OFFICE OF THE INSPECTOR GENERAL

• PROMOTING INTEGRITY •

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

WARDEN DERRAL G. ADAMS

CALIFORNIA SUBSTANCE ABUSE TREATMENT
FACILITY AND STATE PRISON
CORCORAN, CALIFORNIA

JANUARY 2003

GRAY DAVIS, GOVERNOR

State of California

Office of the Inspector General
P.O. Box 1498
Sacramento, CA 95812-1498

Memorandum

Date: January 30, 2003

To: EDWARD S. ALAMEIDA, JR.
Director, California Department of Corrections

From: STEVE WHITE
Inspector General

Subject: MANAGEMENT REVIEW AUDIT OF THE CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

I am pleased to forward to you the enclosed report of the recent management review audit conducted by the Office of the Inspector General of the California Substance Abuse Treatment Facility and State Prison at Corcoran and Warden Derral G. Adams. The audit was performed in accordance with the oversight responsibility provided to the Office of the Inspector General under *California Penal Code* Section 6126.

The audit identified a number of significant problems at the institution. Although some of the problems fall under the jurisdiction of the warden, responsibility for many of the most serious deficiencies—those in the institution's substance abuse treatment program, medical and dental services, and pharmacy operations—rest with the department. The recommendations of the Office of the Inspector General with respect to the problems are included in the report.

The Office of the Inspector General provided a draft version of the report to Warden Adams in December 2002. We also provided a copy of the draft findings pertaining to the substance abuse treatment program to the assistant director of the Department of Corrections Office of Substance Abuse Programs and a copy of the draft findings concerning medical, dental, and pharmacy services to the regional administrator of the Department of Corrections Health Care Services Division. In each case, we asked for a written response by January 10, 2003. At the department's request, we extended the deadline to January 17, 2003. Later, again at the department's request, we extended the deadline to January 29, 2003. At this writing, we have received no formal written responses to the draft report and are releasing the report in final form.

Please call me if you have questions concerning this report.

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
Derral G. Adams, Warden, Substance Abuse Treatment Facility and State Prison at Corcoran
Jim L'Etoile, Assistant Director, Office of Substance Abuse Programs, Department of Corrections
Shereff Aref, Regional Administrator, Department of Corrections Health Care Services Division

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MANAGEMENT REVIEW AUDIT

WARDEN DERRAL G. ADAMS

CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON CORCORAN, CALIFORNIA

REPORT

JANUARY 2003

• PROMOTING INTEGRITY •

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EXECUTIVE SUMMARY

This report presents the results of a management review audit conducted by the Office of the Inspector General of the California Substance Abuse Treatment Facility and State Prison at Corcoran and of Warden Derral G. Adams. The audit was conducted under the provisions of *California Penal Code* Section 6051, which requires the Office of the Inspector General to conduct a management review audit of any California Department of Corrections warden who has held the position for more than four years or who has been recently appointed, unless the Inspector General determines that the audit is not warranted. The purpose of a management review audit is to assess the warden's performance in carrying out the essential functions of the institution. In areas where weaknesses are noted, the Office of the Inspector General makes recommendations to correct the problems. The management review audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran was initiated in response to the July 2000 appointment of Warden Adams. The audit was performed from February 4, 2002 through July 19, 2002.

The audit revealed a large number of serious problems at the California Substance Abuse Treatment Facility and State Prison at Corcoran. Some of the problems fall under the jurisdiction of the warden, but many of the most serious problems, most notably those in the institution's substance abuse treatment program, medical and dental services, and pharmacy operations, do not. Responsibility for administering the substance abuse treatment program rests with the Office of Substance Abuse Programs of the Department of Corrections, while responsibility for the institution's medical, dental, and pharmacy services belongs to the Health Care Services Division of the Department of Corrections and its on-site administrator, who serves as the institution's health care manager and reports to the division's regional health care administrator.

The Office of the Inspector General found that the deficiencies in the substance abuse treatment program are preventing the institution from fulfilling its goal of reducing recidivism by helping inmates overcome drug dependency. At present, as a recent study showed, the recidivism rates of parolees who have completed the program are no different from those of parolees who have not received substance abuse treatment. The audit also revealed serious and pervasive deficiencies in the medical care provided to inmates at the Substance Abuse Treatment Facility and State Prison at Corcoran, with inmates sometimes waiting months for dental treatment and specialized medical care; six-month backlogs in orders for x-rays and in filing vital documents into inmate medical records; and waste, [redacted] and cost over-runs in pharmaceutical operations. Meanwhile, physicians and dentists, who are paid to work a 40-hour week, routinely leave the institution early, engage in personal activities during the workday, and in the case of some of the dentists, maintain private practices on the side. Problems identified by the Office of the Inspector General in institution operations, which are under the responsibility of the warden, include deficiencies in staff training, personnel hiring practices, evidence storage, and communication between the warden and the staff.

It is important to note that this report reflects problems that existed at the time of the audit fieldwork, but that during the course of the audit, a number of changes took place. At the beginning of the audit fieldwork, when the seriousness of the problems in the institution's medical services became evident, the Office of the Inspector General notified the Department of

Corrections of deficiencies requiring immediate action. In January 2002, the health care manager stepped down to accept another position and was replaced by an acting health care manager. As the audit fieldwork progressed, the acting health care manager became the permanent health care manager, but later left the institution for personal reasons. He has been temporarily replaced by an acting health care manager from another institution. [redacted]

In response to the preliminary audit findings, the regional health care administrator for the Department of Corrections and a correctional health care services administrator assigned to the institution developed a medical corrective action plan, which is included in this report as Attachment A. Because many of the key problems noted in the audit are beyond the control of the warden, he will require support and assistance from the Department of Corrections management to address the issues raised. The Office of the Inspector General recommends that Warden Adams work with the Health Care Services Division and the Office of Substance Abuse Programs of the Department of Corrections to develop a comprehensive strategic plan in order to correct the problems identified in this report. The seriousness of the problems also necessitates follow-up by the Office of the Inspector General. Accordingly, the Office of the Inspector General will conduct a follow-up audit about a year from the date of this report to ensure that Warden Adams and the Department of Corrections have developed and implemented a strategic plan and that problems identified in this report have been corrected.

The specific findings from the management review audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran are summarized below. Recommendations of the Office of the Inspector General appear in the body of the report.

FINDING 1

The Office of the Inspector General found that deficiencies in the substance abuse treatment program are preventing the institution from reducing recidivism by helping inmates overcome drug dependency.

The substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran was established by the Legislature in 1993 in response to evidence that prison-based substance abuse treatment programs can lessen criminal behavior and reduce recidivism. With 40 percent of the state's 160,000 prison inmates presently serving sentences for drug offenses and a one-year recidivism rate for drug offenders of about 43 percent, effective drug treatment programs have important potential to lessen the cost to the state correctional system and society at large of criminal activity related to drug addiction. Substance abuse treatment programs are presently in operation at nineteen of the state's 33 correctional institutions, with 8,626 treatment beds now authorized statewide, 7,514 of which are filled. The program at the Substance Abuse Treatment Facility and State Prison at Corcoran has 1,478 treatment beds — accounting for 17 percent of the drug treatment beds statewide and 20 percent

of the inmates receiving treatment each year—and is the state's largest substance abuse treatment program for convicted felons. The state's other in-prison substance abuse treatment programs for convicted felons are much smaller, ranging from 100 beds to 506. In 2000-01, a total of 1,420 inmates paroled from the substance abuse treatment program at the Substance Abuse Treatment Facility.

But the substance abuse treatment program at the Substance Abuse Treatment Facility has fallen far short of its promise. A recently completed five-year evaluation showed no difference in recidivism rates between parolees in a control group and those who participated in the substance abuse program. The reasons center on the failure of the department to place inmates in the program who would be most amenable to treatment and to instead place a high percentage of inmates who are not suited to the treatment model, including sex offenders and inmates suffering from mental illness. Other program deficiencies include a shortage of qualified counselors; under-utilization of aftercare services; lax monitoring of contractors who provide program services; and an absence of sanctions in contracts if providers fail to meet program requirements.

FINDING 2

The Office of the Inspector General found serious deficiencies in the medical care provided to inmates at the Substance Abuse Treatment Facility and State Prison, Corcoran, placing the health of inmates and staff at risk and exposing the State to possible legal action.

The Office of the Inspector General found serious and pervasive deficiencies in the medical services provided at the California Substance Abuse Treatment Facility and State Prison, Corcoran, affecting virtually every aspect of the institution's medical care system. The problems reflect the failure of management to monitor the quality of care provided at the institution and to ensure that the medical services provided meet licensing requirements and conform to state law and regulations.

As a result of the lack of supervision, and despite the fact that they are paid to work a 40-hour a week schedule, the seven staff physicians work short hours and see only a small number of patients each week. One doctor sleeps in his office during working hours. Another routinely tracks his investments during work hours. Inmates with medical appointments are consistently turned away and told to come back another day because doctors have stopped seeing patients early. When doctors do see patients, for the most part they confine treatment to prescribing medication and performing minor procedures, while referring most other cases to contracted medical specialists. In fiscal year 2001-02, the high number of referrals to outside specialists contributed to a cost overrun at the institution for contracted medical services of $5,029,575 — an overage of 81 percent. Meanwhile, inmates referred to a specialist may wait as long as six months for treatment. Delays in receiving medical care cause some inmates to end up in the emergency room or to otherwise undergo more expensive medical treatment later. Nurses do not consistently take patients' vital signs during clinic visits and the medical staff does not keep medication records up to date, leaving physicians without adequate information to make diagnoses and prescribe treatment. Doctors sometimes write prescriptions without the benefit of up-to-date medical records and sometimes without even seeing the patient. No one monitors when doctors arrive and leave or how many patients they see a day; no one reviews a doctor's medical diagnoses and treatment; and no one checks patient medical files to verify that entries

made by doctors are accurate and complete. Likewise, neither the nursing manager nor the nursing supervisors provide direct supervision of the nursing staff. No one monitors nurses' schedules and there are no sign-in and sign-out sheets to document arrivals and departures; there is no effective means of ensuring that inmates receive prescribed medication and no effective system to ensure that records showing what medications inmates have received are up to date.

The deficiencies extend to every other area of the medical care program. The radiology department is backlogged six months with orders for x-rays and magnetic resonance images. The medical records unit is six months behind in filing vital documents into inmate medical records, including inmate medication administration records, laboratory results, doctor's referrals, and disability verification forms. The medical records system in general is inadequate and inefficient, with the result that doctors and nurses lack ready access to patient files. Medical technical assistants, often the only members of the nursing staff assigned to housing facility clinics, are pressed into making triage decisions without consulting physicians or registered nurses about whether inmates need to examined by doctors, even though they are neither licensed nor trained to make such judgments. And the institution's inmate appeal system is flooded with appeals relating to medical care, with the problem compounded by a lack of diligence on the part of physicians in responding to the appeals, causing still more appeals to be filed.

FINDING 3

The Office of the Inspector General found that pharmacy operations at the Substance Abuse Treatment Facility and State Prison at Corcoran are seriously deficient.

The Office of the Inspector General found that oversight of pharmacy operations at the institution is seriously deficient, and that controls over drugs and medical supplies are lacking, resulting in widespread waste, [redacted] and large budget overruns. In fiscal year 2001-02, the pharmacy spent $5,367,156 for drugs and pharmaceutical supplies against an original budget of $1,726,500—an overrun of $3,640,656, or 211 percent — and a deficit is also projected for fiscal year 2002-03. During the audit fieldwork, the institution management [redacted]

Although a pharmacist from the adjacent California State Prison, Corcoran is designated as the "pharmacist-in-charge" at the institution and is scheduled to be at the institution on Tuesdays and Thursdays, in fact he is rarely on site. The Office of the Inspector General noted over a period of several months and confirmed through interviews with the pharmacy and medical staff, that the pharmacist visits the pharmacy only infrequently. In the absence of an on-site pharmacist, the pharmacy is run entirely by registry-hired contract employees who have a high-turnover rate and minimal training in prison pharmacy operations with no guidance from the Department of Corrections or the institution health care manager.

The Office of the Inspector General also found that the pharmacy lacks formal policies and does not comply with existing procedures governing pharmacy operations. *California Code of Regulations* Title 22 requires institutions to maintain specified controls over the procurement, storage, distribution, and disposal of medications, including physical restrictions on access to

drugs and supplies through the use of locks on doors and drawers containing medications. In addition to guarding against theft, institution pharmacies must ensure that medications necessary to the physical and mental health of inmates are available promptly and in appropriate dosages. Pharmacies must also maintain accounting controls to ensure that prescriptions are processed and filled properly. But the pharmacy at the institution's correctional treatment center does not comply with these requirements, and the staff was unable to produce written policies and procedures consistent with *California Code of Regulations,* Title 22 governing pharmacy operations.

FINDING 4

The Office of the Inspector General found that the dental care program at the Substance Abuse Treatment Facility and State Prison, Corcoran is seriously deficient and that inmates are not receiving dental services required under state regulations.

By the chief dental officer's own admission, dental services at the California Substance Abuse Treatment Facility and State Prison at Corcoran, are disorganized and operate in a crisis mode, with poor continuity of care, little preventive dentistry, and low productivity. Although state regulations require that all state prison inmates receive regular dental examinations, the institution does not comply with the requirement and under its present procedures, has no means of doing so, in that it has no computerized system for tracking dental services provided to inmates. Like the staff physicians, dentists at the institution do not work the 40 hours a week they are paid for—and as a result, inmates wait months for a dental appointment and may be transferred or paroled before they ever see a dentist. Dental clinics, which serve as the inmates' primary access to dental care, are held only three or four mornings a week, closing down right after lunch even though inmates with appointments may still be waiting to be seen. Inmates who have an urgent dental problem may be able to see a dentist without a clinic appointment by going through sick call — but if they do, the dentist will have to provide treatment without seeing the inmate's medical records because unless an inmate has an appointment, the records are secured in the correctional treatment center away from the housing facilities. In many cases, by the time an inmate sees a dentist, the problem has become too severe for the tooth to be saved, with the predictable result that the institution dentists pull as many teeth as they fix and in fact spend more time on denture work than on any other type of dental procedures.

FINDING 5

The Office of the Inspector General found that a projected deficit of $8.4 million in the 2002-03 budget for the Substance Abuse Treatment Facility and State Prison, Corcoran could significantly affect institution operations.

A combination of departmental policy changes and institutional issues will leave the institution with a projected budget deficit of $8.4 million by the end of the 2002-03 fiscal year in a total budget of $141,593,401. In the 2001-02 fiscal year, the institution faced a $12 million deficit, which was subsequently covered by funding obtained through a Department of Corrections statewide deficiency request to the Legislature and through additional baseline funding contained in the May revision of the state budget. But a deficiency bill is authorized only for the year requested and does not adjust the baseline budget of the institution. The projected deficit could

affect the ability of the institution to pay for services and supplies and may cause contract personnel and vendors, who historically have been those most affected by budget deficits, to decline to provide services in the future. The institution's deficit results primarily from a department-imposed 15 percent salary savings requirement; transportation costs for inmates needing dialysis; a 29 percent increase in sick leave costs resulting from changes in a bargaining unit contract; and inadequate controls over pharmaceutical expenditures.

FINDING 6

The Office of the Inspector General found that a significant percentage of employees and managers of the Substance Abuse Treatment Facility and State Prison, Corcoran are not fulfilling annual training requirements.

California Department of Corrections regulations, set out in *California Department of Corrections Operations Manual,* Sections 32010.13 and 32010.14, require all non-custody employees of the department to complete 40 hours of training annually in a range of subjects, including emergency response, fire safety, escape prevention, accident prevention, and inmate-staff relations. Specified additional training is required for employees in designated classifications, and specific training is also required for managers and supervisors. Peace officers and others covered under the memorandum of understanding between the State of California and the California Correctional Peace Officers Association (Bargaining Unit 6) are required to participate in 52 hours of annual training in subjects related to working in a custody environment—training commonly referred to as "7k" training. But the Office of the Inspector General found that employees and managers of the Substance Abuse Treatment Facility and State Prison, Corcoran are not consistently fulfilling those requirements and that neither supervisors nor the in-service training unit at the institution are monitoring to ensure that the requirements are met. The training deficiencies present a risk to both institution security and staff safety, as well as limiting opportunities for employees to gain needed skills and exposing the department to potential liability.

FINDING 7

The Office of the Inspector General found that the Investigative Services Unit is not following proper procedures for the temporary storage of evidence.

The Office of the Inspector General found that the institution lacks adequate procedures for the temporary storage of evidence. The procedures currently in use do not satisfy chain of custody requirements or ensure that the evidence cannot be tampered with or contaminated.

FINDING 8

The Office of the Inspector General found that the institution is not properly documenting inmate activity in the administrative segregation units.

State regulations and California Department of Corrections policy require that movement and housing of inmates assigned to an administrative segregation unit be recorded in a hardbound logbook — a CDC Form 114 — which provides a single-source record of daily activity within

the administrative segregation unit. The log is formatted to include the inmate's cell number and bed assignment, the time of the inmate's entry to or exit from administrative segregation, the identity of visitors to the unit, and any unusual incidents within the unit. The CDC Form 114 is a legal document subject to be used as evidence in a civil, criminal, or administrative proceeding. The Office of the Inspector General found, however, that although the administrative segregation staff at the institution maintains the CDC Form 114, the information is not entered into the log immediately. Instead, information is entered into the logbook only once every 24 hours by the administrative segregation unit's first watch floor officer, undermining the purpose of the CDC Form 114 as a source of accurate, up-to-date information about inmate location. The practice of delaying the recording of information into the logbook diminishes the evidentiary value of the CDC Form 114 and presents a safety risk to staff and inmates.

FINDING 9

The Office of the Inspector General found that the institution has not consistently followed required state hiring procedures.

Although the Office of the Inspector General found that the Substance Abuse Treatment Facility is generally in compliance with laws governing state hiring procedures, the audit revealed that in a small percentage of cases, required procedures were not followed and that in other instances even though the laws were followed, the hiring process was otherwise deficient, calling into question the fairness of appointments made.

FINDING 10

The Office of the Inspector General found while institution employees generally regard the warden's communication and management skills to be satisfactory, some described his management style as "reactive," and said that he does not communicate adequately with managers and line staff.

Representatives of five collective bargaining units at the Substance Abuse Treatment Facility praised Warden Adams for his accessibility, his positive attitude, his receptiveness to suggestions for improvement, and his face-to-face communication skills. Most said they enjoyed working for him. But they also told the Office of the Inspector General that the warden does not communicate enough with line staff, does not ensure that managers honor commitments he has made to union members, and does not make a practice of visiting secured areas of the prison. They also said that his management style is reactive, rather than proactive, and representatives of inmate advisory councils said that the warden does not meet with the councils regularly, as required by *California Code of Regulations,* Title 15.

