdominal pain. The OB documented an issue with the quality of OB ultrasounds, which was noted in previous reports.

Opinion:

The intake nurse did not contact a provider urgently regarding this pregnant patient with heroin substance use disorder. Lack of timely treatment for opioid withdrawal in pregnancy results in preventable suffering of both the mother and fetus.

- The patient did not receive reproductive counseling.
- There is an issue with the quality of OB ultrasounds, resulting in lack of adequate information to the Obstetrician and patient, and possibly affecting the ability to make informed decisions about the pregnancy

Compliance Assessment:

- L.1=Partial Compliance
- L.2=Noncompliance
- L.3=Noncompliance.

Recommendations:

1. Nurses need to perform a urine drug screen on all pregnant patients independent of a known history of substance use disorder and if positive for opioids, immediately contact a medical provider. The patient should be housed in the infirmary.
2. Prenatal labs should be ordered at intake and performed prior to the first OB visit.
3. Obstetricians need to see pregnant patients no later than 14 days of arrival and sooner if clinically indicated.

4. Nurses and OB providers need to utilize Centricity OB Flowsheets to document care and monitor the progression of the pregnancy.
5. Nurses need to perform fetal heart tone checks on any patient with a gestation >15 weeks and inquire about fetal movement for patients with a gestation >20 weeks.
6. Custody needs to dedicate sufficient custody escorts to meet the demand for medical appointments.
7. Obstetrical patients should be escorted to and medically evaluated in clinical examination rooms with access to the medical record and that provides auditory and visual privacy.
8. Ensure that medical orders (e.g., labs, snacks) are timely implemented by health care staff and documented in the medical record.
9. When health care staff brings prenatal snacks to the housing units, officers need to escort the nurse to each cell to administer snacks to the patient.
10. ACH should perform CQI studies to ensure that obstetrical provided to patients meets the community standard.

M. Transgender and Non-Conforming Health Care

1. The County shall implement policies and procedures to provide transgender and intersex prisoners with care based upon an individualized assessment of the patient's medical needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate:
    a. Hormone Therapy
    b. Surgical Care
    c. Access to gender-affirming clothing
    d. Access to gender affirming commissary items, make-up, and other property items
2. The County shall ensure that medical and mental health staff have specific knowledge of and training on the WPATH Standards of Care.

Findings:
ACH has developed a Transgender and Gender Nonconforming Health Care[76] Policy that complies with medical care Consent Decree requirements.

The County hired a consultant who developed Transgender and Gender Nonconforming Health Care training. The County requested that the consultant include WPATH Standards of Care, but this did not occur. The County plans to go back to the consultant for modifications based upon feedback from the Mental Health Expert.[77]

Case reviews showed that patients were referred to a medical provider following admission to the jail. In one case, there was a four-day delay in a provider ordering HIV medication.

[76] Transgender and Gender Nonconforming Health Care. 05-12, revised 4/9/2021.
[77] Sherri Chambers and Madie LaMarre Email. 8/5/2022.

Patient #39

This is a 39-year-old transgendered patient admitted to SCJ in February 2022 and again in March 2022. The medical history includes HIV infection, hepatitis C infection, s/p treatment, syphilis in 2019, seizure disorder, major depression, and PTSD.

The patient had previous admissions to SCJ and was treated with estradiol and spironolactone. The patient was also treated with risperidone and benztropine.

In February 2022, the patient was transferred from another county jail. A RN conducted intake screening. According to medical records, the patient reported that he was bisexual and identified as male. The RN ordered a referral to the HIV clinic, STI testing, SUD referral, and essential medication review, and provider initial history and physical. The patient was taking Biktarvy, Phenytoin and Wellbutrin. The patient requested HIV and hepatitis C testing.

That day, a mental health nurse practitioner conducted a record review and ordered Buspirone and Wellbutrin. A medical provider did not conduct an essential medication review and order Biktarvy.

Four days later, a physician saw the patient and ordered Biktarvy, estradiol, spironolactone and low dose aspirin. The plan was to obtain labs and follow-up in one month.

The next day, the patient received the first dose of Biktarvy.

Eight days later, the patient's HIV viral load was undetectable. LDL=54. Hepatitis C antibody was positive and viral load was undetectable.

The next day, the patient, who had been refusing Keppra, told the nurse that he did not have seizures. The next day, a provider saw the patient for chest pain, although he was also scheduled for an H&P. He did not address each of the patient's medical problems. The patient was released the next day.

In early July 2022, the patient was readmitted to the jail. A RN performed intake screening. The patient appeared to be under the influence and unable to give details on meth and Ativan use. The nurse noted that the patient used methamphetamine daily for 24 years via smoking. A urine screen was positive for amphetamines, methamphetamines, and morphine. No information on Ativan use. The nurse ordered labs, STI tests, SUD counselor, HIV clinic, MH referral, Provider H&P, and essential medications. The nurse noted the patient was a detox risk, but did not note for what type of withdrawal or order withdrawal monitoring.

That day, a physician reviewed the patient's record and noted the lack of adherence to HIV medications. The physician ordered labs and follow-up visit. The provider did not order estradiol or spironolactone.

Another physician then ordered Keppra and Dilantin.

Opinion:

- There was a delay in order HIV medication for the first admission and a delay in ordering estradiol and spironolactone on the second admission, although the patient had been ordered these medications on a prior admission.
- The nurse did not order opioid withdrawal monitoring for the patient.

Patient #40

This 47-year-old transgendered female was admitted to the jail in May 2021 and was released in February 2022. Her medical history included, HIV infection, diabetes, bipolar disorder, and methamphetamine substance use disorder. Her medications were estradiol, spironolactone, Epivir, Tivicay, fenofibrate, metformin, Lantus Humulin, Jardiance, spironolactone, and aripiprazole.

In June 2021, a physician saw the patient cell side; she was refusing all care and medications. No vital signs were taken, and no fingerstick blood sugars. The provider ordered metformin and atorvastatin and counseled the patient.

A provider saw the patient routinely during 2021. She was agitated and refused care. She was treated by mental health and became compliant with the medical treatment plan. By September 2021, the physician ordered HIV, diabetes, and transgender medications. Eventually, the patient agreed to take medications, including estradiol, spironolactone and HIV medications.

In late September, the patient's diabetes was in poor control (HbA1C=10.1%).

In early November, the patient's estradiol level (111) and triglyceride level (596) were high.

Ten days later, the patient's HIV viral load was undetectable.

Three days after that, a physician lowered the estradiol dosage.

On 2/14/2022, labs showed the patient's diabetes control was improved and in fair control (HbA1C=7.9%).

The patient was released.

Opinion:

- This patient received timely monitoring for her medical conditions.

Compliance Assessment:

- M.1=Partial Compliance
- M.2=Noncompliance

Recommendations:

1. The County needs to train staff regarding WPATH Standards of Care.
2. The County needs to fully implement the policy.
3. The County needs perform CQI studies assessing policy compliance.

N. Detoxification Protocols

1. Within three months of the date the Remedial plan is issued by the Court, the County shall develop and implement protocols for assessment, treatment, and medication interventions for alcohol, opiate and benzodiazepine withdrawal that are consistent with community standards.
2. The protocols shall include the requirements that:
   - (i) nursing assessments of people experiencing detoxification shall be done at least twice a day for five days and reviewed by a physician.
   - (ii) nursing assessments shall include both physical findings, including a full set of vital signs, as well as psychiatric findings.
   - (iii) medication interventions shall be updated to treat withdrawal syndromes to provide evidenced-based medication in sufficient doses to be efficacious.
   - (iv) the County shall provide specific guidelines to the nurses for intervention and escalation of care when patients do not respond to initial therapy; and
   - (v) patients experiencing severe-life threatening intoxication (an overdose), or withdrawal shall be immediately transferred under appropriate security conditions to a facility where specialized care is available.

Findings:
This review showed that patients with substance use disorders did not receive adequate evaluation, treatment and monitoring, resulting in preventable suffering and a death.

Key findings include:

- ACH leadership revised standardized nurse procedures to be consistent with policy and procedures and the Consent Decree.
- Intake nurses do not consistently take adequate substance abuse histories, obtain urine drug screens, accurately assess the risk of withdrawal and order treatment and monitoring.
- Medical providers do not see patients with substance use disorder within 24 hours and do not provide any medical supervision of patients withdrawing from alcohol, benzodiazepines or opioids.
- Nurses do not timely monitor patients for withdrawal symptoms, sometimes performing CIWA and COWS assessments only at intake, or for one day thereafter.
- Population pressures limiting bedspace management, COVID-19 quarantine requirements, and lack of a dedicated detox unit results in patients languishing in booking cells for up to three days during which time withdrawal symptoms intensify.

We reviewed numerous records that demonstrated the above findings. Two cases are illustrative. In one case, class counsel interviewed and referred a patient to us to conduct record review to assess her reports.

The patient reported languishing in the booking loop for three days, during which time she was sweating, vomiting and defecating constantly. She reported that four of seven women in the holding take were experiencing withdrawal, and none of them were seen at any point by medical staff. She also reported that the holding tanks were freezing cold, filthy and that the toilets worked only intermittently, so the room reeked of vomit. She slept on the floor sandwiched between two dirty mattresses to stay warm. After the third day of incarceration, she was moved to 7W, but did not start medications until her fifth day of custody. We reviewed her record that showed the following:

Patient #2

This is a woman in her early forties with a history of anxiety, major depression, and substance use disorder, who booked into the Main Jail in February 2022. A nurse conducted intake screening. The patient reported a history of depression and anxiety. She reported substance use in the last 24 hours. including heroin and methamphetamine. The nurse documented that the patient did not appear to be under the influence of alcohol or drugs, nor have withdrawal symptoms. Drug and alcohol screen was not performed because a "strip search pending per custody." She had a COWS score of 2 and was referred to "nurse MAT/SUD for urine drug screen." No follow-up detox monitoring was ordered and there are no further medical staff notes for the remainder of her time in the booking loop.

At the end of the third day in booking, she was housed on 7W. The next day, she was seen at nurse sick call for initiation of opioid detox. Point of Care (POC) urine drug testing was positive for amphetamines and opiates. She was given an order for low bunk. The patient complained of nausea, vomiting, diarrhea, body aches, cold sweats. She was described as anxious and diaphoretic with gooseflesh. Opioid detox protocol was initiated and order for COWS Q 12 hours for five days. The COWS score was 13 (moderate). Medication was ordered, including ondansetron, loperamide, diphenhydramine, clonidine, acetaminophen, and Pedialyte. All meds ordered twice a day for three to seven days, depending on the medication. The patients eMAR confirms that all meds were begun that day, administered at 15:18 and continued for six days.

Opinion:

1. This patient spent an excessive amount of time in the booking loop.
2. She was not properly monitored after intake despite reporting opioid use that day. Policy states: "Patients with a history of chronic daily opioid use or past historical or documented opioid withdrawal will receive continuing assessment if opioid withdrawal is not present during intake." This did not occur.
3. She was not monitored timely once noted to be in withdrawal. Policy states: "COWS monitoring will be performed at least twice daily for 5 days … If initial COWS score is < 8, second COWS must be obtained within a 4–6-hour timeframe" This did not occur.
4. The patient was not referred to a provider once she was identified as suffering from withdrawal symptoms. Policy states: "The RN will schedule an urgent Provider Sick Call for any patient starting withdrawal medication treatment protocol… The provider will assess patients identified with possible Opioid Use Disorder and document the signs,

symptoms, diagnosis, initial plan, and any follow up indicated." The patient was not seen by a medical provider at all during this admission.

5. It is shocking that four of seven patients in the women's holding tank were in active withdrawal and no action was taken by custody or health care staff to intervene. It raises serious questions about custody and health care training and supervision.

A second case illustrates the failure to identify a patient at high risk of severe alcohol withdrawal and begin immediate treatment.

Patient # 10

This man in his late thirties was admitted to SCJ in mid-February 2022 and died two days later. His medical history included alcohol substance use disorder. He was taking no medications.

This detainee had a history of previous admissions. In January 2022, the detainee was admitted to the jail. During intake screening, he denied substance use disorder and any medical conditions. He was released five days later.

In February, upon admission, an intake nurse conducted medical screening. The patient reported drinking a gallon of hard liquor daily for two years. Last use was the day of arrest. He had a history of alcohol detox, but the nurse did not document his symptoms (e.g., seizures, delirium tremens). He did not appear intoxicated. CIWA=0, PAWSS=0. The patient declined HIV, HCV, and STI testing. The nurse ordered TST and SARS CoV-2 testing, Medical Quarantine, Health Checks, COVID 10 days release, Discharge Planning, and Nurse MAT/SUD.

The next day, no health care staff member documented a health check or CIWA assessment.

The day after that, a RN arrived in booking due to the patient's "altered mental status." Inmates reported that the patient had a seizure. CPR was immediately initiated. EMS was called. An AED was applied, for 3 shocks given. An IV, oxygen, and narcan were given. Patient taken to the ED via ambulance and pronounced dead at the hospital.

Opinion:

This patient gave a history of severe alcohol substance abuse upon arrival with detox symptoms. The patient remained in booking, but neither CIWA assessments or health checks were documented as being performed per policy. Inmates reported that the patient had a seizure prior to arresting. *This case represents a profound failure to recognize, monitor and treat a patient at risk of severe alcohol withdrawal. The patient was not evaluated by a medical provider in accordance with policy.*

ACH developed a corrective action plan in response to the above case. Actions including assigning a RN to the booking loop to monitor patients for substance use withdrawal in holding tanks. There is no examination room in the booking loop, so these assessments are being done in less-than-ideal circumstances. CQI is also conducting periodic booking audits.

Although ACH has developed policies and standardized nursing procedures (SNPs) for substance use disorder, this review and ACH CQI audits show that the policies and SNP have effectively, not been implemented resulting in preventable suffering and a death.

Compliance Assessment:

- N.1=Noncompliance
- N.2=Noncompliance

Recommendations:

1. The County needs to implement fixed dose treatment regimens (as opposed to symptom triggered treatment) to prevent escalation of withdrawal syndromes.
2. The County needs to provide additional training and real-time feedback to intake nurses regarding substance use disorder histories, including withdrawal symptoms.
3. A medical provider needs to evaluate all patients with substance abuse withdrawal in 24 hours in accordance with policy and procedure.
4. The Medical Director needs to ensure increased medical supervision of patients undergoing substance use disorder monitoring and treatment.
5. The County needs to establish a detox unit to permit timely monitoring and treatment of patients at risk of withdrawal, however we are aware that the Nacht and Lewis report's findings that space is inadequate at the Main Jail to establish such a unit.
6. The Medical Director needs to ensure increased medical supervision of patients undergoing substance use disorder monitoring and treatment.
7. The County should implement more comprehensive CQI studies of performance to track compliance with policies and procedures.

O. Nursing Protocols

1. Nurses shall not act outside their scope of practice.
2. To that end, the County shall revise its nursing standardized protocols to include assessment protocols that are sorted, based on symptoms, into low, medium and high-risk categories.
   a. Low risk protocols would allow registered nurses to manage straightforward symptoms with over-the-counter medications;
   b. Medium-risk protocols would require a consultation with a provider prior to treatment; and
   c. High-risk protocols would facilitate emergency stabilization while awaiting transfer to a higher level of care.

Findings:

ACH has developed standardized nursing procedures (SNP), some of which have been recently revised. The medical monitors have reviewed selected SNPs and are providing feedback to the County.

We found instances in which nurses did not adhere to SNPs, particularly with respect to substance use disorder. We also found instances in which nurses exceeded their scope of practice. For example, nurses independently evaluated and treated a patient for chest pain on multiple occasions without consulting a medical provider. [78]

In another case, a licensed vocational nurse (LVN) independently implemented a standardized nurse procedure without consulting a RN or medical provider.[79]

Compliance Assessment:

- N.1=Partial Compliance
- N.2=Partial Compliance

Recommendations:

1. Nursing leadership should continue to revise Standardized Nursing Procedures (SNP).
2. Nursing standardized procedures should contain adequate clinical referral criteria to minimize the risk that nurse will exceed their scope of practice.
3. The County should perform CQI studies to assess nursing compliance with SNPs.