INTRODUCTION

California Penal Code Section 6051 requires the Office of the Inspector General to conduct a management review audit of any Department of Corrections warden who has been in position for more than four years or has been recently appointed, unless the Inspector General determines that the audit is not warranted. The purpose of a management review audit is to assess the performance of the warden and the institution in carrying out the institution's essential functions. In the case of a warden who has been recently appointed, the management review audit serves as a baseline evaluation. Where the audit reveals deficiencies, the Office of the Inspector General makes recommendations to correct the problems.

This report presents the results of a management review audit conducted under *California Penal Code Section* 6051 of the California Substance Abuse Treatment Facility and State Prison at Corcoran as a result of the July 2000 appointment of Warden Derral G. Adams. The warden is an exempt employee appointed by the Governor. At the outset of the management review audit, Warden Adams had held his position for 18 months.

BACKGROUND

The California Substance Abuse Treatment Facility and State Prison at Corcoran, which opened in August 1997 is the newest of 33 state prisons operated by the Department of Corrections. With approximately 6,200 male inmates, 1,700 employees, and a fiscal year 2002-03 operating budget of $141,593,401, it is also one of the largest prisons in the western world. The institution is designed for inmates ranging from Level II (low medium security level) through Level IV (maximum security level), but houses a small number of Level I (minimum security) inmates as well.

In addition to its mission of providing custody for state prison inmates remanded to the Department of Corrections, the institution includes a 1,478-bed substance abuse treatment program—the largest custody-based substance abuse treatment program in the United States. The institution also provides a variety of other services, including medical, dental, and mental health services, academic and vocational education, reentry and self-help programs, in-prison work experience, and placement programs for disabled inmates.

The Substance Abuse Treatment Facility and State Prison, Corcoran is divided into seven facilities (or "yards") designated A through G, with the elongated grounds extending more than a mile east to west. Altogether, the institution covers 280 acres and has a perimeter of 2.7 miles, secured by an electrical fence of lethal amperage. From west to east, the layout of the seven-facility institution is as follows:

- ***Facilities A and B.*** Each of these facilities houses nearly one thousand general population, low-medium security (Level II) inmates. Like the other two Level II facilities (F and G), the living units are separated into four clusters for facilitating self-help group meetings. Each cluster has group meeting rooms, counselor offices, classrooms, and two separate tiers for dormitories.

- ***Facility C.*** This facility houses approximately 900 maximum security (Level IV) inmates. These inmates are categorized as general population felons.
- ***Facility D.*** Facility D is a sensitive-needs yard for approximately 1,000 inmates ranging in classification from minimum security (Level I) through maximum security (Level IV). A sensitive needs yard is designed for inmates who must be separated from the general population for safety reasons because of the nature of their crimes, their status as gang dropouts, or other factors.
- ***Facility E.*** Facility E is a high-medium security (Level III) yard and also contains the institution's administrative segregation overflow unit. Until recently, the facility housed general population inmates, but it now serves as a sensitive-needs yard.
- ***Facilities F and G.*** Each of these facilities houses up to 739 Level I and Level II inmates enrolled in the substance abuse treatment program. These facilities are the first designed by the Department of Corrections expressly for substance abuse programming. The program in Facility F is administered by Walden House, Inc., a private contractor. The program in Facility G is administered by Phoenix Houses of California, Inc., another private contractor.

In the spring of 2002, the California Substance Abuse Treatment Facility and State Prison at Corcoran opened its new administrative segregation unit. This unit, which is located at the institution's northwest corner adjacent to Facility A, houses approximately 155 inmates of various security levels.

The administration building, which houses the warden's office, those of his two chief deputies, inmate records, and other key functions, is located at the institution's southeast corner outside the secured perimeter, approximately one mile from Facility A.

Warden Derral G. Adams. Derral G. Adams began his tenure as warden of the California Substance Abuse Treatment Facility and State Prison at Corcoran in July 2000. This is Warden Adams's second assignment as California Department of Corrections warden. His first assignment, as interim warden, began in March 2000 at the Central California Women's Facility in Chowchilla, where he had served as chief deputy warden since January 1995. Warden Adams reported to the California Substance Abuse Treatment Facility and State Prison at Corcoran from the Central California Women's Facility. A Department of Corrections employee for 20 years, Warden Adams began his career with the department as a carpenter at the California State Prison, San Quentin. Since starting with the Department of Corrections, he has held increasingly responsible positions in various areas including facilities management, business services, and inmate classification.

Although Warden Adams has overall responsibility for the operation of the institution, two key functions—the substance abuse treatment program and medical, dental, mental health, and pharmacy services—fall outside his authority. As such, the employees administering these functions do not report directly to him and his managerial control is limited. The following describes the administration of these functions:

Medical, dental, mental health, and pharmacy services. The institution's correctional treatment center is the hub of medical, dental, and mental health services. Located inside the secured perimeter, the correctional treatment center is responsible for medical treatment and recovery, mental assessment and care, and clinical services. The correctional treatment center's 40 beds are used for providing in-patient care, treating respiratory illnesses, and providing care to inmates with mental health problems. Clinics affiliated with the correctional treatment center provide medical and dental services within each of the facilities. Pharmaceuticals for the medical, mental health, and dental programs are provided by a pharmacy located in the correctional treatment center.

Medical services for California Department of Corrections inmates are the responsibility of the department's Health Care Services Division. The health care manager at the Substance Abuse Treatment Facility and State Prison at Corcoran reports to the regional health care administrator of the Health Care Services Division and acts as the on-site administrator of health care services for the institution, with responsibility for overall management of the institution's medical, mental health, and dental programs. Health Care Services Division personnel, along with various contract employees, operate the institution's 40-bed correctional treatment center, which provides medical treatment, mental health services, and clinical care to the institution's 6,200 inmates. Medical and dental clinics throughout the institution provide medical and dental services, and pharmaceutical products and medications are provided through a pharmacy located inside the institution's secured perimeter.

In addition to the health care manager, the medical management team consists of a chief physician and surgeon, chief psychiatrist, chief dental officer, and the director of nursing. The professional medical staff is comprised of seven physicians, seven dentists, five psychiatrists, and nine psychologists, who, in addition to providing medical services, supervise the work of nurses, medical technical assistants, registered dental assistants, and other medical employees.

Following the Office of the Inspector General's announced intention to review this function as part of the management review audit, the health care manager stepped down to assume another position. He was replaced by the chief physician and surgeon, whose appointment as health care manager became permanent in August 2002. In September 2002, that health care manager transferred to another institution for personal reasons. The institution presently has no permanent health care manager and also has no permanent on-site pharmacy director because the contract pharmacist occupying that position was recently terminated for suspected drug theft.

Substance abuse program. The Department of Corrections Office of Substance Abuse Programs is responsible for administering the substance abuse program. The office has two on-site correctional counselor III positions and four parole agent II positions to monitor daily program operations and to screen inmates eligible for the 1,478-bed substance abuse program to ensure that the program operates at full capacity. The office is also responsible for monitoring Walden House, Inc. and Phoenix Houses of California, Inc. to ensure that the contractors comply with the terms of their respective contracts. Each contractor has been operating therapeutic community programs at the institution since the program's inception in September 1997, and each has been awarded new four and one-half year contracts by the Office of Substance Abuse Programs. The contracts cover January 1, 2002 through June 30, 2006. Including the after-care

component, each contract has a maximum value of slightly more than $29 million. The institution staff provides custody, drug testing, classification reviews, and administrative support to the Office of Substance Abuse Programs and the contractors.

OBJECTIVES, SCOPE, AND METHODOLOGY

Given Warden Adams's 18-month tenure at the institution, the objective of the management review audit by the Office of the Inspector General was to conduct a baseline evaluation of key operational functions and services. The management review audit team reviewed the following functions: medical and dental services; pharmacy operations; institutional communication; the substance abuse program; inmate appeals and disciplinary system; security; internal affairs investigations; training; personnel hiring practices; and institutional budgeting. The review did not cover the following areas: academic and vocational education; the inmate classification system; inmate work programs and credits; inmate counseling services; procurement; food services; inmate trust fund management; facilities management; the substance abuse treatment program community-based aftercare program or the substance abuse treatment program contractor payment system. Because a review team monitoring the *Coleman* court decision was scheduled to examine the institution's mental health services, the management review audit did not review these services. Similarly, the management review audit did not cover all provisions of the Americans with Disabilities Act because a team monitoring the *Armstrong* court decision reviewed the *Armstrong* remedial plan implementation and issued a report on March 22, 2002.

The Office of the Inspector General performed the following procedures in conducting the management review audit:

- Examined inmate and staff complaints about the California Substance Abuse Treatment Facility and State Prison at Corcoran received earlier by the Office of the Inspector General in order to define the scope of the review.
- Reviewed Office of the Inspector General investigations into the activities of employees of the California Substance Abuse Treatment Facility and State Prison at Corcoran.
- Interviewed Warden Adams, members of his administrative staff, labor union representatives and other employees, members of the institution inmate advisory committees, and other inmates at the institution to gain insight and perspective on various issues.
- Interviewed Department of Corrections administrators and staff regarding the department's role in providing medical, dental, and mental health services and in administering the substance abuse program.
- Administered a survey questionnaire to the California Substance Abuse Treatment Facility and State Prison at Corcoran staff regarding the administration's communication with staff and inmates.
- Administered a second questionnaire to the California Substance Abuse Treatment Facility and State Prison at Corcoran medical staff regarding medical operation issues and concerns.
- Conducted on-site visits and inspections of various facilities, programs, and services, including but not limited to the correctional treatment center, the medical and dental clinics,

the pharmacy, the substance abuse program, and living units and program offices throughout the institution.

- Reviewed various laws, policies, and procedures and other documents related to key institution systems, functions, and processes.
- Gathered and reviewed institution logs, files, records, and transaction documents in various operational areas.
- Performed various analytical techniques, including sampling, to assess compliance with legal and procedural requirements.

FINDINGS AND RECOMMENDATIONS

Findings 1 though 4, covering the institution's substance abuse treatment program, medical care, pharmacy services, and dental services, fall outside the warden's areas of responsibility and control. Findings 5 through 10 concern institution operations within the warden's responsibility. The substance abuse treatment program is the responsibility of the Department of Corrections Office of Substance Abuse Programs. Medical, pharmacy, and dental services are the responsibility of the Health Care Services Division of the Department of Corrections, the department's regional health care administrator, and the institution medical management team, which consists of the health care manager, chief physician, chief psychiatrist, chief dental officer, and director of nursing.

FINDING 1

The Office of the Inspector General found that deficiencies in the substance abuse treatment program are preventing the institution from reducing recidivism by helping inmates overcome drug dependency.

The substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran was established by the Legislature in 1993 in response to evidence that prison-based substance abuse treatment programs can lessen criminal behavior and reduce recidivism. With 40 percent of the state's 160,000 prison inmates presently serving sentences for drug offenses and a one-year recidivism rate for drug offenders of about 43 percent, effective drug treatment programs have important potential to lessen the cost to the state correctional system and society at large of criminal activity related to drug addiction. Substance abuse treatment programs are presently in operation at nineteen of the state's 33 correctional institutions, with 8,626 treatment beds now authorized statewide, 7,514 of which are filled. The program at the Substance Abuse Treatment Facility and State Prison at Corcoran has 1,478 treatment beds — accounting for 17 percent of the drug treatment beds statewide and 20 percent of the inmates receiving treatment each year—and is the state's largest substance abuse treatment program for convicted felons. The state's other in-prison substance abuse treatment programs for convicted felons are much smaller, ranging from 100 beds to 506. In 2000-01, a total of 1,420 inmates paroled from the substance abuse treatment program at the Substance Abuse Treatment Facility.

But the substance abuse treatment program at the Substance Abuse Treatment Facility has fallen far short of its promise. A recently completed five-year evaluation showed no difference in recidivism rates between parolees in a control group and those who participated in the substance abuse program. The reasons center on the failure of the department to place inmates in the program who would be most amenable to treatment and to instead place a high percentage of inmates who are not suited to the treatment model, including sex offenders and inmates suffering from mental illness. Other program deficiencies include a shortage of qualified counselors; under-utilization of aftercare services; lax monitoring of contractors who provide program services; and an absence of sanctions in contracts if providers fail to meet program requirements.

Program description. Legislation establishing the substance abuse treatment program at the Substance Abuse Treatment Facility required that the program be modeled after successful drug treatment programs and aftercare services at other institutions, including the Right-Turn Program at the R. J. Donovan Correctional Facility and the Female Offender Substance Abuse Program at the California Institution for Women. Two private contractors operate the substance abuse treatment program — Walden House, Inc. operates the program in Facility F, and Phoenix Houses of California operates the Facility G program. Each contractor provides services to 739 inmates at a time, with the Walden program averaging 26.2 weeks and the Phoenix program averaging 36 weeks. Contracts reimburse the providers for the same services at agreed-upon rates. The cost of the program for fiscal year 2000-01, including both in-prison and aftercare components, totaled $11.5 million, with an average cost of between $1,312 per inmate for the Walden program and $1,751 per inmate for the Phoenix program—the difference resulting from a longer treatment period in the Phoenix program. Overall, the in-prison cost of the program represents about $3.7 million over the amount spent annually on general population inmates. New contracts with the two providers covering the years 2002 though 2006, including both in-prison and aftercare components, come to $58.9 million.

The substance abuse treatment program at the Substance Abuse Treatment Facility is limited to Level I and II inmates with a documented history of drug or alcohol abuse who are within 18 months of release. To be admitted to the program, inmates must have no prison gang affiliations and must not have been in a security housing unit or protective housing unit for the previous 12 months. Inmates can be assigned to the program during reception center processing or may be identified for the program by the on-site correctional counselor at the institution responsible for inmate recruitment for the program. Inmates who volunteer for the program receive placement priority if they meet the admittance criteria. Inmates who do not volunteer for the program, but who meet the placement criteria and are selected for the program, are compelled to participate on a non-voluntary basis.

Like the programs at R. J. Donovan and the California Institution for Women, the Substance Abuse Treatment Facility program is patterned on the "therapeutic community" model, a proven method for treating drug and alcohol abuse. The model treats substance abuse as a disorder of the whole person rather than as a disease, with the goal of treatment to promote positive social attitudes and behavior. The role of counselors — many of whom are former addicts and ex-felons —is crucial to the program's success. The program consists of a minimum of 20 hours a week of counselor-led training sessions, seminars, and peer encounter groups covering topics such as anger management, conflict resolution, relapse prevention, and family reunification. Counselors emphasize respect and open communication to lead residents to accept responsibility for their behaviors and to develop the strategies and skills necessary to succeed in the community. The feedback and peer pressure exerted by counselors and community residents are pivotal to successful establishment and maintenance of the therapeutic community and to the success of the participants in overcoming substance abuse.

Inmates attend the program for six to 24 months in three structured phases: orientation, primary treatment, and pre-release transitioning. Because aftercare, in the form of community-based substance abuse treatment for paroled inmates, has been found to be critical to program success, the substance abuse treatment program includes an aftercare component providing services to

parolees on a volunteer basis for up to six months following completion of the in-prison treatment phase. As the parole date nears, providers are required to develop a community services plan for each program participant and to arrange aftercare placement with community-based substance abuse treatment providers.

The substance abuse treatment program has not been effective. A just-completed five-year evaluation of the substance abuse treatment program at the Substance Abuse Treatment Facility, conducted by the Integrated Substance Abuse Program at the University of California at Los Angeles, found that the program is failing in its central purpose of reducing recidivism by helping inmates overcome drug dependency. Although the evaluation showed some positive results, including that only 0.19 percent of 27,992 urine tests conducted on program participants over the 46-months of the study period were positive for drugs, and that aftercare participation improved over time, recidivism was unaffected. The study, which had not been formally released at the time of this report, showed no difference in recidivism rates between a sample of 404 parolees who had completed the substance abuse treatment program at the Substance Abuse Treatment Facility and 404 comparable inmates from Avenal State Prison who had received no substance abuse treatment. One year after their release, 53.5 percent of the substance abuse treatment program parolees had returned to custody, compared to 51.9 percent of the Avenal parolees. The study also showed no difference between the two program providers.

Because inmates covered in the study entered the program between June 1999 and June 2000, it is possible that the results may not apply to the program as it is presently operated. According to the UCLA study, during the period under review, some key positions were vacant, there was high turnover in other positions, and there was instability in program management brought on by a succession of prison administrations. But the director of the UCLA study told the Office of the Inspector General that the outcome evaluation shows that the therapeutic community model may not have been implemented successfully at the Substance Abuse Treatment Facility. The Office of the Inspector General found a number of ongoing deficiencies in the program, several of which were also identified in the UCLA study, that may have contributed to the poor results and that suggest the situation has not improved with inmates entering the program after the period covered by the earlier study. The deficiencies consist of the following:

- ***High number of sex offenders and inmates with mental illness in the program.*** The success of the program is hindered by a high percentage of inmate participants who are either sex offenders or inmates designated as correctional clinical case management system inmates—that is, inmates suffering from minor mental illness, many of whom require medication. During the five-year period covered by the UCLA evaluation, researchers found that 13 percent of program participants were registered sex offenders, while another 26 percent were correctional clinical case management system inmates, for a combined percentage of 39 percent of program participants. In the more recent period covered by the present audit, from February to July 2002, Office of the Inspector General found the proportions to be even higher, with 50 percent of participants either sex offenders, correctional clinical case management system inmates, or both. Particularly when they are present in large numbers, neither group is amenable to the program model. The therapeutic community treatment method depends on the participants' openness and willingness to confront their criminal behavior in a mixed group setting, whereas sex offenders are held in low esteem by other

inmates and are at risk of assault if their offense becomes known, making them reluctant to participate openly. Sex offenders also are difficult to place in aftercare programs, which are a critical component of the substance abuse treatment program. Inmates with mental problems of varying degrees are likewise unsuited to the program if their mental conditions or the psychotropic medications they are taking limit their comprehension skills or attention span. Mental problems may also make them disruptive to the group process, undermining treatment for themselves as well as for other participants.

- ***Poor recruitment of inmates who might benefit from the program***. The high percentage of sex offenders and correctional clinical case management system inmates participating in the substance abuse treatment program stems from a related problem—ineffective recruitment of inmates suited to the treatment model. The physical configuration of Facilities F and G, which house the substance abuse treatment program, is suitable only for Level I and Level II inmates and, as a result , the program can accommodate only inmates designated as Level I or II. And despite the prevalence of drug abuse among inmates generally, reception center processing until recently has favored placement of Level I and II inmates in fire camps and other assignments over placement in substance abuse treatment programs, resulting in a shortage of inmates placed into the Substance Abuse Treatment Facility program directly from the reception center. Among inmates already assigned to the institution, recruitment for the program is limited to the Level II inmates assigned to Facilities A and B — a pool of fewer than 2,000. Shrinking the number of potential participants even further is the fact that about 700 of Facility A and B inmates at any given time are aliens on hold for the U.S. Immigration and Naturalization Service, who, as such, are ineligible for the program.