P. Review in Custody Deaths

1. Preliminary reviews of in-custody deaths shall take place within 30 days of the death and shall include a written report of the circumstances of the events leading to the death, with the goal to identify and remedy preventable causes of death and any other potentially systemic problems.
2. Mortality reviews shall include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which may have contributed to the death, and the identification of problems for which corrective action should be undertaken.

Findings:

ACH developed a Medical Review of In-Custody Deaths policy (revised 3/11/2021) that meets Consent Decree requirements.

At our last report, we found that mortality reviews were not timely and consisted of the chronology of care with no meaningful analysis of the appropriateness of care. The reviews failed to identify lapses in care or opportunities for improvement. There were extended delays in obtaining death certificates and autopsy reports, which delayed the final mortality report.

For this review, we reviewed mortalities that occurred in the latter half of 2021 up to July 2022. Although some of the deaths occurred during the prior review period, the final mortality reviews were not completed until this review period and therefore were included in this review.

[78] Patient #5.

[79] Patient #46.

We found that the preliminary death report is conducted within 30 days. The report still consists primarily of a brief chronology of care or is limited to the death event with no identification of issues that might need immediate correction.

The final death report is typically completed, on average, six months later and consists of a more expanded chronology of care. More recent mortality review templates have been updated to include sections entitled, "Appropriateness of care provided," "Effectiveness of relevant policies and procedures," and "Possible medical care or custody improvements." Death certificates and autopsy reports are sometimes, but not always, available.

With some exceptions, final mortality reviews still lack identification of lapses in care, system issues, or opportunities for improvement. *For example, Patient #15 was not seen by a medical provider at all during his six-week incarceration, but this lapse was not mentioned in the mortality report or the corrective action plan*. Similar omissions occurred in the review of patients #14, #17, and #18. The mortality review process should be used not only to identify lapses in care in the individual cases, but also to look for patterns which may highlight areas for focused improvement efforts.

The theme that emerges most commonly among the cases we have reviewed is the failure for patients to be timely evaluated for signs and symptoms of serious illness. The cases of patients #17 and #46 contain perhaps the most egregious examples of this phenomenon. In the former case, the patient had been complaining of feeling sick with profound weakness and inability to walk for a week before he was finally referred to a provider. By that time, he was in overt respiratory failure from COVID-19 and was transferred to the hospital, where he later died. In the latter case, the patient was admitted to the jail in an emaciated state and reported been recently diagnosed with cancer that had not been treated. He weighed 106 pounds, was weak, vomiting and unable to tolerate solid foods, and reported rectal bleeding for 4 months. He was a heroin user, and he reported in a Health Service Request to having an infection in his blood affecting his heart valves and needed to go to the hospital as soon as possible. The patient was not referred for the care he urgently needed until he was found unresponsive just before he died.

Several cases involved patients with serious mental illness who were diagnosed or suspected of being gravely disabled, and for whom signs and symptoms of a serious medical need delayed until the patients deteriorated to the point of cardiac arrest.

In summary, the mortality review process does not reliably and consistently identify lapses in care and opportunities for improvement. The following cases are examples.

Patient #46

This man in his mid-sixties arrived at SCJ in July 2022 and died of septic and hemorrhagic shock twelve days later. His medical history included opioid substance use disorder, hepatitis C infection, weight loss, and back surgery. The patient also reported that he was diagnosed with intestinal cancer. He was taking methadone.

On the day of the patient's arrival to the jail, a RN conducted a medical screening. The patient was in a wheelchair provided by the jail. The patient reported a history of back surgery and intestinal cancer diagnosed four months previously but was untreated. He reported medication-assisted treatment (MAT) for three years for opioid use disorder and having taken methadone and cannabis in the past 14 days. He was prescribed methadone 100 mg daily. His last dose was the day earlier. Weight=106.5 lbs. VP=128/93 mm Hg, pulse=77/minute, respirations=16/minute, Temp=98 F, oxygen saturation=97%. The nurse contacted a physician for bridge medication orders for methadone for three days. The nurse ordered lower bunk housing on 2 East, a referral to a Substance Use Disorder Counselor, and a wheelchair as an assistive device.

The nurse did not make an urgent referral to a medical provider.

Later that day, a RN saw the patient at the request of custody for a reported fall from the bench in booking. The nurse documented that the patient did not have a seizure but rather a slow fall to the ground. He had a scrape to his right temple but did not lose consciousness. The patient requested food and methadone, and the medical record indicates that no housing was available on 2 East. The RN noted that the patient's vital signs were normal. That night, the patient received methadone.

The next day, medical records from Mercy San Juan Medical Center from March 2022 were scanned into the record. Those records indicated that the patient presented at Mercy San Juan Medical Center with abdominal pain, nausea and vomiting for 24 hours. The records indicated that he had a history of hepatitis C infection, and that *the patient reported a history of blood infection but denied fever.* The patient reported heroin and methadone use. Weight=130 lbs. Afebrile. Labs showed normal WBC, thrombocytopenia (Platelets=134,000) and elevated liver function tests. AST/ALT=74/77. The patient left the emergency room before the medical evaluation was completed.

The records were imported into the electronic health records (EHR) ten days after he arrived at the jail.

The day after his arrival, the patient was moved from booking to 2 East. He received methadone.

That day, the patient submitted a Health Services Request (HSR) reporting that he has intestinal cancer with weight loss to 106 lbs. at 6' 1" tall. He stated that he needed milk and fruit juice and that he could not eat solid food without vomiting. ***He also reported a blood sepsis infection.*** The date the HSR was received is illegible. Four days after the HSR was dated, a staff member documented a triage disposition as urgent sick call. (This HSR was scanned into the EHR in early August 2022, after the patient died.)

A RN ordered Nurse Sick Call. There was no indication whether the appointment was routine or urgent. The RN did not document on an HSR.

Note: A complaint of a sepsis warranted immediate notification and evaluation by a medical provider.

The next day, an LVN noted the patient was detoxing. There was no accompanying detoxification assessment in the medical records (i.e., COWS assessment).

The patient received methadone 100 mg that day. The patient's COVID-19 test result was reported as undetected.

The next day, at 01:00, the patient contacted custody through the cell call button reporting he was vomiting. Custody escorted the nurse into the cell. The nurse observed food in the toilet with a small amount of blood on a tissue, but no blood in the toilet. The nurse told the patient not to flush the toilet when he vomited. Food was removed from the cell, and the LVN planned to place the patient on a clear liquid diet. The patient was given Zofran 4 mg intramuscularly in right deltoid to help with retching and vomiting. A RN ordered a clear liquid diet.

Note: A LVN implemented a standardized nurse procedure (SNP) without consulting a medical provider.

Later that morning, a physician saw the patient, who stated: "Everything is wrong." The patient reported being able to swallow, but unable to tolerate solid food without vomiting. He weighed 105 lbs., but was 165 lbs. one year ago. The patient stated that he was diagnosed with intestinal cancer, not colon cancer, one year ago, but was noncompliant with follow-up and has had not treatment. The patient noted that he had blood in his bowel movements, usually bright red blood, occasional small clots, occasionally slightly dark, for four months. He reported that he had been on methadone 100 mg day for years for chronic pain all over. He reported pain from failed back surgery with paresis left leg, for which he is in a wheelchair.

Notes indicate as follows: Tobacco=1/2 pack day, no ETOH (alcohol), no meth, used to heroin and oxycodone but not lately. Appearance: remarkably thin. BP=141/85 mm Hg, pulse-=60/minute, resp=16/minute, Temp=97.9 F. Abdominal exam: scaphoid, no frank masses, small 1 x 2 cm nodular struction (sic) in sq (subcutaneous fat) RLQ, not suggestive of metastases. Assessment/Plan: Significantly underweight patient stating he has intestinal cancer (? Small bowel), never treated, x 1+ years. Needs follow-up with JP (sic), start Carnation instant Pack with meals tid (three times daily), emphasize liquids in diet, Jail panel, methadone 100 mg every 14:00, ondansetron 4 mg IM stat. Will request outside records. Labs and diet-snack of high fat. Follow-up one month for low body weight and history of cancer.