- ***Contractual arrangements lead to high numbers of participants unsuited to the program.*** Also driving the high percentage of sex offenders and mentally ill inmates participating in the substance abuse treatment program is the tendency of the department's Office of Substance Abuse Programs to supply providers with as many program participants as possible. The tendency stems from the fact that providers are reimbursed for actual costs regardless of the number of in-prison participants, giving the department an incentive to provide a large number of participants, even though not all may be suited to the treatment model. That dynamic puts providers in the position of feeling obliged to accept inmates who are not suited to the program even though doing so may lead to program failure.

- ***Large number of beds.*** The substance abuse treatment program at the institution deviates from the therapeutic community treatment model in that other such programs, including those upon which the program was patterned, operate with far fewer beds—200 beds compared to the 739 beds per provider in the program at the Substance Abuse Treatment Facility. According to the director of the UCLA study, the larger number of beds in the program may work to the detriment of the program's success.

- ***Involuntary participation by inmates.*** The successful therapeutic community drug treatment programs upon which the institution's substance abuse treatment program was modeled serve an all-volunteer group of participants, while the Substance Abuse Treatment Facility program includes inmates who participate involuntarily. The UCLA evaluation found a correlation between the recidivism rates of inmates who had been compelled to participate in the

program and those who participated voluntarily, with those who had been forced to participate returning to custody at a significantly higher rate than volunteers. The coerced group was also 40 percent more likely to return to custody than Avenal inmates who had not participated in a substance abuse treatment program and who reported that they did not want to participate in such a program.

- ***Counselors frequently absent from counseling groups.*** For the therapeutic community treatment model to be successful, counselors must actively participate in group sessions to help participants concentrate on the values and behavior contributing to their substance abuse and criminality. In recognition of the importance of the counselor role, the provider contracts for the substance abuse treatment program require that a counselor be present in every therapeutic community group session. But the Office of the Inspector General found from observations of 18 group sessions, that eight (44 percent) had no counselor present. Instead, the groups were led by inmate residents known as "facilitators," who, although they may have some knowledge of therapeutic community principles, are not acceptable substitutes for the trained and experienced counselors for whom the State is paying. During the audit the Office of the Inspector General found several counselors working in their offices or walking through the treatment areas instead of leading their groups. Some counselors said they routinely let inmates run their groups, while others said they had to catch up on clinic notes because of a high workload. Those walking through the treatment areas said it was necessary for them to do that in order to prevent inmates from slipping out of groups that were operating without counselors.

- ***Inadequate number of counselors.*** The provider contracts require a ratio of one counselor for every 18 program participants and that each treatment "cluster," which consists of up to 62 beds, be staffed with at least three counselors. The Office of the Inspector General found that the requirement is not being met. Of 11 clusters visited during the audit, four had fewer than three counselors assigned, and one cluster had only one counselor. The shortage in some cases accounts for the absence of a counselor at counseling groups, and may be attributable in part to the institution's rural location, which makes it difficult to retain qualified staff. The assistant director for the Office of Substance Abuse Programs, however, told the Office of the Inspector General that other substance abuse treatment programs located in rural areas do not have staff retention problems.

- ***Counseling groups too large.*** Therapeutic community counseling groups must be small enough to promote a sense of community among the participants and to foster each participant's self-expression while allowing the counselor to observe and evaluate the behaviors, concerns, and interests of each person in the group. In accordance with these principles, the contracts with the substance abuse program providers require that groups be limited to no more than 18 participants. The Office of the Inspector General found, however, that two (11.1 percent) of the 18 sessions observed exceeded the maximum of 18 participants.

- ***Treatment plans deficient.*** The provider contracts require that treatment plans, signed by the counseling staff and the inmate participant, be maintained throughout the program and that written notes be maintained on each participant's progress. From a review of 44 randomly

selected participant files, however, the Office of the Inspector General found that these requirements are not being met, suggesting that counselors may not be adequately communicating with participants and reinforcing treatment goals. While all of the files contained initial assessment documents and individualized treatment plans, frequently the inmate had signed only the initial plan. In 18 (47.4 percent) of 38 cases requiring an extension or revision, the counselor had not made the required change or the participant had not signed it. In seven (15.9 percent) of the files, counselors had not met the contractor's requirements governing the frequency with which progress notes must be made. In some cases, progress notes were as much as seven weeks overdue.

- ***Participants may not be allowed leave the program.*** Whether inmates enter the substance abuse treatment program voluntarily or are selected for the program and forced to enter, they are not allowed to leave the program voluntarily. Under these circumstances, inmates who initially volunteered for the program may assume the same attitudes as those who had been forced to participate, occasionally resorting to disruptive behavior in an attempt to be expelled, to the detriment of themselves and other program participants.

- ***Under-utilization of aftercare services.*** Aftercare programs—community-based substance abuse treatment for paroled inmates who have completed in-prison treatment—has been found to be critical to program success. Assessments of the R. J. Donovan program, for example, revealed that inmates receiving only in-prison treatment with no aftercare component tended to have similar post-treatment outcomes as those receiving no treatment at all. The successful programs upon which the Substance Abuse Treatment Facility program was modeled benefited from well-coordinated residential aftercare services with extensive participation by the same entities that had provided the in-prison treatment, affording parolees a seamless transition to treatment in the community. The Substance Abuse Treatment Facility's aftercare network, however, lacks such continuity. Moreover, aftercare participation by parolees from the substance abuse treatment program is voluntary, and as a result, aftercare is under-utilized. Although 47.5 percent of the inmates in the UCLA study accepted a referral to aftercare services, the researchers found that only 24.9 percent actually showed up for and only 11.2 percent completed at least three months of aftercare. The 41 parolees who completed three or more months of aftercare had a 37.1 percent recidivism rate.

- ***Inadequate monitoring of providers by the department.*** The Office of Substance Abuse Programs of the Department of Corrections is responsible for monitoring the substance abuse treatment program at the institution. But one of the correctional counselor IIIs, who serve as the highest-ranking on-site staff for the Office of Substance Abuse Programs, said that she is too preoccupied with attempting to fill beds for the program to have time to systematically monitor the contractors. The Office of the Inspector General found in fact that no systematic in-depth monitoring of the program has taken place since May 2000. Up until that time the institution used a detailed audit instrument, including a review of the contractors' files and records, to periodically review contractor obligations and activities. When instances of non-compliance were found, the contractor was required to develop a plan of corrective action, citing methods to be used, titles of accountable staff members, and completion dates. But the Office of Substance Abuse Programs has not used the audit instrument at the institution,

reportedly because of the perception that the instrument tended to be excessive in that it noted non-compliance in minute detail. Instead, the Office of Substance Abuse Programs conducts monthly two-day site visits by its Sacramento-based program manager. The Office of the Inspector General reviewed copies of the site visit reports and found that they lack detail and do not reflect in-depth review of provider records and operations. The reports instead reflect the details of meetings with the provider staff to discuss issues self-reported by the provider in monthly reports to the Office of Substance Abuse Programs, along with other topics raised during the visits. One site report, for example, simply described a tour of the program by an interested government agency. Another site visit report noted that the report's author had told the provider staff that the author's goal was to work in a team relationship with the provider. Although cooperation is desirable, a team approach is inconsistent with the arm's length relationship needed for effective monitoring. The Office of Substance Abuse Programs also receives monthly reports from correctional counselors and monthly reports from the providers, but these reports too provide little evidence of substantive monitoring.

- ***Lack of recourse against providers for noncompliance with contract requirements.*** The contracts with the providers contain no provisions for withholding payments if the providers fail to meet contract requirements for counselor involvement, minimum group size, or other program needs. This weakness, coupled with inadequate monitoring, leaves providers with little incentive to hire counselors, maintain small group size, and otherwise perform as required. In sum, the Office of Substance Abuse Programs has no intermediate recourse against the providers short of exercising its right to terminate the contract, although the assistant director of the Office of Substance Abuse Programs said that the contractors are cooperative and make every effort to correct deficiencies brought to their attention.

In response to the audit by the Office of the Inspector General, the Office of Substance Abuse Programs has advised that it will take steps to address some of the deficiencies in the substance abuse treatment program. The actions proposed include improving the inmate selection process for the program, limiting correctional clinical case management system inmates to 12 percent of the program slots, recruiting inmates from other institutions for the program, and increasing program monitoring.

RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections take the following actions to improve the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran:

- Develop a process for recruiting eligible inmates from other institutions into the program, including those who may be receiving fire camp, facilities maintenance, and similar assignments in lieu of substance abuse treatment program assignments.
- Cease the policy of requiring inmates to participate in the substance abuse treatment program involuntarily.
- Develop alternative methods of providing substance abuse treatment to sex offenders, perhaps by grouping them into specially designated clusters.

- Limit the percentage of correctional clinical case management system inmates and sex offenders that contractors must accept into the substance abuse treatment program.
- Conduct systematic, in-depth monitoring of providers for contract compliance. Deficiencies noted should require corrective action plans with deadlines, as well as follow-up monitoring to verify that satisfactory corrective action has been taken.
- Investigate methods of helping providers retain counselors and other staff members.
- Evaluate all possible means of increasing aftercare participation, including possible legislation to mandate aftercare as a condition of parole for substance abuse treatment program inmates.
- In future contracts with providers, include withholding of payments or other fiscal sanctions as alternatives to contract termination in the event of non-compliance.
- Review and evaluate the recommendations of the UCLA evaluation of the substance abuse treatment program.

FINDING 2

The Office of the Inspector General found serious deficiencies in the medical care provided to inmates at the Substance Abuse Treatment Facility and State Prison at Corcoran, placing the health of inmates and staff at risk and exposing the State to possible legal action.

The Office of the Inspector General found serious and pervasive deficiencies in the medical services provided at the California Substance Abuse Treatment Facility and State Prison, Corcoran, affecting virtually every aspect of the institution's medical care system. The problems reflect the failure of management to monitor the quality of care provided at the institution and to ensure that the medical services provided meet licensing requirements and conform to state law and regulations.

As a result of the lack of supervision, and despite the fact that they are paid to work a 40-hour a week schedule, the seven staff physicians work short hours and see only a small number of patients each week. One doctor sleeps in his office during working hours. Another routinely tracks his investments during work hours. Inmates with medical appointments are consistently turned away and told to come back another day because doctors have stopped seeing patients early. When doctors do see patients, for the most part they confine treatment to prescribing medication and performing minor procedures, while referring most other cases to contracted medical specialists. In fiscal year 2001-02, the high number of referrals to outside specialists contributed to a cost overrun at the institution for contracted medical services of $5,029,575 — an overage of 81 percent. Meanwhile, inmates referred to a specialist may wait as long as six months for treatment. Delays in receiving medical care cause some inmates to end up in the emergency room or to otherwise undergo more expensive medical treatment later. Nurses do not consistently take patients' vital signs during clinic visits and the medical staff does not keep medication records up to date, leaving physicians without adequate information to make diagnoses and prescribe treatment. Doctors sometimes write prescriptions without the benefit of up-to-date medical records and sometimes without even seeing the patient. No one monitors

when doctors arrive and leave or how many patients they see a day; no one reviews a doctor's medical diagnoses and treatment; and no one checks patient medical files to verify that entries made by doctors are accurate and complete. Likewise, neither the nursing manager nor the nursing supervisors provide direct supervision of the nursing staff. No one monitors nurses' schedules and there are no sign-in and sign-out sheets to document arrivals and departures; there is no effective means of ensuring that inmates receive prescribed medication and no effective system to ensure that records showing what medications inmates have received are up to date.

The deficiencies extend to every other area of the medical care program. The radiology department is backlogged six months with orders for x-rays and magnetic resonance images. The medical records unit is six months behind in filing vital documents into inmate medical records, including inmate medication administration records, laboratory results, doctor's referrals, and disability verification forms. The medical records system in general is inadequate and inefficient, with the result that doctors and nurses lack ready access to patient files. Medical technical assistants, often the only members of the nursing staff assigned to housing facility clinics, are pressed into making triage decisions without consulting physicians or registered nurses about whether inmates need to examined by doctors, even though they are neither licensed nor trained to make such judgments. And the institution's inmate appeal system is flooded with appeals relating to medical care, with the problem compounded by a lack of diligence on the part of physicians in responding to the appeals, causing still more appeals to be filed.

Regulatory requirements for inmate medical care. State regulations set out in the *California Code of Regulations* require state correctional institutions to provide specified medical services to inmates, including physician services, psychiatric care, psychological services, nursing services, pharmaceutical services and dental care. To obtain medical care, inmates are supposed to submit a request to be seen by a doctor or go to the housing facility medical clinic during "sick call" hours. At sick call, a nurse determines whether the inmate needs to be seen by a doctor and, if so, whether they should see the doctor that day during clinic hours, also known as "doctor's lines," or be scheduled for the doctor's line on a subsequent day. The regulations also require institutions to provide necessary medical services to inmates, which are defined as those reasonable and necessary to protect life, prevent significant illness or disability, or to alleviate severe pain.

The audit revealed that not only has the institution been seriously lacking in meeting those requirements, but that in numerous areas deficiencies in medical services continually risk inmate health and sometimes have resulted in serious consequences for both staff and inmates. In reviewing available medical records, for example, [redacted]. In a fourth incident, also described below, inmates and staff were exposed to tuberculosis because the medical staff failed to isolate an inmate who, months earlier, had tested positive for the disease. Specifically, the Office of the Inspector General found the following:

[redacted]

[redacted]

- [redacted]

- In August 2000 an inmate tested positive for tuberculosis and began receiving tuberculosis medication, but stopped taking the medication prematurely without the knowledge of key medical staff. A chest x-ray confirming an abnormal lung condition was not performed until April 2001. Although medical documents indicate that a staff physician was notified of the results at that time, another seven months passed before the inmate was confirmed to have active tuberculosis, the custody staff was alerted, and the inmate was isolated from other inmates. As a consequence, numerous inmates and employees were exposed to tuberculosis. Two correctional officers and an inmate who had had contact with the infected inmate subsequently tested positive for the disease.

Following are specific deficiencies identified by the Office of the Inspector General in the medical care system at the Substance Abuse Treatment Center and State Prison, Corcoran, extending through physician practices, nursing services, pharmacy procedures, dispensing of medication to inmates, care of chronically ill patients, and other aspects of institution operations.

Inmates do not have reliable access to doctors. Staff physicians hold "doctors' lines"—clinics set up at the housing units for the purpose of seeing inmates with medical appointments and those identified during sick call as needing to see a doctor—for about three hours a day, four days a week. As a result, doctors are available to the population of 6,200 inmates for only about 12 hours a week. Often doctors' lines end early in the day even if inmates with scheduled appointments have not yet been seen. The Office of the Inspector General observed instances in which doctors' lines ended during the lunch hour even though as many as five inmates with scheduled appointments had to be turned away. Inmates whose appointments are cancelled have to be re-scheduled, delaying diagnosis and treatment and sometimes resulting in trips to the emergency room or the necessity for the patient to undergo more expensive medical treatment later.

Doctors routinely leave the institution early and do not work required hours. Doctors at the institution are allowed to work a four-day, 10-hour-a-day schedule, for which they are paid annual salaries of between $96,000 and $127,800, but management does not monitor when they arrive and leave. In fact, doctors routinely leave early, lessening the already-limited accessibility of medical care to inmates and putting the inmate population further at risk. The Office of the

Inspector General observed doctors regularly arriving at their offices between 7:30 and 8 a.m., leaving their offices between 8:30 and 9 a.m. to conduct doctors' lines at facility clinics until 11 a.m. or noon, returning to their offices by 1 p.m., and leaving the institution before 4 p.m.— falling far short of the required 40-hour work week. Because the full-time doctors on the staff work a four-day-a-week schedule and other doctors work only part-time, only about five or six are present at the institution on any given weekday. When doctors leave early, the number may be reduced to two or three for the institution's 6,200 inmates. On holidays and weekends and between 4 p.m. and 7 a.m. on weekdays there are no doctors at the institution. During those hours, an on-call doctor handles emergencies over the telephone or comes to the institution, or inmates are transported to the local community hospital for treatment.

Some doctors see few patients a day and engage in personal activities during work hours. The institution medical management does not specify how many patients doctors must see each day, leaving that determination to the doctors themselves. The result is wide disparity in the number of inmates seen by each doctor. While some doctors see more than 20 inmates each day, one in particular sees as few as four patients a day. On at least six occasions, the Office of the Inspector General observed that doctor sleeping in his office during working hours. On another five occasions, the Office of the Inspector General observed a second doctor tracking his investments during working hours.

Doctors refer most patients to specialists rather than performing even routine procedures. Doctors at the institution mostly limit themselves to prescribing medication and performing minor medical procedures, while referring inmates to outside specialists for everything else, including minor skin problems, arthritic conditions, broken bones, and minor surgeries that the correctional treatment center at the institution is equipped to handle. In fiscal year 2001-02, the institution's seven physicians together performed only 149 mostly minor procedures, including 88 sutured lacerations, 26 lanced abscesses or removed cysts, 19 in-grown or abscessed toenails and fingernails, and 16 other minor procedures. In sum, for the entire year, each physician performed an average of fewer than 22 minor medical procedures—about 2.01 procedures per month per physician. According to the medical staff, staff doctors prefer to send patients to specialists in part because of concerns about being sued for malpractice. In fiscal year 2001-02, the high number of referrals of inmates to outside specialists contributed to a cost overrun for contracted medical services at the institution of $5,029,575 against the original budget — an overage of 81 percent.

Specialist clinics are backlogged, resulting in long waits for inmates to see specialists. Inmates referred to specialists by staff physicians face waits of several weeks for urology and audiology and as long as six months for orthotics, orthopedics, and surgery. Contracts with external medical providers and specialists restrict the number of specialist clinics held each year, with urology, orthotic, and podiatry clinics held about once a month and orthopedic, opthamology, and surgery clinics held every other week. As a further complication, scheduled specialist clinics are frequently cancelled for one reason or another, delaying medical services to inmates still more. During the period from January to June 2002, 29 of the 114 medical specialist clinics scheduled at the institution—about 25 percent—were cancelled. In some instances, the cancellations resulted from lockdowns related to disciplinary actions or to weather conditions, but in other cases the cancellation was the fault of the institution. For example, some specialist

clinics were cancelled because the medical staff failed to notify specialists of the clinic dates or of changes to the dates, or because the medical staff failed to notify the custody staff about the inmates scheduled for the clinic, with the result that inmates were not brought to the clinic for appointments. In other cases, specialists or other medical entities cancelled the clinics because they had not been paid for previous services. In one such example that occurred during the audit fieldwork, a scheduled visit from a portable medical resonance imaging unit was cancelled because of delinquent payments for billings.