Note: This cachectic patient provided a history of untreated cancer with inability to tolerate solid foods, but the provider did not refer this emaciated patient for immediate medical evaluation to determine the patient's diagnosis and treatment.

The next day, the patient fell in the shower. He did not lock his wheelchair when he stood up. The patient had bruising on his forehead. Neuro checks were ordered for every shift for two days. *No neuro checks are documented.*

The next day, the patient submitted an HSR stating: "I have septic blood infection that gets to my heart valve. Also, intestinal cancer. Liver disease. Need blood work and hospital ASAP. I'm very

weak and sick." The HSR was date stamped the following day. Four days after that, a RN documented a routine sick call visit. The RN scheduled routine sick call. This HSR was scanned in late August, after the patient's death.

That same day, the patient submitted an HSR stating: "Emergency: I am supposed to be on a high CAL/High Pro Diet with snacks. I'm 6'1" and weigh only 103 lbs. Prison gives me double portion trays with 3x day snacks. Can eat solid foods (sic). Need Milks. Thank you." Four days later, a RN (illegible) documented routine sick call. This HSR also was scanned in late August, after the patient's death.

The next day, a CNA conducted a health check and noted the patient was asymptomatic. A CNA noted that she delivered a health snack to the patient's floor.

Two days later, a LVN conducted a health check and noted the patient was asymptomatic.

The next day, the patient's COVID-19 test was negative.

Two days later, a CNA conducted a health check and noted the patient was asymptomatic.

That night, the patient was found unresponsive. Initially, the patient had a weak thready pulse but lost a pulse. CPR was started, and an automated external defibrillator (AED) was applied, but no shock was indicated. Emergency Medical Services staff was notified, and the fire department arrived and took over emergency response. The patient was transported to Sutter Medical Center.

The next day, Sutter physicians diagnosed the patient with septic and hypovolemic shock. He was in acute renal failure with severe hypophosphatemia and hyperkalemia, he was severely neutropenic with very low platelets. Aggressive treatment was done, and he was intubated and given broad spectrum antibiotics and bicarbonate drip. CT studies were done that did not show any pathology that needed surgical intervention. The patient remained severely septic and in severe shock. He was given two units of blood and pressors for blood pressure support. Nephrology was consulted and the patient was too unstable for consideration of CRRT (continuous kidney replacement therapy). He developed asystole cardiac arrest and further intervention was determined to be futile.

Imaging results: CT of the chest, abdomen and pelvis showed a right lower lobe mass like consolidation with central gas foci which may represent necrotizing pneumonia or tumor. There is right upper lobe airspace disease which may represent atelectasis or pneumonia. No pleural effusion. Liver is unremarkable. No pancreatic mass, pancreatic duct dilatation or peripancreatic edema. Adrenal glands unremarkable. Kidneys: No hydronephrosis or nephrolithiasis. Bowel. Evaluation is limited due to lack of intravenous and enteric contrast. Stomach is grossly unremarkable. No evidence of bowel obstruction, colitis or diverticulitis. Appendix not visualized. No mesenteric or retroperitoneal lymphadenopathy.

Opinion:

1. When the patient arrived at the jail, he was cachectic with a reported a history of weight loss and cancer, warranting an immediate referral to a medical provider, or declaring the patient unfit and sending him to the hospital.
2. The patient remained in booking for approximately 18 hours because there was no bedspace available in 2 East. During this time, he fell off the bench. The patient's clinical condition warranted a medical bed.
3. A medical provider did not see the patient within 24 hours for a history of opioid substance disorder. This encounter would have provided an opportunity to inquire about a history of injection drug use and endocarditis (a bacterial infection of the heart valves) which the patient later reported in health requests.
4. The patient submitted a Health Service Request stating that he had intestinal cancer weighed 106 lbs. and was unable to eat solid food. He reported having a "blood sepsis infection." An RN apparently examined this HSR and scheduled a routine nurse sick call, but did not document this on the HSR. This RN should have immediately notified a medical provider.
5. The day after the patient's arrival, Kaiser medical records were noted to be scanned into the EHR from an emergency department visit months earlier. The patient reported a history of hepatitis C infection, current heroin and methadone use and complained of nausea and vomiting for 24 hours and inability to tolerate solid food. The patient also reported having a blood infection. Another electronic note indicates the records were imported into the EHR over a week later, suggesting delay from the time of receipt until scanned into the record.
6. A medical provider saw the patient, who reported profound weight loss, intestinal cancer, inability to tolerate solid foods without vomiting and rectal bleeding. The provider did not hospitalize the patient for medical evaluation and treatment. Instead, treating the patient's condition as routine with plans to see him in one month. This is egregious.
7. The patient submitted two HSRs, one that stated "I have septic blood infection that gets to my heart valve. Also, intestinal cancer. Liver disease. Need blood work and hospital ASAP. I'm very weak and sick. Although the form was received the next day, a RN did not triage the HSR for three more days. The nurse did not immediately contact a medical provider.
8. A CNA performed a health check and noted the patient was asymptomatic. Approximately, 11 hours later the patient went into cardiac arrest. Given the patient's medical condition, it was not possible for the patient to be described as asymptomatic. Health care staff cannot limit "health checks" only to COVID symptoms but have to respond to the overall condition of the patient.
9. The Medical Director completed a preliminary mortality review. The review does not accurately capture pertinent clinical events described above, and identifies the only issue as: "No care was provided for a Health Services Request submitted on 7/21/2022" (it was submitted on 7/17/2022). This is profoundly inadequate. In our opinion, the issues

include lack of intake referral, failure of the access to care system, medical provider lapses of care, lack of detox monitoring, ineffective COVID-19 checks, and delayed scanning of medical records.

10. We recommend that both preliminary and final mortality reviews are conducted by a multidisciplinary team to promote broader discussion and identification of systemic issues, lapses in care, and opportunity for improvement.

Patient #18

This patient was a man in his mid-fifties with COPD, hypothyroidism, and advanced methamphetamine induced cardiomyopathy with an ejection fraction (EF) of 10-15% whose course was complicated by repeated nonadherence to medical treatment. He was seriously chronically ill at the outset of his incarceration, and his condition gradually deteriorated from intake in March 2022 until he decided on comfort care only in May 2022 shortly before he died.

The preliminary mortality review identified no problems with any of his care and identified no opportunities for improvement. However, our review revealed several instances where care deviated from standard. For example, in early March, the day after his intake assessment, one of the physicians ordered as part of his essential medications two loop diuretics (furosemide and bumetanide), which is not appropriate. The patient had been relatively hypotensive since arrival with systolic blood pressures in the 90s. He was seen the next day by a different physician, at which time is his blood pressure was 86 over 64 with a pulse of 99. That doctor noted the hypotension, but made no changes to his medications. Later that morning, he was seen at nurse sick call for dehydration, was given 900 cc of fluids by mouth and a third doctor discontinued all of his cardiac medications without seeing the patient.

The patient presented the next day concerned about not getting his cardiac medication, particularly the Entresto. Of note, his blood pressure was still relatively soft at 95/71 mm Hg with a heart rate of 100/minute. The nurse noted an upcoming MD sick call and sent the patient back to his unit. He came back the following day with the same concerns, at which time his blood pressure was 86/66 mm Hg with a heart rate of 102/minute. This time he was seen by yet a fourth physician who quoted the patient as saying, “I need my Entresto, I will die without it. I will not leave until I get my Entresto.” Patient’s blood pressure at the time of the visit was 100/73 mm Hg and so the doctor decided to continue withholding all of his cardiac medications.

The patient's outside cardiology records were uploaded to the chart and signed off by a fifth doctor in late March, and indicated that the patient was actually not on both loop diuretics simultaneously, but that his bumetanide was discontinued in September and he was switched to furosemide at that time. Simultaneously, his Entresto dose was increased as compared with what was originally prescribed on his admission to the jail.