At the time of the audit by the Office of the Inspector General in April and May 2002, the surgery clinic was backlogged to November 2001 with more than 100 referrals; the orthopedics clinic was backlogged to July 2001; and the orthotics clinic was backlogged to October 2001, with more than 100 referrals outstanding. Nor are inmates on the waiting list necessarily scheduled for the specialist clinics according to the urgency of the referral or even in chronological order. The Office of the Inspector General found instead that the institution has no systematic method of establishing priority for the specialist clinic referrals.

Delays in specialist care may result in permanent damage. An inmate who was injured in a December 2001 fall was delayed in receiving x-rays and the services of an orthopedic specialist, with the result that on March 18, 2002, a doctor noted that the inmate now has a deformed finger on the left hand and restricted motion in the right knee. Another inmate, who waited more than three months for an appointment with a contracted neurosurgeon, told the Office of the Inspector General that according to the surgeon, the delay caused the damage to his spine to become permanent and that his condition will continue to deteriorate. The inmate's medical documents are consistent with his statements.

Because of delays in seeing a doctor, inmates often end up in emergency rooms. Inmates who do not succeed in seeing a doctor during doctors' lines can ask to be taken to the correctional treatment center emergency room, but the Office of the Inspector General found from reviewing inmate files that nearly all who went to the emergency room at the institution were returned to their housing units with instructions to report to the next available doctors' lines. In two such instances noted by the Office of the Inspector General, inmates instructed to return to their housing units had to be transported to local hospitals for emergency treatment within hours of being denied care at the correctional treatment center emergency room.

Doctors sometimes write prescriptions without seeing the patient. A review by the Office of the Inspector General of the medical files of 13 inmates who were receiving medication for seizure disorders revealed that prescriptions for seven of the inmates had been renewed even though the files contained no evidence that the doctor had first examined the inmate to review his medical condition. Only two of the 13 files contained documentation of the effect of the medication on the patient. In another example, the Office of the Inspector General noted that an inmate with asthma had received five prescriptions for the asthma medication *theophylline* covering a period of more than a year, even though the inmate's medical files contained no physician's notes or other documentation that he was seen by a doctor during that period.

Institution doctors write an unnecessarily large number of prescriptions. Doctors at the institution write large numbers of new prescriptions each day. At the time of the audit, the eight

physicians at the institution were writing an average of 110 orders a day for medication prescriptions for the institution's 6,200 inmates, many of them for over-the-counter medications such as antacids and skin creams. The 110 daily orders do not include automatic refills for prescriptions written earlier, which brought the total number of prescriptions processed every workday by the pharmacy to approximately 800 at the time of the audit and to about 1,000 prescriptions a day by the end of the audit fieldwork According to the institution's health care manager, the large volume results from doctors often writing prescriptions simply to placate inmates without providing thorough diagnoses and sometimes without even seeing the patient. The excessive number of prescriptions overburdens the institution pharmacy and contributes to budget overruns for drugs and pharmaceutical supplies,

Doctors' prescriptions contain a high number of errors. In reviewing doctor's orders written by institution physicians during January and February 2002 the Office of the Inspector General found 91 errors in prescriptions for medications ranging from aspirin to *Prozac, nitroglycerin,* and *Baclofan.* The most common errors consisted of the omission of vital information, such as the patient's identification, the medication dosage or frequency, or the doctor's signature. In many cases, the dosage ordered by the physician exceeded the manufacturer's recommended daily maximum. The errors require the pharmacy to request clarification from the doctor, delaying the delivery of medication to the inmate.

Nurses do not consistently take necessary vital signs, compromising patient diagnoses. During doctors' lines, nurses do not consistently take patients' vital signs or when they do, may measure only weight and blood pressure while neglecting to take needed specimens or to measure heart rate, temperature, or, in the case of diabetics, blood sugar. The Office of the Inspector General found from reviewing the medical file of a patient with a seizure condition, for example, that a specialist noted that blood work and other tests would have to be performed by an outside hospital because no vital sign measurements or laboratory work had been performed at the institution.

Nurses do not keep inmate medication records up to date. *California Code of Regulations,* Title 22, Sections 79805 and 79635 require that inmate health records include dated and signed health care notes, including copies of signed and dated medication administration records completed by the nursing staff showing the type, dosage, and time of all medications administered, the method by which the medication was administered, and site of injection if the medication was administered other than orally. The Office of the Inspector General found, however, that nurses at the institution do not complete the medication administration records in a timely fashion, resulting in long delays in filing the documents into inmate health records. Nurses do not complete medication administration records at the time the medication is delivered to inmates and often do not complete them for hours or even days after the medication is dispensed. The Office of the Inspector General found stacks of medication administration records in a box separate from the corresponding patient files months after they had been prepared. The medication administration records themselves also appeared to contain questionable documentation, including redundant entries, records of apparently duplicative medication doses and entries that apparently were made long after the medication was administered. Those failures render inmate medication records unreliable, making it difficult to determine what medication an inmate has received or whether he has received the medications doctors have prescribed.

Nursing staff does not check medication deliveries. Nurses at the housing facility medical clinics do not check the accuracy and completeness of medication deliveries from the institution pharmacy to detect mistakes in delivery or missing medication. When bags containing medication arrive at the clinics from the pharmacy each day, the nursing staff simply signs for the bags and begins delivering the medication to the inmates without conducting an inventory of the medication received or determining whether all medications needed for the inmates are contained in the bags. During the audit fieldwork, the institution pharmacist instituted a labeling system to provide confirmation that orders leaving the pharmacy arrived at the housing facilities, but the system ensures only that a package purporting to contain prescriptions for several inmates arrived at the facility. The nursing staff does not independently verify that the quantity and types of medication in the packages match the accompanying labels.

Nursing staff shortages. The institution has been unable to fill 13 of its nursing positions—more than a third of the 38.6 registered nurse positions currently budgeted for the institution. Even with up to 13 additional temporary nurses contracted through medical registries, the shortage leaves the institution with too few nurses to adequately cover all nursing functions. As a result, housing facility clinics are staffed by only one nurse, or in some instances by only a medical technical assistant. Because the nursing staff has other assigned duties to perform, daily sick calls are held for only 60-90 minutes four days a week, and in the absence of a nurse, may be handled by a medical technical assistant.

Nurses are not adequately supervised. Because of the shortage of nurses at the institution, nursing supervisors are called upon to perform routine nursing duties at the expense of providing necessary supervision to the nursing staff. Neither the nursing manager nor the nursing supervisors provide direct supervision of nurses, and there are no sign-in or sign-out sheets to document nurses' arrival and departure times. The lack of supervision creates the potential for nurses to arrive late or to leave the institution before the end of a scheduled shift and contributes to problems described elsewhere in the report, such as the failure of nurses to adequately check patients' vital signs and to keep patient medication records up to date, and, in general, for lack of compliance with required procedures.

Registry nurses lack sufficient training in correctional institution nursing care. The director of nursing told the Office of the Inspector General that the registry nurses at the institution—who make up as much as 33 percent of the registered nursing staff — do not receive adequate institutional training. At most, registry nurses receive only a three-day orientation, which she said does not sufficiently prepare them for interacting with inmates, responding to inmate fighting, safeguarding supplies and instruments, and understanding and applying department policies and procedures. As a result, most of the training takes the form of on-the-job training with a nursing peer, but because of the nursing shortage, even that training may not occur.

Required audits and reviews of nursing services are not performed. The *Substance Abuse Treatment Facility Correctional Treatment Center Policy and Procedures Manual* requires the institution nursing director to evaluate the quality of nursing care provided at the institution by randomly selecting and auditing patient charts and care plans on a quarterly basis. The Office of the Inspector General found no evidence that any of the required audits had been completed from the time the institution was activated in August 1997 up to the time of the audit fieldwork. The

director of nursing and the nursing supervisors at the institution acknowledged in discussions with the Office of the Inspector General that the nursing supervisors do not ensure that required audits and reviews of the nursing staff take place, although toward the end of the audit fieldwork, the director of nursing began a review of the direct-observed therapy.

Medical technical assistants may work beyond licensing limits. When medical technical assistants are the only members of the nursing staff present during sick call hours, they are obliged to carry out triage assessments to determine whether inmates need to be referred to doctors—a function their licenses do not allow them to perform. The same is true when medical technical assistants are the only members of the nursing staff assigned to a housing facility clinic and they are called upon to make medical judgments they are not trained or licensed to make.

Shortage of medical technical assistants. The institution is presently short 11 of the 31 medical technical assistants budgeted for the institution. Five of the positions are vacant; three medical technical assistants are out on long-term sick leave, principally for stress-related problems; and the remaining three are out because they were walked off the institution grounds because of charges of drug theft or other illegal or improper activities and are awaiting possible disciplinary action. Although registry staff can be used to fill the gap temporarily, none of the six positions related to sick leave or disciplinary problems can be permanently filled until the issues are resolved or those on sick leave return to work. The shortage of medical technical assistants worsens the effect of the institution's nursing shortage in that medical technical assistants perform many of the functions that nurses perform.

Poor coordination of medical services. In a survey conducted by the Office of the Inspector General of the institution medical staff, more than half of the respondents reported that communication in the medical department is so deficient as to preclude adequate medical treatment. The audit revealed a number of examples of the communication problems both within the medical department and between the medical department and other areas of institution operation. For example, the Office of the Inspector General noted that patient files included repeated requests for x-ray services because initial requests had received no response, even though many such requests were designated high priority. The incident described earlier in which staff and inmates were exposed to tuberculosis because the medical staff failed to coordinate information between various medical units and did not notify the custody staff of an inmate's diagnosis and the need for the patient to be isolated provides another example of a communication lapse. The failure of the staff to notify all affected parties of re-scheduled or cancelled specialist clinics provides still another example.

Radiology services are backlogged more than four months. As of April 3, 2002, the institution's senior radiology technician was backlogged with doctors' orders for approximately 60 magnetic resonance images dating back to November 2001 and for more than 200 x-rays dating back to October 2001. The Office of the Inspector General found no evidence of a systematic means of tracking the status of magnetic resonance imaging and x-rays or of prioritizing orders based on urgency. On several occasions during the audit, the Office of the Inspector General also observed that the technician was inexplicably absent from the radiology facility or had left the institution before the end of scheduled working hours with no evidence of approval from his supervisor or management.

Radiology services are out of compliance with regulations. *California Code of Regulations,* Title 22, Section 70715 requires that a physician have overall responsibility for radiological services. The physician is required to be certified or eligible for certification by the American Osteopathic Board of Radiology. But the Substance Abuse Treatment Facility and State Prison at Corcoran has not had a physician certified and performing in this capacity since January 2001.

Inmate medical records are months out of date. The medical records unit at the correctional treatment center is months behind in filing critical medical information into inmate medical files, impairing diagnosis and treatment, delaying reports of laboratory and test results, and raising the possibility of lapses and duplication in administering medication or of different doctors prescribing incompatible medications. In one case, for example, the Office of the Inspector General found a doctor's order for the drug *cordarone* for a chronically ill inmate who was also on *digoxin* as part of a cardiac regimen, even though an institution pharmacist noted that adding *cordarone* to the regimen could increase *digoxin* levels by as much as 70 percent and cause heart problems. In May 2002, the Office of the Inspector General found large volumes of documents waiting to be filed into inmate medical files, including boxes of documents dating back to October 2001. The unfiled material included information vital to the accurate portrayal of inmates' current medical needs and conditions, including doctors' referrals, medical chronologies, medication records, laboratory results, and disability verification forms. The Office of the Inspector General also noted that some of the documents that had been filed were filed incorrectly. In May 2002, the institution health care manager said that he is aware of the filing problems but has no plan for correction other than using staff overtime.

Inmate medical records are not readily accessible to the medical staff. The institution lacks either an automated online medical records system or an adequate manual medical records system to allow medical staff ready access to inmate medical records. Nor is there a medical file management system to identify inmates requiring follow-up appointments or to ensure that requests and orders for medical procedures are fulfilled. Instead, medical records are maintained in an inefficient and inadequate manual system and are secured in the central medical records unit. On the day before a medical clinic, the staff requests medical files for all inmates scheduled to be seen at the clinic. But on the day of the clinic, doctors arrive at the same time as the inmates and immediately begin seeing patients, giving them no opportunity to review the medical files, which in some cases comprise several volumes. The files remain in the clinic during the day to allow nurses to note the doctors' orders, requests for medication, follow-up appointments, or specialist referrals, but again, without a tracking system to monitor those requests and orders. The files are returned to the medical records unit at the end of each clinic day, but are unavailable to doctors examining patients on sick call or at the correctional treatment center emergency room after normal business hours. In such circumstances, doctors may delay seeing the inmate until he can be seen with his medical file, or may diagnose and treat inmates as if the patient is being seen for the first time, relying on their own observations or on the inmate's requests for medication, rather than on complete medical histories. In one such case, for example, the Office of the Inspector General found that a doctor wrote a prescription for *phenobarbitol* for an inmate with a history of seizures, even though the doctor noted that he did not have the inmate's medical file when he wrote the prescription.

Medical care for chronically ill inmates is inadequate. Health Care Services Division guidelines for the care of chronically ill inmates require patients whose disease process is not under control to be monitored at least monthly and to be seen more frequently if a physician determines that more frequent monitoring is necessary. Patients whose disease process is under control can be seen every six months if data gathered by physicians on two consecutive visits with the patient show that the program of continuing care has the disease process under control. Although these guidelines and a formal chronic care program have not been implemented at the institution, the medical staff is still required to ensure that inmates with chronic medical conditions are periodically examined and evaluated, have periodic laboratory tests performed, and continuously receive appropriate medication.

The Office of the Inspector General found that the institution is not fulfilling those requirements and is not providing adequate care to chronically ill inmates. Both the regional health care administrator for the Health Care Services Division and the institution health care manager acknowledged in discussions with the Office of the Inspector General that the institution has no systematic continuing care program for chronically ill inmates and that the absence of such a program puts inmates' health at risk. Toward the end of the audit fieldwork, the regional health care administrator and the institution's medical management began implementing an automatic prescription refill program and a specialized inmate identification card system through the pharmacy for chronically ill inmates on life-sustaining medications, but the effectiveness of those measures has not yet been evaluated.

Examples of the deficiencies in chronic care identified in the audit:

- ***Chronically ill inmates are not adequately monitored.*** A review of the medical files of 23 chronically ill inmates—10 inmates with asthma and 13 inmates suffering from chronic seizures—revealed that none of the asthmatic inmates had been monitored through regular medical appointments. In five of the 10 files reviewed, doctors had seen the inmates three times or less in the previous year and one inmate had been seen only once in 18 months. None of the files contained documentation to justify not scheduling periodic medical appointments. All 13 of the inmates reviewed with seizure disorders were receiving medication and therefore required regular monitoring, and 11 of the inmates had been receiving the medication for more than a year. Yet none of the files of the 11 inmates contained documentation that they had been seen regularly by a physician during that period. One of the 11 inmates had been receiving seizure medication since April 2001, but his medical file contained no record that he had been seen by a doctor during that time.

- ***Laboratory testing inadequate.*** All of the 10 asthmatic inmates reviewed were receiving asthma medication, but the medical files of only one contained laboratory results. Even though all of the inmates with seizure disorders were also on medication and most had had laboratory tests performed to evaluate the effect of medications, in some cases the laboratory testing was too infrequent to be of value. Laboratory testing for those inmates had been conducted at intervals ranging from one month to more than a year. In one case, laboratory testing had been significantly delayed—a doctor's order dated December 5, 2000 requested that laboratory tests be performed "within two weeks," but the work was not performed until March 28, 2001, almost four months later. Nor did it appear that where laboratory tests had

been conducted, the laboratory test results had influenced the medication prescriptions. Out of 29 laboratory results reported for the 13 inmates on seizure medication, only four laboratory results for two of the inmates indicated that the medication had been effective in controlling seizures. The remaining 25 results for the other 11 inmates indicated that the medication had not been effective, yet it appeared that the medication continued to be administered.

- ***Lapses in medication.*** Seven of the 10 inmates with asthma and six of the 13 inmates with seizure disorders had experienced gaps in medication because of delays in obtaining prescription refills at the institution. One inmate with asthma was deprived of medication for 30 days because of delays in having his prescription refilled, while another asthmatic inmate went without medication for three full months for the same reason. More than half of the chronically ill inmates covered in the review—seven of the 10 inmates with asthma and five of the 13 inmates with seizure disorders—had been sent to emergency rooms for treatment at least once, which may have resulted from lapses in medication. One inmate, whose asthma medication lapsed on August 1, 2001 and who obtained no refills until October 19, 2001, went to the emergency room with breathing problems on September 19, 2001. Another inmate, whose asthma medication ran out on October 20, 2001, complained to the doctor on November 2, 2001 and again on December 20, 2001 about not receiving the medication. Meanwhile, he was treated for breathing problems at the emergency room on October 27, 2001, November 24, 2001, and November 29, 2001.

- ***No chronic care for diabetics.*** The institution has no program of chronic care for diabetics—and, indeed, cannot even identify all of its diabetic inmates. The institution has no database of diabetic inmates and doctors do not monitor their conditions. Diabetic inmates who require regular tests to measure blood glucose levels must take the initiative of going to the window of the housing unit clinic for a "finger stick" test to determine the appropriate insulin dosage, after which the nursing staff administers the insulin shots. Those in confined housing must rely upon the nursing staff to come to them to administer the test and the insulin shots. The Office of the Inspector General also noted that the equipment for testing blood glucose levels may not be adequately maintained. The blood glucose meters used to determine the amount of insulin to inject are required under federal guidelines to be calibrated daily, but the audit revealed that daily calibration often is not performed.

Inmate appeals system inundated with appeals relating to problems with medical care. Deficiencies in medical care lead to large numbers of inmates filing appeals through the inmate appeal system, contributing to a backlog in the appeals system and impairing the ability of the institution to process appeals within required time limits. Overall, in calendar year 2000, 1,005 (16.2 percent) of the 6,197 inmate appeals filed at the institution concerned medical issues and in 2001, 998 appeals related to medical issues accounted for 14.8 percent of the 6,763 inmate appeals filed. Because the medical staff is slow in responding to inmate appeals, appeals related to medical issues also represent the majority of inmate appeals that fail to be completed on time. The Office of the Inspector General found from a review of 134 medically related appeals filed between November 1, 2000 and January 9, 2002 that 64 percent exceeded allowable time limits. In calendar year 2000, an average of 191 appeals were overdue each week, with 84 percent of the late appeals medically related. In calendar year 2001, an average of 123 appeals were overdue

each week, with 83 percent of them related to medical issues. In May 2002, 234 inmate appeals related to medical issues were overdue—accounting for 90.7 percent of all overdue appeals.

Americans with Disabilities Act requests are backlogged. More than 700 inmates at the institution—11 percent of the 6,200-inmate population—have been identified as having disabilities and as eligible for modification or reasonable accommodation under the Americans with Disabilities Act. But the institution is not adequately tracking Americans with Disabilities Act requests and is delinquent in ensuring that medical orders for accommodation are implemented. The delay results, for example, in wheelchair-bound inmates being placed in non-wheelchair-accessible housing units; inmates with housing tier or bunk restrictions being placed improperly; those needing special assistance such as sign-language interpretation, canes, or special mattresses, doing without the necessary aids; and those with mobility impairments not receiving needed personal hygiene supplies and equipment. The backlog in fulfilling Americans with Disabilities Act requests spills over to the already over-burdened inmate appeals system. In the fiscal year ended June 30, 2002, 282 inmate appeals related to the Americans with Disabilities Act requests were filed, and, at the time of the audit, a large percentage of them were overdue. The Office of the Inspector General found from a review of 66 Americans with Disabilities Act-related inmate appeals, that 42 (63.6 percent) were delinquent by an average of 19 days.

Medical committees not operating as required by licensing regulations. Department of Health Services licensing requirements for correctional treatment centers require institutions to establish specified medical committees and that these committees meet according to specified schedules. The purpose of the committees is to set management standards, policies, and procedures for the institution medical staff and to ensure compliance with Department of Health Services regulations and professional medical standards. The required committees include a medical executive committee, a credentialing committee, and a committee of the whole — all of which are required to meet quarterly — and a peer review committee, which is supposed to meet monthly.

The purpose of the credentialing committee is to ensure that members of the medical staff have the appropriate credentials for the functions they perform at the institution. The peer review committee is intended to ensure that the quality of the work performed by the medical staff meets required policies and procedures and appropriate medical standards. The purpose of the committee of the whole is to establish policy and procedures for physicians, psychiatrists, psychologists, dental services, nursing, pharmaceutical, dietetic services, and housekeeping, and is supposed to be comprised of the health care manager, the director of nursing, a pharmacist, and a representative from each of the services.

The medical executive committee has full legal authority and responsibility for the operation of the correctional treatment center and is to address issues arising from the other committees; promulgate appropriate by-laws; ensure that required positions such as chief of staff for medical services and secretary for emergency medical services are filled and that physicians-in-charge have been designated for radiology, laboratory services, outpatient surgical care, and standby emergency medical services; see that the certification requirement of the radiology physician-in-

charge is met; and ensure that the credentialing and peer review committees have committee chairs in place to make certain that the committees carry out their functions.

The Office of the Inspector General found that none of the committees at the institution are functioning as required. The committee of the whole meets only two or three times a year and does not regularly include a representative from pharmaceutical services. The medical executive committee last met in January 2000. And the institution has no credentialing committee and no peer review committee.

RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and the medical management of the California Substance Abuse Treatment Facility and State Prison at Corcoran take the following actions to improve medical services and operations:

- Develop a plan for re-activating medical operations at the institution. The plan should include the following: a component for recruiting, training, and retaining adequate professional staff; written department and institution-specific policies and procedures covering all areas of operation, including nursing; and provisions for regular on-site monitoring and assistance by the Health Care Services Division.
- Develop a plan to bring the institution's correctional treatment center into compliance with all licensing requirements. The institution medical management team should establish and staff all required committees and ensure that the committees meet as required. The medical management team should also ensure that the functions of the pharmacist-in-charge and the radiology physician are being performed.
- Obtain the resources to establish a management information system by which to track and monitor backlogs in pharmacy, radiology, medical records, specialist clinics, and medical appeals. The system should prioritize backlogged items according to urgency.
- Develop methods to reduce or eliminate backlogs without placing inmates at risk.
- Ensure that doctors work required hours and are fully productive during working hours.
- Review the number of hours scheduled for doctors' lines to ensure that enough time is scheduled to address inmate medical needs.
- Establish a quality control procedure to ensure that entries into inmate medical files are complete, accurate, and timely.
- Hold the medical staff responsible for completing administrative activities, including responding to inmate medical appeals, in a complete and timely manner.
- Foster effective communication and coordination of medical activities between medical and custody staff.

- Actively manage the medical function by establishing goals, setting priorities, defining expectations, and communicating these to the medical staff.
- Perform periodic audits and reviews of all medical activities, including nursing, to monitor compliance with policies, procedures, and regulations.
- Ensure that all staff members, including temporary nursing registry staff, are thoroughly trained in delivering health care in a custody environment.
- Provide resources to allow clinics to remain open for more hours per day and more days per week for sick call and doctors' lines to allow more inmates to receive care.
- Ensure that treatment in the emergency room meets minimum standards of care before inmates are released to housing facilities with instructions to return to facility doctors' lines.
- Establish an automated on-line medical records system to allow the medical staff access to inmate pharmaceutical records and medical histories. The system should also record and track follow-up appointments to ensure that these appointments occur.
- Review all medical procedures currently referred to contracted specialist clinics or outside providers in order to evaluate which of those procedures can be performed by institution doctors.
- Review current backlogs of cases referred to specialist clinics to assess the appropriateness of providing specialist clinics more often.
- Establish procedures and systems to ensure that all inmate requests for reasonable accommodation and medical verification of disabilities under the Americans with Disabilities Act are processed in a timely manner and that all appropriate accommodations or modifications are implemented without delay.
- Track pending actions on Americans with Disabilities Act requests to ensure completion within established time limits and follow up on medical chronologies or modifications to ensure that these are implemented without delay.
- Systematically identify inmates with chronic medical conditions and ensure that these inmates are monitored through regular appointments with institution doctors.
- Establish policies and procedures to require periodic laboratory work and measurement of vital signs for chronic care inmates. Ensure that this information is available to doctors at the time of examinations so they may adequately assess chronic medical conditions.

FINDING 3

The Office of the Inspector General found that pharmacy operations at the Substance Abuse Treatment Facility and State Prison at Corcoran are seriously deficient.

The Office of the Inspector General found that oversight of pharmacy operations at the institution is seriously deficient and that controls over drugs and medical supplies are lacking, resulting in widespread waste, [redacted] and large budget overruns. In fiscal year 2001-02, the pharmacy spent $5,367,156 for drugs and pharmaceutical supplies against an original budget of $1,726,500—an overrun of $3,640,656, or 211 percent — and a deficit is also projected for fiscal year 2002-03. [redacted]

Although a pharmacist from the adjacent California State Prison, Corcoran was subsequently designated as the "pharmacist-in-charge" at the institution and is scheduled to be at the institution on Tuesdays and Thursdays, in fact he is rarely on site. The Office of the Inspector General noted over a period of several months and confirmed through interviews with the pharmacy and medical staff, that the pharmacist visits the pharmacy only infrequently. In the absence of an on-site pharmacist, the pharmacy is run entirely by registry-hired contract employees who have a high-turnover rate and minimal training in prison pharmacy operations with no guidance from the Department of Corrections or the institution health care manager.

The Office of the Inspector General also found that the pharmacy lacks formal policies and does not comply with existing procedures governing pharmacy operations. *California Code of Regulations* Title 22 requires institutions to maintain specified controls over the procurement, storage, distribution, and disposal of medications, including physical restrictions on access to drugs and supplies through the use of locks on doors and drawers containing medications. In addition to guarding against theft, institution pharmacies must ensure that medications necessary to the physical and mental health of inmates are available promptly and in appropriate dosages. Pharmacies must also maintain accounting controls to ensure that prescriptions are processed and filled properly. But the pharmacy at the institution's correctional treatment center does not comply with these requirements and the staff was unable to produce written policies and procedures consistent with *California Code of Regulations,* Title 22 governing pharmacy operations.

Specifically, the audit of pharmacy operations revealed the following:

- ***Pharmacy's tracking system is inadequate to handle the large number of prescriptions.*** The large number of prescriptions processed by the pharmacy each day far exceeds the capacity of the pharmacy's existing system to handle the load. At the time of the audit, the institution pharmacy was filling an average of 800 prescriptions daily. Soon after the audit fieldwork was completed, the average climbed to almost 1,000 prescriptions per day. The pharmacy lacks an automated system to carry out the process and is not tied to a centralized computer database of inmate records. Instead, the pharmacy relies on an inadequate manual system to process prescriptions. One result is that the pharmacy may continue to refill prescriptions for inmates long after they have been paroled, with the medication later discarded when it cannot be delivered. The Office of the Inspector General found that in one case, for example, the pharmacy processed a prescription for an inmate who had been paroled eight months earlier. The audit revealed a host of other problems. Examples:

- ***Prescription records not matched to doctors' orders.*** The pharmacy has no means of matching doctors' orders to a record of prescriptions filled by the pharmacy and does not maintain a system intended to account for narcotic drugs. As a result, the pharmacy cannot ascertain whether all filled prescriptions were properly authorized by a doctor, whether medications were dispensed without a doctor's order, whether legitimate orders were filled or not filled, whether inmates are receiving appropriate medications or are receiving them in a timely manner, or whether narcotics or other drugs have been stolen. When inmates complain that they have not received prescribed medications, the pharmacy and medical staff simply reorder the "missing" medications rather than to try to determine from the system whether the claim is legitimate, often resulting in duplicate orders and additional staff time and expense.

- ***Pharmacy sometimes fills prescriptions incorrectly.*** In a review of prescriptions, the Office of the Inspector General found at least seven instances in which the pharmacy staff had erred in filling prescriptions. Common errors included prescriptions filled with medications other than those prescribed, medications with dosages or frequencies different from those specified in the prescription, and medications with expired dates. In one example, an inmate who routinely receives *levothyroxine* and *cytomel* for a thyroid condition also received *hydrochlorothiazide,* although the file contained no doctor's order prescribing the latter medication and the medical staff could not explain why the pharmacy issued the medication. The pharmacy has no review process or other quality control procedures to ensure that prescriptions are filled correctly, and interviews with the medical staff confirmed that under the current system, no one independently verifies that prescriptions are filled properly.

- ***When inmates transfer, medication cannot be forwarded and instead is discarded.*** Because the institution lacks a tracking system, when inmates are transferred to another housing unit at the institution, the pharmacy is not informed of the transfer and the institution has no formal procedure for forwarding medication to the new housing unit. As a result, inmates who transfer do not receive the medication previously prescribed for them. Instead, the medication is delivered to the inmate's former housing assignment, where it is considered unclaimed, and, if it cannot be returned to pharmacy stock, is discarded. During the audit fieldwork, the Office of the Inspector General saw the institution staff disposing of numerous 30-gallon bags of medication for that reason.

- [redacted]***Pharmacy door unlocked.*** Despite the potential for theft of drugs and other critical items from the institution pharmacy, the Office of the Inspector General noted during the audit that the door to the pharmacy was often unlocked and that on at least one occasion the pharmacy was completely unattended. The pharmacy door opens to a hallway frequented by inmate porters, institution employees, and registry-hired employees. When the Office of the Inspector General informed the pharmacist about the unlocked door, he appeared to ignore the warning. During the audit fieldwork, [redacted]

RECOMMENDATIONS

The Office of the Inspector General recommends that the medical management team at the institution take the following actions to improve administrative controls over pharmacy operations:

- Develop written institution policies and procedures, consistent with Title 22 of the *California Code of Regulations,* governing the institution's pharmacy operations and comply with existing department policies and procedures. The institution policies and procedures should include the physical controls and accounting controls necessary to correct the problems identified by this audit.
- Consider implementing an automated barcode system for tracking the inventory and movement of pharmaceutical products within the institution. Bar-coding improves accuracy in identifying items and in determining quantities on hand, thus increasing efficiency by reducing the staff time required to prepare replenishment orders.
- Develop a systematic means of transferring inmate medications when inmates change housing assignments at the institution.
- Staff the pharmacy with full-time employees hired by the Department of Corrections in order to minimize the turnover in those positions and enhance the quality of service.
- Ensure that the current pharmacist-in-charge is present at the pharmacy as required until a permanent pharmacist-in-charge can be hired.
- Develop management information systems, on-site monitoring methods, and management reports to more directly monitor pharmacy operations.

FINDING 4

The Office of the Inspector General found that the dental care program at the Substance Abuse Treatment Facility and State Prison, Corcoran is seriously deficient and that inmates are not receiving dental services required under state regulations.

By the chief dental officer's own admission, dental services at the California Substance Abuse Treatment Facility and State Prison at Corcoran, are disorganized and operate in a crisis mode, with poor continuity of care, little preventive dentistry, and low productivity. Although state regulations require that all state prison inmates receive regular dental examinations, the institution does not comply with the requirement and under its present procedures, has no means of doing so, in that it has no computerized system for tracking dental services provided to inmates. Like the staff physicians, the five full-time and two part-time dentists at the institution do not work the hours they are paid for—and as a result, inmates wait months for a dental appointment and may be transferred or paroled before they ever see a dentist. Dental clinics, which serve as the inmates' primary access to dental care, are held only three or four mornings a week, closing down right after lunch even though inmates with appointments may still be waiting to be seen. Inmates who have an urgent dental problem may be able to see a dentist

without a clinic appointment by going through sick call — but if they do, the dentist will have to provide treatment without seeing the inmate's medical records because unless an inmate has an appointment, the records are secured in the correctional treatment center away from the housing facilities. In many cases, by the time an inmate sees a dentist, the problem has become too severe for the tooth to be saved, with the predictable result that the institution dentists pull as many teeth as they fix and in fact spend more time on denture work than on any other type of dental procedures.

Management deficiencies. Responsibility for the deficiencies in the dental program rests with the institution's dental management—the chief dental officer and health care manager—as well as with the California Department of Corrections Health Care Services Division. Neither the chief dental officer nor the health care manager has established appropriate policies and procedures governing dental services at the institution or set standards of dental care. The chief dental officer acknowledges that the policies and procedures that do exist are outdated. He also admits that he does not attempt to supervise the eight dentists on the staff, monitor when they come and go, or review the quality of the dental care they provide to inmates.

The Department of Corrections and its Health Care Services Division have been similarly inattentive. The department has no chief of dental services, leaving dentistry as the only health care profession not represented at headquarters — a deficiency cited by a recent department task force on the delivery of dental care, which noted in an April 2002 report that dentistry has been ignored by the department. The department has also failed to issue regulations bringing institution dental services into compliance with *California Code of Regulations* Title 15 requirements for routine dental examinations. The *California Department of Corrections Operations Manual* provides instead that the level of dental treatment provided is subject to availability of funds, facilities, and staff. Nor has the department reviewed the institution's dental program since the institution became operational in 1997.

Regulatory requirements governing dental services to inmates not met. *California Code of Regulations,* Title 15, Section 3355.1 requires every inmate to receive a complete dental examination resulting in an individual treatment plan within 14 days of arrival at an assigned facility from a reception center. Title 15 also requires institutions to provide every inmate under the age of 50 with a dental examination at least once every two years and every inmate over the age of 50 with a dental examination every year. But at the California Substance Abuse and Treatment Facility and State Prison at Corcoran, those examinations do not take place and individual treatment plans are nonexistent, as are preventive dental services and continuity of care.

In a random sample of 24 inmates under the age of 50, for example, the Office of the Inspector General found that 16 (67 percent) had not been seen by a dentist within the previous two years as required by Title 15, and that eight who had been at the institution for more than four years had received no dental services at all. Four of the 24 inmates in the sample had been seen for emergency dental treatment and the remaining four had received non-emergency dental treatment that they, rather than the institution, had initiated. Nine of the 24 had had teeth extracted at the institution.

Similarly, in a sample of 20 inmates over the age of 50, the Office of the Inspector General found that none had ever received an annual dental examination and that eight had never received dental services of any kind at the institution even though they had all been at the prison for more than three years. Of the remaining 12 inmates in the sample, nine had been seen for dental emergencies. Five of the 12 inmates who had received dental services had had teeth extracted and five had been seen for denture fittings or denture repairs.

Specific problems identified by the audit. The deficiencies of management are mirrored in the problems revealed by the present audit. Specifically, the Office of the Inspector General found the following:

- ***Dentists work short hours and some maintain private practices on the side.*** The five full-time staff dentists are paid between $90,000 and $116,000 a year to work a 40-hour week on a four-day-a-week, 10-hour-a-day schedule and the two part-time staff dentists are paid to work two 10-hour days a week, but they actually work much less than that. The Office of the Inspector General found that dentists routinely arrive at the institution between 7:30 and 8 a.m. and leave by 2 p.m., having put in less than six of the 10 hours for which they are paid — for a total work week of about 22 hours. The chief dental officer at the institution confirmed that the dentists have usually left the institution by 2 p.m., although he also said that he does not attempt to monitor or document when they come and go. The Office of the Inspector General also found and the chief dental officer again confirmed that at least one and possibly two of the dentists on the staff maintain private dental practices in the local community despite holding full-time positions at the institution. Both of the part-time dentists on the staff also maintain private practices.

- ***Clinics are open only a few hours a week regardless of how many inmates need to be seen.*** To obtain dental services, inmates must request a dental clinic appointment by submitting a request to see a dentist during the housing facility sick call. At that time, a dental technician determines whether the inmate in fact needs to be seen by a dentist, and if so, makes an appointment for the inmate to be examined by a dentist during one of the scheduled dental clinics. But sick call and dental clinics are held only three or four days a week beginning at 8 a.m., and the dental staff closes the clinics no later than 1:30 p.m., even though inmates with appointments may still be waiting to be seen. The Office of the Inspector General noted instances in which as many as six inmates with scheduled appointments were still waiting to see the dentist when the clinic closed. Overall, the clinics are open less than 20 hours a week, with access to dental care for inmates limited to those hours unless they are sent to the correctional treatment center emergency room.

- ***Dentists see only a small number of patients at each scheduled clinic.*** During the two-month period of the audit, the Office of the Inspector General found that two of the institution dentists consistently saw fewer than six inmates during a scheduled 10-hour work day, mostly for routine dental procedures, while the other dentists averaged 10-15 inmates per day. On some days, the two dentists with the lowest productivity saw as few as two patients each.

- ***Inmates wait months for a dental appointment and may never see a dentist.*** Because dental clinics are open only a few hours a week and dentists see no more than about 15 patients at

each clinic, and sometimes as few as two patients, the clinics have long waiting lists for dental appointments. As a result, inmates may wait more than five months to see a dentist. At the time of the audit, the dental clinic at one housing facility had a waiting list of 99 inmates, another had a waiting list of 217, and a third had a waiting list of 225. And because dentists treat only one dental problem at a time, inmates with more than one unrelated dental problem must start over at the bottom of the waiting list each time to have each problem treated separately, causing dental problems to worsen, often resulting in infections and more severely decayed teeth. If an inmate is transferred to another housing facility at the institution, he may lose his place on the waiting list and must go back through sick call to be rescheduled for an appointment at the new facility. Often inmates are paroled or transferred before ever receiving needed treatment. During the audit period, 85 inmates who had been on dental clinic waiting lists at the three housing facilities noted above left the institution without ever receiving treatment.

- ***A large proportion of the dental care consists of tooth extractions and denture work.*** Because of long delays in treatment of inmate dental problems and resultant worsening of the problems, institution dentists perform as many tooth extractions as they do restorative work such as fillings and crowns and spend more time on denture work than any other type of procedure. Of the inmates seen by staff dentists between January 2002 and March 2002, according to the institution's quarterly reports, 27 percent received fillings or crowns, while 26 percent had teeth extracted. During the same period, 30 percent were seen for fitting or repair of dentures.