This doctor saw the patient on 3/28/2022, at which time he described him as unwell looking and hyperventilating. The patient was tearful during the exam, complaining of chest pain, shortness of breath, malaise, and fatigue. He was again insisting on getting Entresto and furosemide, but

the physician was reluctant given that his blood pressure systolic blood pressure was still in the 90s. He sent the patient to the emergency department where he was admitted to the CCU. The discharge notes the following, “Patient admitted for heart failure exacerbation… in the setting of not receiving oral medications while in prison. Please ensure the patient has a regular access to the following medications…asymptomatic hypotension of 80s/60s likely from extremely reduced EF.” *However, the discharge summary was not uploaded to the health record until 10 days after the patient returned*.

He had been started on low dose low dose antidepressant at the hospital, but this was discontinued upon his return to the jail. He was started on Jardiance for heart failure and then was incorrectly assumed to have diabetes when he returned to the jail. *When he refused to have an A1c test because he was not diabetic, he was described as “difficult,” then placed on a diabetic diet.*

Opinion:
There were multiple lapses in the care of this patient which were overlooked on the mortality review. These began from essentially the moment the patient arrived at the facility with the discontinuation of all of his cardiac medications despite severe systolic heart failure which caused the patient to have acute decompensation requiring hospitalization in the cardiac intensive care unit. Patients with this degree of heart failure commonly have low baseline blood pressure, which admittedly does make management challenging. However, if the facility clinicians were uncomfortable managing his care, they should have called his cardiologist as they knew where he was getting care prior to his incarceration. When the patient expressed anxiety and depression about his medical condition and the care he was receiving at the jail, he was appropriately placed on an antidepressant at the hospital only to have it summarily discontinued by the jail staff without discussion.

Patient #20
This was a man in his late fifties admitted to the jail in early May 2022, with a history of type 2 diabetes, hyperlipidemia, substance use disorder including intravenous drug use (IVDU), and back pain, who presented at intake with right groin pain and tachycardia. By the following afternoon, he was crying in pain and unable to bear weight. His pain was rated 10/10. The nurse contacted a provider, who ordered an x-ray and pain medication. He was seen cell side the next morning by a physician, who suspected sciatica and treated with prednisone and naproxen. The x-ray showed no abnormalities. There were no assessments the following two days, even though the patient was still on quarantine and should have had COVID checks.

The patient refused follow-up at MD sick call five days after his admission to the jail, but during COVID rounds that afternoon, was described as profusely sweating and the thermometer was not able to register his temperature. There was no other assessment documented, and the MA did not alert a nurse or provider.

Ten hours later, he was found naked on the floor with altered mental status the following day. He was taken to the medical housing unit where he became unresponsive and coded. He was transported to the ED, where he was admitted to the ICU with septic shock from soft tissue infection around the right psoas muscle with gas in the fascial planes noted on CT. His condition deteriorated and family decided to make him DNR. He died shortly thereafter.

Opinion:
The preliminary mortality review states that the provider who saw the patient on two days after his admission to the jail "considered infection and noted that he did not have fever," but there is nothing in the provider's note to support this statement. The review did appropriately identify the lapses in care including the lack of COVID checks, and the failure of the MA to alert a nurse or provider regarding the patient's profuse sweating and tachycardia. The autopsy report, final mortality report and corrective action plan, if one was completed, were not available for our review.

Patient #21
This was a man in his thirties with alcohol use disorder who reported consuming a gallon of alcohol per day for more than 20 days within the past month at the time of his intake to the jail in February 2022. The nurse noted no signs of intoxication on intake, and his CIWA score was zero. PAWSS was not completed at intake as required.

The patient remained in booking because no beds were available in the jail. Given his reported heavy alcohol use, he should have been started on alcohol withdrawal treatment, and had another CIWA assessment in six hours, then at least twice daily for at least five days. However, there were no further assessments until he coded in the early morning two days after his jail admission, after having had a seizure.

Opinion:
The Medical Experts reviewed this death and provided feedback to ACH. The preliminary mortality report identified the lapse in monitoring and a corrective action plan was developed.

Patient #17
This patient was in his late sixties with hypertension, diabetes, polysubstance use, Benign Prostatic Hyperplasia (BPH), hyperlipidemia, and chronic pain who booked in August 2021 and died of COVID-19 pneumonia at Kaiser hospital in November 2021.

He tested negative for COVID-19 by PCR after his admission and refused the COVID vaccine. He transferred from the Main Jail to RCCC in early September and was placed on intake quarantine. He was seen near daily for health checks and described as afebrile and asymptomatic.

In September, he tested positive for COVID-19 by PCR and was rehoused the next day. Over the next several days, he was described as asymptomatic until he was released from quarantine on after only five days of isolation. On that date his temperature was 99.0.

He was seen for a variety of routine visits between late September and mid-October. Then on 10/23/2021, he refused his medications stating, “I am already sick. Going out in the rain will get me more sick. I also have a fever and toothache.” These complaints were not addressed when he was seen later that day by a nurse for evaluation for a walker. No vitals were taken and no physical assessment was performed.

Four days later, he again refused his meds stating, “can’t walk that far.” He sent an HSR that day asking for a wheelchair, “I cannot make it back and forth to pill call do[sic] to dizziness,” and again the next day, “can’t walk, it’s too far, I have a walker, I need a wheelchair.” *He was not seen by a provider.*

At midnight in late October 2021, the patient “refused to come out” for his medications, then was seen urgently that afternoon for extreme weakness. He was found to be hypoxic (84-87% on room air) and tachycardic (pulse=112/minute). He was described as “sick looking, weak and exhausted” with “diminished breath sounds bilaterally” and a runny nose. His rapid COVID test was positive. Temperature on site measured at 97.8 but was 100 degrees per the EMT. He was sent to emergency department, where he was diagnosed with COVID-19 pneumonia later died.

Opinion:
The patient should have isolated for ten days after testing positive for COVID-19. This was not commented upon by the internal mortality report.

1. The patient was not appropriately assessed after reporting symptoms including fever and weakness on multiple occasions beginning.
2. This case is another tragic reminder of the importance of thoroughly evaluating older patients who present with weakness as this is a common symptom of underlying illness, especially infection.
3. The discrepancy between the temperature measured by EMT and that measured by the RN calls into question the accuracy of the onsite thermometer.
4. The corrective action plan identified multiple problems in this case and outlined a comprehensive plan of correction.

Patient #15
This patient was a male in his mid-fifties with hepatitis C, back pain, alcohol use disorder, and schizoaffective disorder who booked in the jail in August 2021 . The intake nurse saw him outside in the screening area because he was extremely agitated and uncooperative, yelling, screaming, singing, cursing the staff, mumbling to himself incoherently. He was referred to mental health urgently and was seen at 20:35 that day by an LCSW. He was described as agitated, aggressive, and irritable with a labile affect, pressured speech, impaired attention and concentration, and poor insight and judgment. He was uncooperative and agitated, unable to meaningfully engage in the assessment, disheveled and malodorous. He denied suicidal ideation or intent. He was judged to be at high chronic risk and moderate acute risk of suicide. He was noted to have multiple prior suicide attempts.

The day after he was booked, there was at mental health visit. The patient was delusional at the time, though able to participate in the visit. He had begun medication as ordered, including olanzapine, valproic acid, and buspirone. The clinician notes that there was no suicidal ideation. The patient was described as oriented, somewhat agitated but cooperative, with pressured speech and tangential disorganized thinking. He was experiencing visual and auditory hallucinations, impaired attention and concentration, and poor insight and judgment.

During the mental health evaluations that followed, the patient was described generally as calm and cooperative, delusional with tangential, bizarre or grandiose thoughts

In late August, the MH NP saw the patient for follow-up and ordered labs including a valproic acid level.

In early September, labs revealed an elevated valproic acid level at 126.7 ug/mL (50–100) and a low blood glucose level at 49 mg/dL. I could find no evidence that these results were reviewed by a clinician. Three days later, the mental health nurse practitioner reordered the same dose of medication. About two weeks after that, the pharmacist and physician respectively signed off on this dose as part of the patient’s discharge meds. The patient refused the medication on multiple occasions, but what effect this had on his subsequent blood levels is unknown, as the level was never repeated. At one point he complained of side effects, but it does not appear that this was addressed.