- ***Dentists sometimes lack access to patient medical records when they provide treatment.*** When inmates with urgent needs for dental treatment are identified at sick call, they may be added to the list of inmates to be seen by the dentist during that day's clinic. But in such cases, the inmate's medical records are not available to the dentist providing treatment because medical records are kept secured in the correctional treatment center. On clinic days, only the records of inmates with scheduled appointments are brought to the clinics, and the medical records are not automated to allow computerized access.

- ***Dentists prescribe medication even when they cannot consult patient medical records.*** The Office of the Inspector General found from reviewing a sample of 44 patient records that institution dentists routinely prescribe antibiotic and anti-inflammatory medication to patients even in cases where the inmate's medical records are not available, as during sick call or emergency dental care——with the result that dentists cannot be certain whether the inmate is allergic to the medication or whether the medication would be incompatible with the inmate's medical condition or with other prescribed medications.

- ***Dentists do not provide follow-up care after prescribing medication.*** The review of the files also revealed that when dentists prescribe medication, they routinely do not schedule follow-up visits to determine whether the medication had adverse effects or addressed the inmate's problem. None of the files reviewed in the sample contained documentation that dentists had provided follow-up treatment to the inmates for whom they had prescribed medication.

- ***Dentists and dental assistants do not document medication provided to inmates.*** The Office of the Inspector General found from comparing clinic pharmacy logs to the medical records

of a sample of inmates, that dentists routinely provide inmates with medication from supplies kept on hand at the clinic pharmacy without documenting a diagnosis or recording on medication administration records that the medication was administered.

RECOMMENDATIONS

The Office of the Inspector General recommends that the Health Care Services Division take the following actions to improve dental services at the California Substance Abuse Treatment Facility and State Prison at Corcoran:

- Develop a plan for "re-activating" the dental operation at the institution. The plan should provide the dental function with the number of dental professionals necessary to provide a minimum standard of care consistent with Title 15 of the *California Code of Regulations*. The plan should also include detailed policies and procedures for the efficient delivery of dental services. To this end, the policies and procedures should include methods for ensuring that dentists examine inmates within 14 days of arrival at the institution and for developing individual treatment plans, based on regular examinations, within the framework of preventative dentistry.
- Improve communication with and support of the institution's dental function by:
    - Conducting scheduled and unannounced site visits to monitor and inspect dental operations.
    - Holding regular meetings with on-site managers to discuss issues of concern to both headquarters and on-site staff.
- Address and resolve the issue of institution dentists not reviewing or using the dental assessments completed by reception center dentists. Institution dentists should either use the screening as part of the continuum of care or the Health Care Services Division should eliminate the screening and its attendant costs.
- Obtain the resources to develop a management information and reporting system to monitor key indicators of the efficiency and effectiveness of the dental function. These indicators should include, but not be limited to, the following: backlogs in inmate requests for dental services at the various clinics; number of patients seen by dentists; number of patients examined (and not examined) within the 14-day limit established by Title 15; number of individual treatment plans developed; number of fillings and other preventive procedures compared to the number of extractions and denture procedures.
- Develop a strategy to eliminate the backlog within a reasonable period based on the urgency of each request.
- Hold the health care manager and the chief dental officer accountable for managing dental operations at the correctional treatment center, including the following: ensuring that dentists work appropriate hours and are fully productive during scheduled working hours; reviewing the number of hours scheduled for dental sick call and clinics to ensure sufficient time is allotted to address inmate dental problems; establishing a quality control

procedure to ensure that entries into inmate medical files are complete and accurate; ensuring that staff respond to inmate medical appeals in a complete and timely manner.

- Review the chief dental officer's duty statement and either require him to devote 40% of his time to clinic work or change the duty statement.
- Provide management training to the on-site dental management staff. The training should include: planning and goal setting; performance measurement; interpersonal communication; and principles of supervision.
- Require the health care manager and the chief dental officer to develop policies and procedures for local operation of dental services. These policies and procedures should include the following:
    - Longer and more frequent hours of clinic operations, and the posting of these hours in the facilities.
    - A system of accountability for the time worked by dentists, dental assistants, and other dental staff.
    - Alignment of the work schedules of dentists and dental assistants to maximize the efficiency of clinic operations.
    - Use of benchmarking and minimum standards of productivity for dental staff, including number of patients seen daily, weekly, and monthly by dentists.
    - Use of progressive discipline for employees who fail to comply with policies, procedures, and minimum productivity standards.

FINDING 5

The Office of the Inspector General found that a projected deficit of $8.4 million in the 2002-03 budget for the Substance Abuse Treatment Facility and State Prison, Corcoran could significantly affect institution operations.

A combination of departmental policy changes and institutional issues will leave the institution with a projected budget deficit of $8.4 million by the end of the 2002-03 fiscal year in a total budget of $141,593,401. In the 2001-02 fiscal year, the institution faced a $12 million deficit, which was subsequently covered by funding obtained through a Department of Corrections statewide deficiency request to the Legislature and through additional baseline funding contained in the May revision of the state budget. But a deficiency bill is authorized only for the year requested and does not adjust the baseline budget of the institution. The institution's projected deficit could affect its ability to pay for services and supplies and may cause contract personnel and vendors, who historically have been those most affected by budget deficits, to decline to provide services in the future. *California Government Code* Section 13324 also holds those who incur expenditures in excess of the fiscal year budget approved by the Department of Finance—in this case, the warden and the health care manager, who are responsible for managing the

institution's custody and health care budgets, respectively — liable both personally and on their official bond for the amount of excess expenditures.

The deficit results primarily from the following:

- ***Personnel services funding in the fiscal year 2002-03 budget.*** The department has imposed on all institutions a 15 percent salary savings requirement for custody operations, which includes all non-medical personnel. The requirement represents an increase from a 4.9 percent salary savings requirement in fiscal year 2001-02. The purpose, according to the department is to align institution budgets to the department's overall budget and to accommodate state budget cuts and personnel costs related to unbudgeted merit salary adjustments, unfunded promotions, and position reclassifications. But in fact, the institution cannot meet the 15 percent requirement without eliminating entire programs, such as education. The reason is that 62 percent of the institution's employees are assigned to custody positions that cannot be held vacant to achieve this level of savings. The chart below shows the percentage of custody positions in relation to the overall budget:

Description	Positions	Dollars	%
Custody*	940	50,014,696	62%
Non-Custody	566	27,173,449	38%
Total	**1,506**	**$77,188,145**	**100%**

*Correctional officers, sergeants and lieutenants

In addition, the majority of those in custody positions are correctional officers represented by bargaining unit 6. The unit 6 contract prohibits wardens from imposing a 15 percent salary savings, and in fact, the current negotiated institution vacancy plan for correctional officers achieves less than 3 percent in salary savings — far short of even last year's 4.9 percent requirement.

- ***Transportation costs for inmates needing dialysis.*** A departmental policy change in fiscal year 2001-02 required the institution to begin transporting inmates to a local hospital for dialysis treatment, making it necessary for the institution to hire additional transportation staff at an estimated cost in fiscal year 2002-03 of $530,659. At the time of the Office of the Inspector General's audit, no funding had been provided for this purpose.

- ***A 29 percent increase in sick leave costs.*** As a result of contract negotiations between the Department of Corrections and the California Correctional Peace Officers Association (Bargaining Unit 6), the institution is incurring high overtime costs for sick leave usage by custody staff. The negotiations eliminated language that pertained to the extraordinary use of sick leave by Bargaining Unit 6 employees. As a result, it is now more difficult for managers and supervisors of Unit 6 employees to oversee sick leave usage and to take corrective action against employees who use an excessive amount of sick leave. As a result, sick leave usage at the institution during fiscal year 2001-2002 increased 29 percent over the previous fiscal year, resulting in nearly $1 million in additional expenditures. The Department of

Corrections did not anticipate the impact of the change in the bargaining unit contract and did not request additional funding.

- ***Lack of adequate controls over expenditures for medical supplies and pharmaceuticals.*** In fiscal year 2001-02, the institution incurred a $3.7 million deficit as a result of costs for medical supplies and pharmaceuticals. Although the department was successful in obtaining baseline funding to cover the 2001-02 pharmaceutical deficit, unless the institution implements more stringent controls for monitoring and tracking medical supplies and pharmaceuticals, the deficits are likely to continue. The department is now projecting a deficit in pharmaceutical expenditures of $422,047 for fiscal year 2002-03, but because of the lack of internal controls contributing to both theft and over-prescribing of pharmaceuticals, as described in Finding 3 of this report, the deficit may be understated. At present the institution tracks only the cost of pharmaceuticals as a whole after orders are placed and has no data to determine what pharmaceuticals are driving excessive costs or to identify areas of waste.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the California Department of Corrections take the following actions to better manage the operating budgets of the institutions:

- Continue to request resources to address the issues driving deficits in the institutions.
- Prepare cost estimates of all changes to employee bargaining unit contracts before committing to changes in the contracts. Request additional funding to mitigate the effect of increased sick leave usage in future fiscal years.
- Provide institutions with adequate resources before initiating policy changes, such as designating an institution for dialysis treatment.
- Assist the institution in improving the control and monitoring of pharmaceuticals.

FINDING 6

The Office of the Inspector General found that a significant percentage of employees and managers of the Substance Abuse Treatment Facility and State Prison, Corcoran are not fulfilling annual training requirements.

California Department of Corrections regulations, set out in *California Department of Corrections Operations Manual,* Sections 32010.13 and 32010.14, require all non-custody employees of the department to complete 40 hours of training annually in a range of subjects, including emergency response, fire safety, escape prevention, accident prevention, and inmate-staff relations. Specified additional training is required for employees in designated classifications, and specific training is also required for managers and supervisors. Peace officers and others covered under the memorandum of understanding between the State of California and the California Correctional Peace Officers Association (Bargaining Unit 6) are required to

participate in 52 hours of annual training in subjects related to working in a custody environment—training commonly referred to as "7k" training. But the Office of the Inspector General found that employees and managers of the Substance Abuse Treatment Facility and State Prison at Corcoran are not consistently fulfilling those requirements and that neither supervisors nor the in-service training unit at the institution are monitoring to ensure that the requirements are met. The training deficiencies present a risk to both institution security and staff safety, as well as limiting opportunities for employees to gain needed skills and exposing the department to potential liability.

A review by the Office of the Inspector General of a sample of employee files revealed the following:

- Twenty-seven (22.3 percent) of a sample of 121 employees did not meet the minimum requirement of 40 hours of annual training. The employees failed to fulfill the 40-hour requirement by an average of 16 hours.

- Thirty-five (28.9 percent) of the sample of 121 employees did not attend mandatory training classes required for specific classifications, with the number of training classes not attended ranging from one to eight. For example, five custody employees, including the custody captain and the Investigative Services Unit lieutenant, did not attend annual firearms range training. Three facility captains did not complete baton and chemical agent training.

- A significant percentage of managers and supervisors had not completed specific manager and supervisor training courses. Sixteen (38.1 percent) of 42 managers and supervisors in the sample had not completed Supervisor Orientation, and seven (16.7 percent) had not completed Basic Supervision. Ten (40 percent) of 25 managers had not completed Advanced Supervision and the Management Training program.

- From January 2001 through February 2002, 211 custody employees failed to attend the required number of "7k" training hours. A total of 1,169 hours were missed. Although 148 employees missed four or fewer hours, others missed substantially more. Eight employees missed between 20 and 24 hours of training.

The deficiencies stem from the following:

- ***Inadequate monitoring of compliance.*** Neither employee supervisors nor the in-service training unit monitor employees' training throughout the year. The in-service training unit has no system in place for tracking the attendance of custody employees at "7k" training classes.

- ***Inadequate record keeping for individual employees.*** The in-service training unit does not maintain a complete and accurate record of each employee's training history.

- ***Lack of access to employees' previous training history.*** When employees transfer between institutions, neither the former nor the receiving institution reviews the employee's training records to determine whether they are complete, accurate, and up-to-date.

- ***The in-service training unit staff is relatively new.*** Employees and supervisors of the in-service training unit are new to the job. At the time of the audit, only one employee had been with the unit for more than a year and the manager and two supervisors were appointed to their positions between November 2001 and January 2002.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the management of the California Substance Abuse Training Facility and State Prison at Corcoran take the following actions to ensure that employees receive required training:

- The in-service training unit should periodically review each employee's training records to ensure that all employees meet departmental training requirements and should notify appropriate supervisors of instances of non-compliance. For those employees consistently not attending "7k" training, the in-service training unit should determine the cause of the employee's inability to attend and make training schedule adjustments if necessary.

- As a part of the annual performance evaluation process, supervisors should work with employees to include specific plans to meet training requirements for the following year.

- Develop a systematic means of acquiring the training records of newly arrived employees from the sending institution or agency.

FINDING 7

The Office of the Inspector General found that the Investigative Services Unit is not following proper procedures for the temporary storage of evidence.

The Office of the Inspector General found that the institution lacks adequate procedures for the temporary storage of evidence. The procedures currently in use do not satisfy chain of custody requirements or ensure that the evidence cannot be tampered with or contaminated.

For physical or forensic evidence to be admissible in court a "chain of custody" must be established proving that someone was responsible for and can testify to the security of the evidence from the time it was collected until the time it is presented to the court. The custody chain often includes a period of temporary storage between the time the individual who collected the evidence leaves it at a collection station and it is taken into the custody of an evidence room employee. Property and evidence storage standards of the International Association for Property and Evidence address temporary storage as follows:

Temporary storage refers to the gap between the time the employee who seized the evidence leaves it at the station [sub-evidence locker], and the time that it is actually received by a property room employee. During this time, which could vary from a few hours to a few days, depending on the agency and the time of the evidence seizure, the property has left the hands of one person, but has not yet been received by another.

Since there is not a person in physical control of the property during the time of temporary storage, there must be a storage facility and methodology that will allow a person to testify to the security of the property, even though there was not a person physically present. . . . If the officer securing the evidence can get it back, or if [others can] readily gain access to the property, then the entire custody chain becomes suspect.

At the Substance Abuse Treatment Facility, the main evidence room is located inside the offices of the Investigative Services Unit and is not immediately accessible to officers or employees who seize evidence, especially when the seizure occurs at a time other than during second watch. Evidence seized when the primary evidence officer is unavailable, therefore, requires the use of a temporary, or "sub-evidence," storage area. Because storage and office space at the institution is in short supply, the area presently used for temporary evidence storage is the entryway to the prison's Central Control area. Although the area has the advantage that access is limited to the relatively few employees assigned to Central Control in Facility D, the temporary storage facilities also present the following problems:

- The sub-evidence room has only one drying locker (for clothing and similar articles that may contain forensic evidence such as blood), creating an environment for cross contamination of evidence should articles from different subjects be placed together in the same locker. Further, the sub-evidence room consists of a small entryway leading to the Central Control office.
- The refrigerator used to store urine samples awaiting laboratory analysis is not equipped with a lock.
- A loose-leaf binder serves as the evidence log for recording details of initial evidence acquisition, and of subsequent movement and disposition of evidence.

Because of these arrangements, evidence stored in the drying lockers may be subject to contamination simply by pedestrian traffic moving through Central Control, while urine samples are vulnerable to possible tampering or removal by anyone passing through the entryway to Central Control on their way to a work site. As a matter of practicality, employees passing through are not required to sign the evidence room log even though evidence storage standards require that they do so. Any employee passing through this area also may be exposed to blood-borne pathogens originating from evidence stored in the drying locker. In addition, the loose-leaf design of the evidence log makes it possible for the log to be altered to conceal any tampering with physical evidence located in the sub-evidence storage area.

Although the chances of an actual event of cross-contamination or tampering may be remote, the current location of the sub-evidence area, combined with its lack of critical control and security features, creates an environment inadequate to provide reasonable assurance that evidence is safeguarded against tampering or cross-contamination. Accordingly, the chain of custody for

evidence stored in this area may be suspect, which could jeopardize prosecution efforts in cases requiring the presentation of physical evidence stored under the existing conditions.

RECOMMENDATIONS

The Office of the Inspector General recommends that the management of the California Substance Abuse Treatment Facility and State Prison at Corcoran take the following actions to improve the integrity of temporary evidence storage at the institution:

- Re-locate the sub-evidence area to a separate room, unexposed to extraneous pedestrian traffic. All persons entering the room should be required to sign the logbook documenting the date, time, and purpose of their visit. The storage refrigerator should be fitted with a lock if it cannot be moved to a secured and locked room.
- Replace the current loose-leaf evidence log with hardbound logbooks with pre-numbered pages. The logbook for urinalysis samples should be separate from the logbook used for other evidence. Information recorded in the logs should include date and time of access, the badge number (or other identification) and name of the person submitting the evidence, the subject's name and identifying number, a description of the evidence, and the locker number in which it is stored. When an evidence officer retrieves the evidence, the log entry should include the date and time evidence was removed from the sub-evidence locker, the name of the evidence officer, and the final disposition of the evidence.

FINDING 8

The Office of the Inspector General found that the institution is not properly documenting inmate activity in the administrative segregation units.

State regulations and California Department of Corrections policy require that movement and housing of inmates assigned to an administrative segregation unit be recorded in a hardbound logbook — a CDC Form 114 — which provides a single-source record of daily activity within the administrative segregation unit. The log is formatted to include the inmate's cell number and bed assignment, the time of the inmate's entry to or exit from administrative segregation, the identity of visitors to the unit, and any unusual incidents within the unit. The CDC Form 114 is a legal document subject to be used as evidence in a civil, criminal, or administrative proceeding. The Office of the Inspector General found, however, that although the administrative segregation staff at the institution maintains the CDC Form 114, inmate movement is not entered into the log immediately. Instead, inmate movement is updated in the logbook only once every 24 hours by the administrative segregation unit's first watch floor officer, undermining the purpose of the CDC Form 114 as a source of accurate, up-to-date information about inmate location. The practice of delaying the recording of information into the logbook diminishes the evidentiary value of the CDC Form 114 and presents a safety risk to staff and inmates during an emergency.