The patient was not seen by a physician at all during this incarceration. The only provider notes were written by the mental health NP and LCSW

In later September, he was seen by a social worker. He was expressing suicidal ideations but denied intent. He reported that he had stopped taking the valproic acid due to “shaking.” That night, the patient was found unresponsive in his cell. CPR was started by custody. The automatic external defibrillator (AED) advised no shock x 3. Emergency Medical Services (EMS) arrived and continued CPR for about 20 minutes before pronouncing the patient deceased.

Opinion:

1. This patient was begun on a fairly high starting dose of valproic acid (1750 mg). It is usually started at a lower dose and titrated upward with monitoring of side effects and drug levels.
2. This medication should be used with caution in patients with even mild liver impairment such as was possible in this patient who had a history of hepatitis C and alcohol use disorder, as this can lead to increases in drug levels beyond that which is detectable by measuring the total valproic acid level.
3. Significant abnormal lab results (low blood sugar and elevated valproic acid level) were not addressed.
4. This patient had a pattern of refusing medications, but was not referred to a provider for follow-up of this issue.

5. The only problem listed in the corrective action plan is the low blood sugar reading. The mortality review fails to identify the fact that the patient was never seen by a medical provider. Although he had an H&P during a prior incarceration earlier in the year, he was over 50 years old with chronic medical conditions and therefore should have been seen by a provider for an initial H&P within 14 days of intake per policy.

Patient #14

This patient was a man in his thirties with a history of substance use disorder, including heroin and alcohol use, with a documented alcohol withdrawal seizure documented from a prior incarceration in 2019. He had no other known medical history. He was admitted to the jail in July 2021, with normal vital signs, but was initially deemed not fit for incarceration due to swelling and redness of the legs. He was sent to Sutter Emergency Department (ED) for medical clearance and diagnosed with bilateral lower extremity cellulitis and an open ulcer. He was returned to the jail with orders for antibiotics and basic wound care.

That day, during RN intake screen, he reported nasal heroin use less than 24 hours ago. He was described as "often nod[ding] off to sleep, awakens quickly w/ loud voice command or gentil (sic) nudge. Pupils [about] 3mm. Verbally responds clearly. Gait is steady unassisted." Under Injury Precaution, nurse noted, "Will likely begin to detox from Heroin later today and has lower leg wounds. Medical appointment was made to address this." He was referred for urgent history and physical (H&P), as well as to see a substance use disorder (SUD) counselor. No further COWS assessments were done that day.

The patient was seen the next day by the NP for follow-up of cellulitis. His vital signs were unremarkable. She described him as "alert and oriented." She cleaned the wound and changed the dressing.

Later that day, the patient was seen by the nurse for a detox evaluation, at which time he was symptomatic with a COWS of 11. His urine drug screen was positive for opioids. Detox protocol was initiated. Twice daily COWS assessments were ordered per protocol, but no further evaluations are documented. About an hour later, he refused a health check. He was seen once the following day for a COVID check and was described by the medical assistant as asymptomatic. Temperature was 97.9.

The next entry – two days later – is the code note. The patient was found by custody staff pulseless and not breathing. The AED indicated asystole/no shock advised four times. EMS arrived and continued CPR another 15 minutes. The patient was pronounced dead.

An autopsy was performed, showing moderate CAD (coronary artery disease), dilated cardiomyopathy, hepatosplenomegaly, cholelithiasis, and healing cellulitis of the lower extremities. Toxicology was positive for diphenhydramine only. Cause of death determined to be dilated cardiomyopathy.

Opinion:

1. Detox protocol was initiated the afternoon after the patient was booked, including COWS assessment every 12 hours, but no further COWS were performed after the first one.
2. None of the providers (hospital staff included) documented an evaluation of calf tenderness or other evidence of possible deep vein thrombosis. Though not the case for this patient, pulmonary embolism secondary to undiagnosed DVT is a relatively common cause of morbidity and mortality which should be considered in the setting of leg swelling and redness.
3. The mortality review did allude to the ER clinician's failure to evaluate for DVT but did not comment on the same lapse on the part of ACH's own staff. Nor did it comment on the delay initiating the opioid withdrawal protocol or lack of detox evaluations once the protocol was initiated.

Patient #16

This patient was in his mid-seventies and booked into the jail in July 2021. He had a history of hepatitis, transient ischemic attacks (TIA), atrial fibrillation (AF), pulmonary embolism (PE), chronic obstructive pulmonary disease (COPD), diastolic heart failure, hypertension, iron deficiency anemia and substance use. He was housed at RCCC and died of COVID-19 pneumonia at the hospital in November 2021.

Prior to falling ill with COVID-19, the patient was being worked up for anemia (hemoglobin 6.9 mg/dL). He was referred for colonoscopy but ultimately refused. He was transferred to the emergency department in early October for further evaluation and transfusion, but was returned to jail after again refusing further work up. We could find no official emergency department report in the chart.

The patient returned to RCCC and was placed in quarantine. Health checks were performed every day except one, and he was described as asymptomatic and well appearing. He remained afebrile during that time; however, his blood pressure was extremely elevated on most occasions. He was seen by a physician for hypertension three times during quarantine. He was released from quarantine on 10/17/2021.

Two days later, he was reported as having difficulty with mobility and was seen the following day by a physician for follow-up of hypertension and confusion thought to be due to methadone. He was described as healthy looking with clear lungs, normal temperature, and normal oxygen saturation.

Six days later, he was brought from the barracks with lethargy, weakness, and hypoxia. Temperature was normal. The physician was contacted and ordered that he be sent to ED, where he was admitted with COVID-19 pneumonia and later died.

Opinion:
In retrospect, could this patient's presentation with limited mobility and confusion have been the onset of his symptomatic COVID infection? It is impossible to determine in hindsight, but may serve as a reminder that confusion and weakness can be harbingers of serious illness in older patients, and that the absence of fever is an unreliable indicator in this population. The final death review does not consider this except to say that he was reportedly asymptomatic on that date.

Patient #19
This was a woman in her mid-sixties admitted to the jail in early March 2022 with hypertension, obesity, fatty liver disease, back pain, and mental illness. She was diagnosed with type 2 diabetes during her incarceration, a diagnosis that she refuted.

She was seen on Day 14 for her history and physical examination, at which time her blood pressure (BP) meds were adjusted and a hemoglobinA1c was ordered. This was elevated at 8.2% (HbA1C goal=<7%). She subsequently refused further workup. She was seen on in mid-April by the same doctor who explained the diagnosis of diabetes and risks of ongoing refusal to monitor blood glucose or limit carbohydrates. Her BP meds were adjusted again. She was also referred to a gynecologist for postmenopausal bleeding. A week later, the gynecologist saw the patient, who had a normal exam given her history of prior hysterectomy. In mid-May 2022, she was found dead in her cell. The emergency response appeared to be appropriate.

Opinion:
The Medical Experts agree with the preliminary mortality review conclusion that this patient was appropriately treated for her medical conditions. No issues were identified.

Patient # 22
This man in his early fifties was admitted to SCJ in November 2019 and died of COVID-19 related respiratory failure and septic shock in early February 2022. His medical history included hypertension, idiopathic thrombocytopenic purpura (ITP), HCV infection, treated, alcohol, heroin and methamphetamine substance use disorder, cirrhosis, latent TB infection, COVID-19 infection, and schizophrenia. At the time of his death, his medications were losartan, apixaban, propranolol, trihexyphenidyl, bupropion, divalproex sodium, fluoxetine, olanzapine, and Haldol.

The patient was housed in the jails in 2016 and, at some point, was transferred to a state mental health hospital. In mid-November 2019, he transferred from Napa State Hospital to the jail. Napa State Hospital medical records provided at that time showed his medical conditions included alcohol substance use disorder, hepatitis C, treated, and elevated ammonia, suggesting hepatic encephalopathy.