California Code of Regulations, Title 15, Section 3332 (g) (1) and *California Department of Corrections Operations Manual,* Section 52080.22.5 require that the CDC Form 114 be kept continually up to date. Title 15 provides as follows:

> *[A] Disciplinary Detention Log, CDC Form 114, will be maintained in each designated disciplinary detention unit. Specific information required in this log will be kept current on a daily and shift or watch basis.*

But at the Substance Abuse Treatment Facility, only the first watch officer enters information about the location of administrative segregation inmates into the CDC Form 114 log; second and third watch officers do not. As a result, the information in the log may be hours old. The first watch officer records the information into the log each night using reports about changes in the administrative segregation population from Central Control. Instead of maintaining the CDC Form 114 log on each watch, the administrative segregation staff records unusual incidents and other noteworthy information exclusively into the sergeant's log and uses other records and census systems to record the status of inmate housing assignments. These alternative records, which include a wall-mounted board holding the inmates' identification cards in numbered slots corresponding to cell and bed assignments, consulted collectively, may provide officers with reasonably accurate information about inmate location. But the failure to keep the CDC Form 114 up to date prevents officers from relying on the log information to determine, for instance how many inmates occupy a particular cell, and creates a safety hazard if an officer enters a cell believing that it houses only one inmate when it actually houses two.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the management of the California Substance Abuse Treatment Facility and State Prison at Corcoran require the administrative segregation unit staff to take the following actions to comply with regulations and policies governing inmate activity in the administrative segregation unit:

- Record inmate movements and other activities in the CDC 114 as they occur, rather than waiting for the first watch administrative segregation floor officer to update the log.
- Record unusual incidents and other noteworthy conditions in the CDC 114 instead of exclusively in the sergeant's log.

FINDING 9

The Office of the Inspector General found that the institution has not consistently followed required state hiring procedures.

Although the Office of the Inspector General found that the Substance Abuse Treatment Facility is generally in compliance with laws governing state hiring procedures, the audit revealed that in

a small percentage of cases required procedures were not followed and that in other instances even though the laws were followed, the hiring process was otherwise deficient, calling into question the fairness of appointments made.

State law requires agencies to follow prescribed procedures in hiring candidates for state jobs. The requirements, set out in the *California Government Code*, generally require agencies to advertise positions; issue examination bulletins communicating the minimum qualifications necessary for candidates to test for the position; administer examinations; provide an examination score for each candidate; and rank the candidates into groupings on a hiring list, with those in the top three ranks eligible for appointment. Eligible candidates from the hiring list may then be interviewed for the position. The hiring authority also may fill vacant positions by making appointments through lateral transfers and other means, but these types of appointments generally follow the same procedures — advertising for the vacant position, screening applicants, conducting interviews, and making job offers. The *California Department of Corrections Operations Manual* also requires that specific procedures be followed in hiring for correctional agency positions.

The Office of the Inspector General found that the Substance Abuse Treatment Facility is not consistently following these requirements. A review of the records of 55 hiring appointments made at the Substance Abuse Treatment Facility from 2000 through 2002 revealed the following violations:

- ***Three positions were not advertised.*** *California Government Code* Section 18933 requires appointing powers to announce or advertise examinations to fill positions. But the Office of the Inspector General found that three (5.5 percent) of the 55 appointments reviewed in the Substance Abuse Treatment Facility files were made for position openings that were never advertised. One of the appointments was for the position of administrative assistant/public information officer, and the other two positions were for correctional lieutenants.

- ***Interviews not held.*** The institution appointed two correctional lieutenants (3.6 percent of the 55 appointments) without interviewing the candidates. In addition, an appointment of an administrative assistant/public information officer was made after the panel interviewed only one candidate. That appointment accounted for 1.8 percent of the 55 appointments. Section 31060.17 of the *California Department of Corrections Operations Manual* requires that "In keeping with the merit system principle of appointing the best person available, hiring authorities shall interview at least three persons interested in a vacancy before an appointment is made." Although the procedures provide for circumstances in which three applicants are not interviewed, none of the circumstances were present in these three appointments.

The Office of the Inspector General identified a number of additional irregularities, which, although they do not constitute violations of state law, may have compromised the actual or perceived fairness of the hiring process. The irregularities included the following:

- Interview panel members did not consistently keep thorough notes of the interview and hiring process.

- One appointment—for an administrative assistant/public information officer—was made after an interview in which the interview panel consisted only of the warden.
- In six instances, the institution did not appoint the candidates with the highest interview scores and instead appointed candidates with lower scores. In one instance for example, in which 11 correctional sergeants were appointed, two of the successful candidates had ranked 15 and 18, while two candidates ranked 5 and 7 were not appointed. In another instance, in which eight sergeants were appointed, one of the successful candidates had been ranked 15th, and on the interview score-sheet, a panel member had made the comments, "Did fail one question," and on two of the questions wrote, "not too good." The hiring documents do not explain why candidates with higher interview scores were not appointed to the positions for which they had applied.
- The warden consistently neglected to date the hiring documents he signed, raising questions about when in the process the documents were completed.

RECOMMENDATIONS

The Office of the Inspector General recommends that the institution management take the following actions to improve employee hiring:

- In consultation with the department's Office of Personnel Management, develop a policies and procedures manual for the hiring process. The manual should incorporate the applicable provisions of the *California Department of Corrections Operations Manual*, department policy memoranda, and state laws and regulations.
- Advertise all vacancies for at least 14 days in accordance with the *Department Operations Manual* and other department policy memoranda.
- Provide training to appropriate managerial personnel on the hiring process and on the responsibilities and duties of interview panel members.
- For each examination, have all members of interview panels document the candidates' interview performance and rate each candidate using a pre-determined scoring system and a standardized scoring sheet.
- Use interview panels consisting of at least three members whenever possible.
- Interview a minimum of three candidates for each vacancy whenever possible.
- Have the warden date all documents at the time of signature.

In addition, the Office of the Inspector General recommends that the Department of Corrections conduct periodic reviews of institution hiring policies and procedures to ensure they are used consistently.

FINDING 10

The Office of the Inspector General found while institution employees generally regard the warden's communication and management skills to be satisfactory, some described his management style as "reactive," and said that he does not communicate adequately with managers and line staff.

Representatives of five collective bargaining units at the Substance Abuse Treatment Facility praised Warden Adams for his accessibility, his positive attitude, his receptiveness to suggestions for improvement, and his face-to-face communication skills. Most said they enjoyed working for him. But they also told the Office of the Inspector General that the warden does not communicate enough with line staff, does not ensure that managers honor commitments he has made to union members, and does not make a practice of visiting secured areas of the prison. They also said that his management style is reactive, rather than proactive, and representatives of inmate advisory councils said that the warden does not meet with the councils regularly, as required by *California Code of Regulations,* Title 15.

Lack of effective communication can lead to low productivity, low morale, or non-compliance with applicable policies, procedures or regulations. In a custodial setting, the lack of communication between the warden and inmates may create misunderstanding and tension leading to inmate frustration, which may manifest itself in violence and other disruptive behavior and create an unsafe working environment for custody staff and other prison employees. Effective communication, on the other hand, fosters informed, motivated, loyal, and well-trained employees. Regularly scheduled management and staff meetings are essential for disseminating information about changes in policies and procedures, for addressing operational issues, and for advising staff members about events and conditions affecting the institution.

To assess the warden's effectiveness in communicating with employees and inmates, the Office of the Inspector General conducted interviews with employee union representatives, distributed a questionnaire to 175 employees, and interviewed members of inmate advisory councils from five of the institution's seven facilities. The Office of the Inspector General found the following areas needing improvement:

- ***The warden does not adequately communicate with line staff.*** Union representatives said that the warden does not communicate adequately with line staff, does not disseminate information from department headquarters, and does not often visit the inmate housing areas and secured areas of the institution.
- ***The warden has a reactive management style.*** Union representatives characterized the warden's management style as reactive, in that he has a tendency to address problems as they arise, rather than to manage in a more systematic fashion. Managers also suggested that the warden should provide stronger management support to his line supervisors and that he should be more decisive in making policy decisions.
- ***The warden does not ensure that managers implement his commitments.*** Union representatives said that while they do not doubt the warden's sincerity and good intentions,

it appears that he does not communicate effectively with managers responsible for implementing commitments he has made to union members and that the managers frequently do not carry out the warden's directives. In response to this issue, Warden Adams reported that he has instituted a "tickler system" in which his secretary records his directives and monitors the progress of managers in implementing them. The status of the directives is also now a regular topic at management meetings.

- ***The warden does not visit secured areas.*** Employees and inmates said that the warden seldom visits the secured areas of the prison and the facility living units and that such visits would enable him to have more direct contact with the custody staff and inmates.

- ***The warden does not meet regularly with the inmate advisory council.*** Representatives of the inmate advisory council said that the warden does not meet on a regular and consistent basis with the inmate advisory council, even though *California Code of Regulations* Title 15, Section 3230(i) requires the warden to meet with the councils at least monthly. The council is a body of inmates selected by the inmate population to act in an advisory capacity to the warden and his administrative staff regarding matters of common interest and concern to inmates. The inmate advisory council provides inmates with representation and a voice in administrative decisions affecting the welfare and interests of all inmates, as well as providing the warden and his administrative staff a vehicle for communicating with the inmate population. Council representatives said that at the Substance Abuse Treatment Facility, meetings between inmates and the institution staff are rare and usually are held with a facility captain or lieutenant, or occasionally with the associate warden, rather than the warden.

- ***The warden does not respond to inmate advisory council proposals.*** Inmate advisory council representatives said that the warden does not hear or respond to their proposals for improvements in their living or working environment, and that instead proposals are usually resolved with the facility captain, or, on rare occasions, with the associate warden.

- ***The warden has not provided inmate advisory councils with needed office space.*** Inmate advisory council representatives said that the institution is not providing the councils with the office space and other equipment and supplies they need to conduct approved activities as required by *California Code of Regulations* Title 15, Section 3230(g).

- ***The institution does not have an inmate advisory council coordinator.*** *California Code of Regulations* Title 15, Section 3230(h) requires institutions to have an inmate advisory council coordinator for the purpose of scheduling and conducting meetings between the warden and the council in addition to the monthly meetings with the warden. But the Substance Abuse Treatment Facility does not have an inmate advisory council coordinator.

The questionnaire distributed by the Office of the Inspector General to employees of the California Substance Abuse Treatment Facility and State Prison at Corcoran asked respondents to rate the warden's communication skills, including any systems used by management to communicate with staff and inmates, and to provide comments as necessary.

Responses to the questionnaire included following:

I would work for Mr. Adams anyplace, anytime, anywhere. Mr. Adams is decent, caring and above all else has integrity.

Anytime I have had the opportunity to deal with Mr. Adams, he has been extremely courteous and receptive to my ideas.

This is the fourth warden since I've been at (the institution). I like how much smoother the institution seems to be running.

I have seen major improvements in this institution, since Warden Adams started. It is nice to finally have some consistency in the administration here. Warden Adams has finally created consistency in the daily operations at the institution.

I would like to take this opportunity to share with you that Warden Adams was a breath of fresh air, coupled with his abilities to successfully motivate all staff.

I have been assigned to the (institution) since March of 2001. During my tenure I have not seen the Warden in the secured area of the prison but one time and that was January 9, 2002 on Facility 'C'.

I came to (the institution) about 11 months ago. The first time I saw the warden was last month. He came to my building and because I had not seen or met him I was embarrassed that I did not know who he was. Consequently he did not introduce himself and left with me still wondering who he was.

Warden should be more viewable and tour the facility once in a while. He might learn more about what staff do/don't here.

Would like to have the warden out on the line talking to his officers.

The morale at this prison has to be the lowest in the state.

Staff moral [sic] is at its lowest since July 1997.

The morale here at CSATF-SP is not very good.

Moral [sic] here is very low.

RECOMMENDATIONS

To improve communication among the warden, his executive staff, employees, and inmates, the Office of the Inspector General recommends that the warden take the following actions:

- Conduct regularly scheduled staff meetings with employees, permitting them to identify and define important issues.

- Within the framework of institution security and existing policy, respond promptly to as many employee and inmate concerns as practicable. When the warden's

commitment to an action is made, ensure that a "tickler system" is used to monitor implementation of the commitment.

- Form a committee of representatives from various employee areas (administration, custody, facilities, programming, etc.) to provide a forum for identifying factors relating to employee morale, recommending solutions, and monitoring the effectiveness of the solutions implemented.

- Conduct regular walking tours of the institution, visiting all work sites to talk with employees about the institution's mission and to receive feedback directly from employees responsible for carrying out that mission.

- Meet with the inmate advisory councils at least once a month.

In addition, the warden should:

- Arrange with facility captains to provide the inmate advisory councils access to dedicated office space and the necessary office equipment and supplies to conduct approved council activities and business.

- Have an appropriate staff person appointed as the institution's inmate advisory council coordinator.

SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

MEDICAL CORRECTIVE ACTION PLAN

ITEM #	AREA OF DEFICIENCY	FINDING	CORRECTIVE ACTION NEEDED	RESPONSIBLE PARTY	DUE DATE	PROGRESS NOTES
1	MANAGEMENT	LACK OF EFFECTIVE ORGANIZATIONAL STRUCTURE	Establish organizational chart with personnel	Health Care Manager, CHSA II, IPO	July 9, 2002 in Regional Administrator's Office c/o CHSA II	Completed see attached
2	MANAGEMENT	COMMUNICATION OF CLEAR AND CONCISE DIRECTIONS TO MIDDLE MANAGEMENT	formulate strategic plan to offer supervisors specific goals and objectives with due dates	Institution/Medical management team	Incorporate the initial direction to management of team process by July 12, 2002	Strategic planning meeting schedule for Sept 12, 2002
3	MANAGEMENT	LACK OF TRACKING SYSTEM TO DETERMINE TIMELY COMPLETION OF TASKS ASSIGNED	implement automated tic system to track assignments	Install tic system into computer of the two secretaries in the Executive offices of the CTC, Train the clerical staff of the CTC on the proper protocol of input and tracking and reporting. The tickler system should be reported on to the health care manager, CHSA II, and Department heads in the weekly executive medical staff meeting.	July 12, 2002 for installation/training to be completed by July 19, 2002	Task completed, presently 0 overdue TIC'S
4	MANAGEMENT	LACK OF BUY IN OF MIDDLE MANAGEMENT IN THE CORRECTIVE ACTION PROCESS	Include middle managers in the planning and corrective action process	Unit Supervisors are responsible. Compile representatives from each unit to put together a problem list for each area. Each unit shall appoint a representative to the CTC Strategic planning committee. The members of the committee will have one week to put together proposed resolutions to the problems listed and identify the priorities for each problem and solutions including the resources needed to complete each solution. These items will be presented to the Regional Executive Board for adoption and approval of proposed implementation schedule.	12-Jul-02	
5	MANAGEMENT	LACK OF CONTINUOUS/DAILY/WEEKLY/MONTHLY FOLLOW UP ON TASKS ASSIGNED	identify required reporting of specific items for reporting on a predetermined time line	Unit Supervisors, Department heads, and HCM. The tasks will be monitored and discussed during the weekly meetings and any task delinquent more than one week shall result in a Letter of instruction to the staff. The Department head shall issue a letter of Instruction to the Supervisor when delinquent greater than one week if an extension has not been granted. The HCM shall issue a Letter of instruction/expectation to the Department head if the item is delinquent beyond one authorized extension. The justification for any extension shall be provided to the Regional CHSA II.	Develop reporting form by July 18, 2002. Initiate reporting by August 2, 2002.	
6	MANAGEMENT	ESTABLISHMENT OF REPORTING REQUIREMENTS FOR ACTIVITIES OF THE MEDICAL STAFF	weekly reporting of number of cases seen and diagnoses	Unit Supervisors shall be responsible. Division heads shall compile Departmental reports for HCM.	Begin by July 26, 2002. First reports to be received by HCM and CHSA II on August 2, 2002	

7	MANAGEMENT	ESTABLISHMENT OF REGULAR AND ORGANIZED MEDICAL STAFF	establish quarterly meetings of medical staff with minutes transcribed for follow up	Begin quarterly meetings and elect Chief of Staff and Secretary. Develop institutional guidelines for presentation to next medical staff meeting for adoption and presentation to Regional Executive Board.	Jun-02	Medical Executive board has meet and selected Chief of Staff and Sec. Now has regular monthly meeting
8	MANAGEMENT	ESTABLISHMENT OF REGULAR MEETINGS WITH INMATE COMMITTEES TO SOLICIT INPUT AND COOPERATION IN THE RESOLUTION OF PROBLEMS	Calendar of meeting schedule to HCM and CHSA II. Each yard shall have designated representative of HCM. Effective communicate of issues and time frames of resolution to inmates shall be documented by minutes to be approved by HCM and Inmate committee elected representative.	HCM or designee	July 18, 2002 for calendar to Regional Executive Board. Minutes to HCM by first meeting in August.	IMAC meetings on all yards being conducted see attached schedule
9	MANAGEMENT	LACK OF COMMUNICATION WITH INMATE COMMITTEES	provide meeting with representatives of all yards to enhance standardization of messages communicated to inmates	HCM designee	Begin meetings by August 1, 2002	IMAC meetings on all yards being conducted see attached schedule
10	MANAGEMENT	FAILURE OF ADEQUATE DIRECT SUPERVISION OF STAFF TO ENSURE COMPLIANCE WITH DEPARTMENTAL POLICIES CONCERNING THE OPERATION OF A MEDICAL ORGANIZATION	have each manager communicate on a weekly basis with staff and provide minutes to HCM and RA	Unit Supervisor	26-Jul-02	ongoing
11	MANAGEMENT	LACK OF DOCUMENTATION OF FAILURE TO PERFORM DUTIES OF SUPERVISION	meet with managers to discuss and train in the resolution of personnel issues with staff performance	HCM followed by Unit Supervisors and Department heads.	26-Jul-02	Letter of expectations issued to supervisors and follow-up when not in compliance
12	MANAGEMENT	FAILURE TO ESTABLISH CHAIN OF COMMAND FOR APPROPRIATE SUPERVISION AND FOLLOW UP/STAFF ARE PUSHING THE ASSIGNMENTS BACK TO MANAGEMENT/ MAY LACK TRAINING OR CLEAR DIRECTION	support lower level supervisors and managers by communicating with staff the appropriate lines of communication. Do not allow staff to communicate directly to 3rd level of supervision without exhausting communication to first and second level supervisors. make treatment of people and customer service a priority	HCM and CHSA II	26-Jul-02	Directive has been issued regarding the proper chain or command and the expectation that it must be followed
13	MANAGEMENT	FAILURE TO ESTABLISH TEAM BUILDING PROCESS TO GAIN SUPPORT OF STAFF	have external facilitator e.g. RA meet with staff on a regular basis to ensure managers are using principals of responsive treatment of people	Dr. Bendon shall mentor Dr. Salama	First meeting in August. Dr. Bendon may elect to combine team building session with those ongoing in Corcoran or initiate new upon consultation with Regional Administrator and Dr. Salama.	Meeting Schedule for Sept. 12, 2002
14	PHARMACY	INADEQUATE CIVIL SERVICE PERSONNEL STAFFING	review and enhance recruiting efforts and advertising with outreach efforts to attract and change the reputation of the institution	Institutional IPO in coordination with recruiting specialist.	Plan of action by July 18, 2002	Sgt. has been assigned to assist in the recruitment efforts. See attached vacancy report and recruitment efforts.
15	PHARMACY	LACK OF KNOWLEDGE CONCERNING THE USE OF THE PPTS (TRACKING SYSTEM)	provide training for pharmacy manager/pharmacists in the use of the tracking system. Establish daily reporting of performance	Fred Raleigh/Pharmacy Manager	Training agreement and schedule to CHSA II/RA by July 12, 2002	daily assessment of pharmacy back log--OT auth as needed