Upon arrival, an ACH physician enrolled the patient in the chronic disease clinic for treatment of hypertension, but no other medical conditions such as ITP. In April 2020, the Medical Director saw the patient and identified him as being gravely disabled and being unable to get a history from the patient. Beginning in June 2021, the patient stated that he was paralyzed and unable to

get out of bed. The patient was never evaluated for liver disease and hepatic encephalopathy related to his history of hepatitis C infection, alcohol and heroin substance use disorder.

Recent Care

In January 2022, the patient developed altered mental status and was sent to Sutter Medical Center (SMC). An “Intent to Incarcerate” form with confidential medical information was signed by the transporting officer. At SMC, the patient was diagnosed with metabolic encephalopathy attributed to COVID-19 related poor oral intake. He developed acute kidney injury, hyperammonemia, rhabdomyolysis, transient hypotension, and severe constipation. He was also diagnosed with COVID-19. He was prescribed Eliquis for DVT prophylaxis due to immobility. According to the hospital physician, treatment was supportive as “he did not qualify for any specific medication, even dexamethasone.”

The patient was medically cleared for discharge back to the jail and housed on 2M. There is no nursing admission note when he arrived on 2M.

That night, an ACH physician saw the patient, documenting that the patient was in a wheelchair and did not want to be examined. The plan was to follow-up the patient in one week.

Later that night, a RN found the patient lying on the floor. The nurse noted two open non-raised areas about 2 cm in diameter to his back. The patient was assisted back to bed. The nurse did not document vital signs and did not notify a provider.

The next morning, a social worker saw the patient for a non-confidential encounter at cell side due to his being on medical quarantine. The social worker observed the patient on the floor with minimal movements. The social worker contacted medical to express concerns. Medical reported that they were aware and this was the patient’s baseline. Patient presented lethargic and drowsy. The patient was observed as minimally responsive and did not engage with writer. The patient was encouraged to stay safe and to submit an HSR or press the emergency button in case of an emergency.

The next morning, an RN documented that the patient was supine on his mattress and unwilling to move. Oxygen Saturation=96%; Temp=97.9 F; Pulse=79/minute. Blood pressure not measured. Glasgow Coma Scale=15. Morning medications were given. There are no further nursing notes for the remainder the day.

The next morning, a RN documented that the patient was on the floor mattress, unwilling to sit up. The nurse documented that they tried to assist, but the patient was argumentative. The nurse was unable to get BP as patient kept moving and getting angry. Temp=97.7 F. *Oxygen Saturation=Not measured. There are no further nursing notes for the remainder of the day.*

The next day, a LCSW saw the patient following discharge from 2P. “Patient seen cell side due to current level of impairment. Patient was observed laying on his mattress which was placed on the cell floor. Patient was asked to roll onto his side; however, patient was unable to do so.

Patient currently denied SI/HI/AH/VH by responding no. When asked about sleep, patient mumbled incoherently. Patient was unable to inform the writer what he ate for breakfast. Patient responded 'yes' when asked about his medications. Patient stopped engaging in the interview. Custody reported that the patient fell off his bed and his mattress was placed on the floor. "

Her assessment was that: "Limits of confidentiality unable to be discussed due to patient's level of impairment. Patient was assessed [that day] and placed on APU pre-admit last for GD (Grave disability . . . Patient unable to follow prompts to sit up or face the writer. Patient attempted to move upper torso, however he presented with a tremor. Patient exhibited vague thought process and it was unclear if patient understood the writer. *Patient is unable to attend to his ADL's."*

The next day, a RN documented that the patient was found lying on the floor between the cell bed and wall. The patient did not verbally respond to questions, but raised his arm when informed by writer the need to reposition. The notes read: "Noted +strong grips when medical staff tried to move inmate to sitting position, noted resistance when repositioning. …. Informed onsite provider of current oxygen saturation=79-80%. Started on O2 via non-rebreather mask @ 10L/minute, O2 Sat=90%. Hospital send-out by on-site provider. EMS Called=No."

Later that morning, a physician saw the patient for COVID-19 and hypoxemia in a non-confidential encounter in the patient's infirmary cell. The patient did not respond to speech. Oxygen saturation=79% and improved to 90% on 10 L oxygen non-rebreather mask. Audible breathing accessory muscle use. Decreased breath sounds. BP=Unable to get at time of writing. *The physician documented that the patient was counseled about medical conditions and management. Patient verbalized understanding and consent to current management. This is highly questionable given the patient's condition at this time.*

There is no documentation of when EMS arrived and transported the patient to Sutter Medical Center.

That night, the patient arrived at Sutter Medical Center. He was bradycardic and hypotensive. His condition steadily deteriorated, and he was intubated and given pressors to maintain his blood pressure. Despite medical measures his condition did not improve, and in early February, he was taken off ventilatory support and died.

Opinion:

This patient had a history of severe mental illness, alcohol use disorder, hepatitis C infection, elevated ammonia levels, and encephalopathy. Although Napa State Hospital Medical records noted serum ammonia elevations, during his incarceration he was not evaluated and treated for liver disease. The patient's mental status was attributed to mental illness but may also have been exacerbated by untreated hepatic encephalopathy.

The patient was housed on 2P, and physicians made monthly then weekly visits as the patient's condition deteriorated. On in January 2022, he was hospitalized for altered mental status and diagnosed with COVID-19, metabolic encephalopathy, rhabdomyolysis and acute kidney injury.

He was discharged four days later and housed on 2M. Four days later, a physician documented that he was unable to conduct a physical examination and planned to see the patient in one week, *which was not appropriate given the patient's medical condition*.

Nurses conducted rounds once every 24 hours, even as the patient's condition deteriorated as documented by mental health staff. The patient became gravely disabled, and nurses were unable to obtain full sets of vital signs. This patient did not receive timely and appropriate medical care during his incarceration at the jail following his return. In addition, the care he received on 2M was indifferent to his serious medical needs. His condition was deteriorating with no meaningful medical evaluation. This patient had both serious mental and medical illness. His condition deteriorated and ultimately exceeded care that could be provided at the jail.

In summary, <u>record review of deaths during this monitoring period showed significant lapses of care, and in some cases preventable deaths.</u> The Consent Decree requires:

> *Mortality reviews shall include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which may have contributed to the death, and the identification of problems for which corrective action should be undertaken.*

We find that although ACH is conducting mortality reviews, the process does not meaningfully analyze care to identify acts or omissions that may have contributed to the death and identify problems for which corrective action needs to be taken. We found that that individual or system performance issues are unrecognized, glossed over, or ignored. This affected the compliance assessment for this provision of the mortality review. We have expressed our concerns to ACH regarding the thoroughness and quality of mortality reviews, which in several cases has resulted in updated review and corrective action plan.

Compliance Assessment:

- P.1=Partial Compliance
- P.2=Noncompliance

Recommendations:

1. Ensure that all relevant clinical history is included in the mortality review.
2. Ensure that all mortality reviews critically evaluate the provision of care to identify opportunities for improvement in order to prevent future deaths.
3. Both preliminary and final mortality reviews need to be conducted by a multidisciplinary team to promote broader discussion and identification of systemic issues, lapses in care, and opportunity for improvement.
4. Update the Policy to include a provision to proactively obtain the autopsy report for all in-custody deaths.

Q. Reentry Services

1. The County shall provide a 30-day supply of current medications to patients who have been sentenced and have a scheduled release date, immediately upon release.
2. Within 24 hours of release of any patient who receives prescription medications while in custody and is classified as presentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the patient's current prescription medications.
3. The County, in consultation with Plaintiffs, shall develop and implement a reentry services policy governing the provision of assistance to chronic care patients, including outpatient referrals and appointments, public benefits, inpatient treatment, and other appropriate reentry services.

Findings:

ACH revised its Discharge Medication policy on 10/29/2021 and its Discharge Planning for Reentry policy on 5/18/2022. Both policies are compliant with Consent Decree requirements.

ACH reports that approximately 70% of eligible sentenced and court ordered inmates receive discharge medications upon release. Staff continues to work on the discharge medication release process with medical leadership and custody staff.[80]

ACH reports that pre-sentenced inmates may obtain a prescription for a 30-day supply of medication at the County Primary Care Pharmacy, but that very few presentenced patients pick up their medications. No data was provided to demonstrate that prescriptions are timely called in to the pharmacy for presentenced inmates who are released.[81]

Discharge medications for presentenced inmates began in January 2022 with a small pilot that initially included patients with serious mental illness (SMI) and comorbid diseases. The program was recently expanded to include patients with type 1 diabetes, hepatitis C and HIV infection and antibiotics. No data was provided regarding this program.

The County described activities underway to support discharge planning, however no data was provided regarding the number and percentage of eligible patients to actually receive discharge planning services.

Compliance Assessment:

- Q.1=Partial Compliance
- Q.2=Partial Compliance
- Q.3=Partial Compliance

[80] Fifth Mays Report. Page 43.
[81] Fifth Mays Report. Page 43.

Recommendations:

1. The County should track how many sentenced and pre-sentenced inmates are eligible for discharge medications and/or prescriptions and measure to determine the percentage of inmates successfully provided discharge medications.
2. The County should track the number of discharge prescriptions forwarded to pharmacies for released unsentenced detainees.
3. The County should implement the Discharge Planning policy and provide data on re-entry services.

R. Training

1. The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:
   a. All jail custody staff shall receive formal training in medical needs, which shall encompass medical treatment, critical incident response, crisis intervention techniques, recognizing different types of medical emergencies, and acute medical needs, appropriate referral practices, relevant bias and cultural competency issues, and confidentiality standards. Training shall be at a minimum every two years.

Findings:

The Mays 180 Day Status report did not substantively address this area. The medical experts were not provided information to support compliance with this provision.

Compliance Assessment:

- R.1=Noncompliance

Recommendations:

1. ACH and SSO should collaborate to determine whether health related policies should be combined into a single policy, rather than two separate policies, as was done with the suicide policy.
2. The SSO policies should be updated to reflect current health care operations and training performed.
3. The County should develop curricula and implement training for each of the areas identified in the Remedial Plan.
4. The County should maintain centralized records and tracking system of staff training.
5. The County needs to ensure that training is performed and documented every two years.

Medical Remedial Plan Compliance Summary

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
1.	A.1.		01/21/2021 8/27/2021 **9/1/2022**		
2.	A.2.			01/20/2021 8/27/2021 **9/1/2022**	
3.	B.1.	1/20/2021 8/27/2021	**9/1/2022**		
4.	B.2.			8/27/2021 **9/1/2022**	01/20/2021
5.	B.3.	**9/1/2022**	01/20/2021 8/27/2021		
6.	B.4.		8/27/2021 **9/1/2022**	01/21/2021	
7.	B.5.		01/20/2021 8/27/2021 **9/1/2022**		
8.	B.6.		01/20/2021 8/27/2021 **9/1/2022**		
9.	B.7.	**9/1/2022**			01/20/2021 8/27/2021
10.	C.1.	8/27/2021		01/20/2021	**9/1/2022**
11.	C.2.		01/20/2021 8/27/2021		**9/1/2022**
12.	C.3.a			01/20/2021 8/27/2021 **9/1/2022**	
13.	C.3.b			01/20/2021 8/27/2021 **9/1/2022**	
14.	C.3.c			01/20/2021 8/27/2021 **9/1/2022**	
15.	C.3.d			01/20/2021 8/27/2021	**9/1/2022**
16.	C.4.			01/20/2021 8/27/2021	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
				9/1/2022	
17.	C.5			01/20/2021 8/27/2021 **9/1/2022**	
18.	C.6.	8/27/2021 **9/1/2022**		01/20/2021	
19.	C.7.a		8/27/2021 **9/1/2022**	01/20/2021	
20.	C.7.b		8/27/2021 **9/1/2022**	01/20/2021	
21.	D.1.			01/20/2021 8/27/2021 **9/1/2022**	
22.	D.1.a			01/20/2021 8/27/2021 **9/1/2022**	
23.	D.1.b			01/20/2021 8/27/2021 **9/1/2022**	
24.	D.1.c		**9/1/2022**	01/20/2021 8/27/2021	
25.	D.1.d		**9/1/2022**	01/20/2021 8/27/2021	
26.	D.2.			01/20/2021 8/27/2021 **9/1/2022**	
27.	D.3			01/20/2021 8/27/2021 **9/1/2022**	
28.	E.1.	8/27/2021 **9/1/2022**			01/20/2021
29.	E.2.	8/27/2021		**9/1/2022**	01/20/2021
30.	E.3.			**9/1/2022**	01/20/2021 8/27/2021
31.	E.4.		8/27/2021	**9/1/2022**	01/20/2021
32.	E.5			8/27/2021 **9/1/2022**	01/20/2021
33.	E.6.	**9/1/2022**		8/27/2021	01/20/2021
34.	E.7.			8/27/2021 **9/1/2022**	01/20/2021
35.	E.8.	8/27/2021			01/20/2021

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
		9/1/2022			
36.	E.9			**9/1/2022**	01/20/2021 8/27/2021
37.	E.10.	8/27/2021 **9/1/2022**			01/20/2021
38.	F.1.a	01/20/2021 8/27/2021 **9/1/2022**			
39.	F.1.b	01/20/2021 8/27/2021 **9/1/2022**			
40.	F.2.			01/20/2021 8/27/2021 **9/1/2022**	
41.	F.3.		8/27/2021 **9/1/2022**	01/20/202	
42.	F.4.			01/20/2021 8/27/2021	**9/1/2022**
43.	F.5.			01/20/2021 8/27/2021 **9/1/2022**	
44.	F.6.		01/20/2021 8/27/2021 **9/1/2022**		
45.	G.1.		01/20/2021	8/27/2021 **9/1/2022**	
46.	G.2.			8/27/2021 **9/1/2022**	01/20/2021
47.	G.3.				01/20/2021 8/27/2021 **9/1/2022**
48.	G.4				01/20/2021 8/27/2021 **9/1/2022**
49.	H.1.			01/20/2021 8/27/2021 **9/1/2022**	
50.	H.2.		01/20/2021	8/27/2021 **9/1/2022**	
51.	H.3.			8/27/2021 **9/1/2022**	01/20/2021

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
52.	H.4.	8/27/2021 **9/1/2022**		01/20/2021	
53.	I.1.	01/20/2021 8/27/2021 **9/1/2022**			
54.	I.2.		01/20/2021 8/27/2021 **9/1/2022**		
55.	I.3			01/20/2021 08/27/2021 **9/1/2022**	
56.	J.1.	8/27/2021 **9/1/2022**	01/20/2021		
57.	J.2.		01/20/2021 **9/1/2022**		8/27/2021
58.	J.3.			01/20/2021 **9/1/2022**	8/27/2021
59.	J.4		8/27/2021	01/20/2021	**9/1/2022**
60.	K.1	**9/1/2022**		01/20/2021 8/27/2021	
61.	L.1.		01/20/2021 8/27/2021 **9/1/2022**		
62.	L.2.		01/20/2021 8/27/2021	**9/1/2022**	
63.	L.3.		01/20/2021 8/27/2021	**9/1/2022**	
64.	M.1.		**9/1/2022**	01/20/2021 8/27/2021	
65.	M.2.			01/20/2021 8/27/2021 **9/1/2022**	
66.	N.1.		**9/1/2022**	01/20/2021 08/27/2021	
67.	N.2.		**9/1/2022**	01/20/2021 08/27/2021	
68.	O.1.		**9/1/2022**	01/20/2021	
69.	O.2.			01/20/2021 8/27/2021 **9/1/2022**	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
70.	P.1.		**9/1/2022**	01/20/2021 8/27/2021	
71.	P.2.			01/20/2021 8/27/2021 **9/1/2022**	
72.	Q.1.		01/20/2021 8/27/2021 **9/1/2022**		
73.	Q.2.		**9/1/2022**	01/20/2021 8/27/2021	
74.	Q.3.		**9/1/2022**	01/20/2021 8/27/2021	
75.	R.1.			8/27/2021 **9/1/2022**	01/20/2021
	Total	**13 (17%)**	**22 (29%)**	**33 (44%)**	**7 (9%)**