16	PHARMACY	FAILURE TO CLOSE THE LOOP ON THE DELIVERY OF MEDICATIONS TO THE INMATES (MAR's)	assign specific areas of responsibility to pharmacy staff for prescription filling	Fred Raleigh/Pharmacy Manager/HCM	Plan of action by July 18, 2002	
17	PHARMACY	LACK OF TRAINING OF PROFESSIONAL STAFF IN THE OPERATIONS OF THE PHARMACY RESULTING IN FALSE EXPECTATIONS OF INMATES	establish quarterly training and have pharmacy representative meet with each staff meeting to hear concerns of each unit	Fred Raleigh/HCM	July 12, 2002 for installation/training to be completed by July 19, 2002	ongoing
18	PHARMACY	FAILURE TO CORRECT PRESCRIBING PRACTICES OF THE PHYSICIANS TO FOLLOW FORMULARY	monthly training on the appropriate use of formulary and exclusion of canteen prescriptions	Fred Raleigh/HCM	Initiate new practices after first training by July 26, 2002	ongoing
19	PHARMACY	OVERPRESCRIBING MEDICATIONS IN AMOUNTS NOT MEDICALLY NECESSARY	exclude from pharmacy unnecessary prescriptions	Fred Raleigh/AW-BS/CHSA II/HCM	Begin monitoring reports by August 1, 2002	
20	PHARMACY	PRESCRIBING OVER THE COUNTER TYPE ITEMS THAT MAY BE AVAILABLE THROUGH THE CANTEEN	educate inmates on the availability of over the counter type items in the pharmacy	Fred Raleigh/AW-BS/CHSA II/HCM	2-Aug-02	memo draft and submitted for review for institutional managers
21	PHARMACY	LACK OF SUFFICIENT COMPUTER STATIONS TO INPUT DATA ON PRESCRIPTIONS	network computer stations in the pharmacy/arrange for alternating input and retrieval	Fred Raleigh/AW-BS/CHSA II/HCM	July 12, 2002 for installation	additional computers installed number increase to 4 with a 5 pending
22	PHARMACY	FAILURE TO SPECIFICALLY ASSIGN RESPONSIBILITY TO AREAS OF THE INSTITUTION TO ENHANCE ACCOUNTABILITY IN THE RETRIEVAL AND DELIVERY OF MEDICATIONS TO THE UNITS	clearly establish areas of responsibility and expectations of each pharmacy tech and pharmacist	Fred Raleigh/AW-BS/CHSA II/HCM	12-Jul-02	
23	PHARMACY	RESEARCH AVAILABILITY OF AUTOMATED SYSTEMS	compile report on available technology for inventory control	Fred Raleigh	12-Jul-02	reported submitted to HQ Pharmacy task force
24	PHARMACY	MEDICATION INVENTORIES ARE NOT COMPLETED ACCORDING TO LICENSING GUIDELINES	educate staff on inventory requirements including reporting according to pharmacy regulations	Fred Raleigh/HCM/Pharmacy manager	Present Guidelines by July 18, 2002	Reconciliation completed by pharmacy staff
25	PHARMACY	FAILURE TO DELIVER MEDICATIONS TO INMATES UPON HOUSING UNIT CHANGES	hold accountable pharm tech an pharmacists for delivery of meds. Include physicians in the process by regular follow-up on their prescriptions	Unit Supervisors	2-Aug-02	policy inplace -requires continued monitoring
26	PHARMACY	INADEQUATE PHARMACIST COMMUNICATION WITH PHYSICIANS WHEN DISCREPANCIES ARE FOUND	establish contact numbers and names with signatures of physicians so that pharmacy can contact in case of discrepancy	Unit supervisors/Physicians/HCM/Pharmacy Manager/DON	Immediately/ASAP	
27	PHARMACY	LACK OF QUALITY ASSURANCE TO IDENTIFY AND CORRECT MEDICATION ERRORS	establish institutional committees for quality assurance of each unit's performance	Unit supervisors/Physicians/HCM/Pharmacy Manager/DON	12-Jul-02	
28	PHARMACY	LACK OF PROTOCOL FOR RENEWAL OF MEDICATIONS	HCM shall establish committee to formulate renewal of prescription process. Pharmacy shall be included to monitor compliance and notify HCM in cases of non compliance for counseling of physician	Medical Staff/HCM/CHSA II	next medical staff meeting	
29	PHARMACY	EXCESSIVE NUMBER OF REGISTRY STAFF BEYOND THAT AUTHORIZED FOR STAFFING OF THE INSTITUTION	reduce the number of registry staff in pharmacy within the month of July 2002	CHSA II/HCM/Fred Raleigh/Pharmacy Manager	First reduction July 1, 2002	no further reductions
30	PHARMACY	INEFFICIENT DESIGN OF PHARMACY FOR THE APPROPRIATE PROCESSING OF PRESCRIPTIONS	make appointment for pharmacy consultant to produce plans to remodel pharmacy for ergonomic and work efficiency	Fred Raleigh/HCM/Pharmacy Manager	Obtain appointment with consultant for plan by July 12, 2002	plans completed pending budget to proceed

31	APPEALS	SIGNIFICANT NUMBER OF OVERDUE INFORMAL AND FORMAL APPEALS	assign appeals to physicians, dentists and mental health staff for resolution within 30 days penalize non compliance with letter of instruction.	CHSA II/HCM/DON	July 12, 2002 assign appeals	As of Aug. 14, 2002 overdue appeals were down to 64 verses 400+ in March, 2000.
32	APPEALS	URGENT MEDICAL APPEALS NOT IDENTIFIED FOR APPROPRIATE TIMELY ACTION	formulate medical appeals committee and assign nurse to triage appeals within one work day of receipt	CHSA II/HCM/DON	12-Jul-02	
33	APPEALS	APPARENT ABUSE OF THE APPEALS PROCESS BY INMATES	meet with appeals coordinator to identify abuse by inmates of appeals process. Identify supervisors policy to ensure adequate response to appeals in a timely manner within 30 days	Appeals Coordinator/CHSA II/HCM/Chief Deputy Warden	12-Jul-02	meeting held and issues resolved. Additional the Warden assigned a CCII who was a SMTA to assist with appeals.
34	APPEALS	LACK OF AVAILABILITY OF FORMS REQUESTING SERVICES	meet with AW=BS to obtain and resolve lack of forms issues and place forms in designated areas around the clinic. Remove inappropriate signage from clinic windows	HCM/AW-BS/CHSA II	identify forms by July 12, 2002; Order forms by July 18, 2002	forms completed and received
35	APPEALS	EDUCATION OF STAFF AND MANAGEMENT REGARDING THE TIMELINES FOR RESPONSE TO APPEALS COORDINATOR	this shall be reiterated in the unit meeting by every supervisor until backlog of appeals has been resolved	Appeals coordinator	First report by July 11, 2002	LOI were issued to staff for continued failure to complete appeals in a timely manner.
36	ACCOUNTABILITY	LACK OF ACCOUNTABILITY OF PHYSICIANS/STRUCTURED WORK ENVIRONMENT	establish guidelines for the review of physician/dental/mental health staff performance and clearly delineate expectations in writing with signature upon receipt	HCM/Medical staff	Present plan to RA by July 11, 2002	
37	ACCOUNTABILITY	LACK OF ACCOUNTABILITY OF MENTAL HEALTH STAFF	same as above	HCM/Chief Mental Health	11-Jul-02	
38	ACCOUNTABILITY	LACK OF NURSING/MTA ACCOUNTABILITY	same as above	HCM/DON	11-Jul-02	
39	ACCOUNTABILITY	FAILURE OF MANAGERS/SUPERVISORS TO BE HELD ACCOUNTABLE FOR FAILURE TO COMPLETE DIRECTIVES	clearly train/identify and follow up on the achievement of expectations by supervisors and their ability to hold staff accountable to deadlines and performance	HCM/Department Heads	ASAP	
40	ACCOUNTABILITY	LACK OF COMPLETED STAFF WORK	obtain training from state training center on the value of completed staff work and define completeness	CHSA II/Regional Analyst (Karen Huston	12-Jul-02	
41	ACCOUNTABILITY	FAILURE TO IMPLEMENT CORRECTIVE ACTION WHEN STAFF ARE INSUBORDINATE IN A TIMELY MANNER	establish expectation of supervisors to document and counsel staff on the failure to meet deadlines	HCM/Department Heads	ASAP	
42	ACCOUNTABILITY	LACK OF EFFICIENT USE OF TIME	Establish set parameters for working hours and track delinquent assignments with weekly reports. Train and Educate to level of Expectation. All assignments shall be completed within the month of assignment unless specifically in writing given alternative due date.	HCM/Department Heads/Unit Supervisors	Present Plan and training documents by July 26, 2002	
43	ACCOUNTABILITY	INAPPROPRIATE USE OF MODIFIED WORK SCHEDULES	rescind all modified work schedules on failure of performance. Establish weekly mentoring meetings as initial step in the removal of alternate work schedule.	HCM/Department Heads/Unit Supervisors	Inform staff by July 18, 2002	
44	ACCOUNTABILITY	LACK OF CLEAR AND CONCISE DUTY STATEMENTS	complete and review a duty statement for each employee due July 30, 2002	HCM/Department Heads/Unit Supervisors	26-Jul-02	Duty Statements for Managers and Supervisors have been updated, setting clear expectations

45	ACCOUNTABILITY	LACK OF CLEARLY DEFINED EXPECTATIONS	establish set of expectations for each classification providing examples of each expectation	HCM/Department Heads/Unit Supervisors	26-Jul-02	
46	ACCOUNTABILITY	LACK OF RESPONSE TO CORRESPONDENCE/DO NOT ANSWER ISSUES DIRECTLY	Provide supervisorial review of correspondence to answer questions directly in a concise manner using standard format for outlining issues of concern, actions taken and future follow up to ensure issue will not recur	HCM/Department Heads/Unit Supervisors	Immediately/ASAP	Implemented several layers of review for correspondence
47	ACCOUNTABILITY	LACK OF ABILITY TO PROVIDE COMPLETE MEDICAL RECORDS TO UNITS	ensure all scheduled appointments have medical records delivered to physicians in a timely manner by set schedule of patient visits.	HCM/CHSA II/Medical Records Supervisor	Develop plan by July 26, 2002	
48	ACCOUNTABILITY	SIGNIFICANT AMOUNT OF LOOSE FILING	assign supervisor to monitor the completion or state of backlog of loose filing on a daily basis	HCM/CHSA II/Medical Records Supervisor	Develop plan by July 26, 2002	Light Duty officers have been assigned to assist with filing as well as overtime has been auth to address excessive back log
49	ACCOUNTABILITY	LACK OF FOLLOW UP ON PHYSICIAN ORDERS IN CHARTS	Physicians shall indicate in the charts upon review by initialing each item for completion of chart orders.	HCM/Medical staff	Based on plan item 36	
50	ACCOUNTABILITY	NURSES MUST CLEARLY INDICATE TIME, DATE AND ITEMS COMPLETED WHEN NOTED IN CHARTS (UHR)	all orders shall be initialed and dated individually by the completing staff member.	HCM/DON	ASAP	
51	X-RAY DEPARTMENT	SIGNIFICANT BACKLOG OF APPROXIMATELY 200-300 ORDERS	Assign and establish through a supervisor, the schedule for the reduction in the backlog of x-ray orders without falling further behind. The supervisor will report on the progress in a weekly memo to the HCM and CHSA II due by noon on Friday of each week.	Assigned Supervisor	Supervisor assignment by July 9, 2002;Plan of Action by July 19, 2002	
52	X-RAY DEPARTMENT	LACK OF SYSTEM TO TRACK AND FOLLOW UP ON DELINQUENT X-RAY/IMAGING ORDERS	Supervisor shall document all orders for imaging in a weekly log and be responsible for the completion of all orders on a weekly basis for all orders made during the week.	Assigned Supervisor	26-Jul-02	
53	X-RAY DEPARTMENT	MRI BACKLOGGED DUE TO LACK OF CONTRACT	Contact contract unit and establish interim contract until appropriate bidding process has been completed.	HCM/CHSA II/RA	ASAP	
54	X-RAY DEPARTMENT	LACK OF SUFFICIENT STAFFING OF TECHNICIANS	enhance all recruiting efforts and contact schools for the use of interns and student assistants	Institution IPO/CHSA II	18-Jul-02	
55	UTILIZATION MANAGEMENT	LACK OF AUTHORITY/COMMUNICATION WITH THE HEALTH MANAGER ON INAPPROPRIATE REFERRALS	HCM may delegate authority to the UM nurse or Chief P&S for the continual review and weekly reporting to the HCM and Regional administrator the appropriate referral of cases. The HCM/Chief P&S shall counsel within one week any staff member making as inappropriate referral so as to not have a recurrence.	UM Nurse/HCM/CHSA II	18-Jul-02	all cases for medical procedures or outside referrals are reviewed by committee
56	UTILIZATION MANAGEMENT	HCM OR CHIEF P&S MUST COUNSEL STAFF MAKING INAPPROPRIATE REFERRALS UPON NOTIFICATION BY UM	see above	UM Nurse/HCM/CHSA II	Within one week of reporting of negative reporting on referral	

57	UTILIZATION MANAGEMENT	PROVIDE TRAINING ON THE RESOURCES AVAILABLE	On a monthly basis the contract analyst shall inform the staff through a memo to each unit supervisor the availability of new resources and the expenditures associated with the each staff member	UM/HCCUP Analyst/HCM	26-Jul-02	
58	AMERICANS WITH DISABILITIES ACT ISSUES	LACK OF FOLLOW THROUGH TO ENSURE RECEIPT OF ASSISTIVE DEVICES BY INMATES	The coordinator shall provide a weekly report to the HCM of the inmates provided assistive devices by name CDC number and type of device allocated.	ADA coordinator/HCM/CHSA II	18-Jul-02	
59	AMERICANS WITH DISABILITIES ACT ISSUES	ESTABLISH TIMELINES FOR THE APPROPRIATE DELIVERY OF ASSISTIVE DEVICES	The above mentioned report shall identify the date of request for assistive device by physician and the number of days to date the device has been pending until delivery. The ADA coordinator shall notify the listed physician directly and the supervisor through memorandum on the 20th day after request. The supervisor shall ensure that the requestor has ducated the inmate to be seen before 30 days has elapsed and note the chart and reply by memorandum to the ADA coordinator of the condition of the inmate and continued need for the device. The supervisor shall report to the department head any device taking longer than 30 days to be delivered in order to take appropriate action to fill the needed order.	ADA coordinator/HCM/CHSA II	18-Jul-02	
60	AMERICANS WITH DISABILITIES ACT ISSUES	LACK OF REGULAR COMMUNICATION WITH ADA INMATES REGARDING THEIR NEEDS	All ADA inmates shall be seen every 90 days unless medical necessity or court order mandates they be seen in a shorter time frame.	HCM/ADA Coordinator/CHSA II/HCM designee to inmate committees	Begin with next inmate committee meeting	
61	AMERICANS WITH DISABILITIES ACT ISSUES	LACK OF STANDARDIZATION OF PHYSICIAN APPLICATION OF ADA DEFINITIONS	All those with the authority to request ADA devices shall be trained within 90 days as to the appropriate definitions and requests for assistive devices. Any new employee shall be given all materials concerning litigation and training regarding the authority to request assistive devices.	HCM/Chief of Staff/HQ Resource/CMO Med-Dental	26-Jul-02	

62	USE OF CONTRACTUAL SERVICES	REGISTRY RN ARRANGES APPOINTMENTS	The Director of Nurses or her designee shall have the authority to request registry services. The training and orientation of these registry nurses shall be completed in previously scheduled sessions before any registry nurse will be allowed to enter the facility. The director of nursing shall be responsible to provide a list of all those registry nurses trained/oriented before a registry service may dispatch to the institution that nurse to provide services to the institution. The Director of nurses shall formulate or obtain a institution specific training an orientation program within 30 days .	DON/HCM	Full-time Civil Service RN assigned to Specialty clinic	
63	USE OF CONTRACTUAL SERVICES	PHYSICIANS GOVERN THEIR OWN APPOINTMENTS	The HCM shall establish a program to relieve the Physicians of the responsibility of scheduling inmate visits. The HCM or designee for each area of specialty shall propose for approval by the health care Manager and medical staff and appropriate schedule of appointments over the course of each week to be completed as determined by complexity of case and review of complexity by the Chief of the department. This shall be reviewed on a monthly basis with the Regional Administrator or his designee for appropriate achievement of Regional Executive Board determination. The achievements of each institution in each area shall be reviewed by the Regional Executive Board on a monthly basis.	HCM/CHSA II	July 18, 2002 for plan to Regional Executive Board. Reports to HCM by first meeting in August.	
64	USE OF CONTRACTUAL SERVICES	INORDINATE WAITING TIME FOR CLINIC REFERRALS	The UM Nurse shall notify the listed physician directly and the supervisor through memorandum on the 20th day after request. The supervisor shall ensure that the requestor has ducated the inmate to be seen before 30 days has elapsed and note the chart and reply by memorandum to the UM Nurse of the condition of the inmate and continued need for the referral. The supervisor shall report to the department head any referral taking longer than 30 days to be completed in order to take appropriate action to complete the referral.	UM Nurse/HCM/CHSA II	26-Jul-02	

65	USE OF CONTRACTUAL SERVICES	ESTABLISH A UTILIZATION MANAGEMENT COMMITTEE FOR RETROSPECTIVE REVIEW OF CASES	The HCM shall establish a utilization management committee that shall meet on a monthly basis to perform a retrospective review of all cases referred and the completion of counseling of the requestor of the referral when appropriate. This committee shall formulate a report for presentation to the Regional Executive Board on a Quarterly basis in order to review and approve the actions of the committee.	UM Nurse/HCM/CHSA II	Establish committee by July 26, 2002	
66	USE OF CONTRACTUAL SERVICES	ESTABLISH REGULAR MONITORING TIME FRAMES FOR THE FOLLOW UP OF CASES NOT SEEN UPON REFERRAL IN A TIMELY MANNER	see number 64.	HCM/Chief P&S/CHSA II/Department heads	26-Jul-02	
	USE OF CONTRACTUAL SERVICES	ESTABLISH WEEKLY FISCAL REPORTS FOR THE USE OF CONTRACTUAL RESOURCES	The HCCUP analyst shall present a monthly report to the medical staff on the use of contracted resources and identify the usage by physician in cooperation with the UM Nurse to correlate the appropriateness of each expenditure and the ongoing expenditure for each medical staff member of referral resources. This report shall include a listing of all resources and their use that week, the highest week of expenditure and the cumulative expenditure for each resource and medical staff member for each fiscal year. This report shall be presented to the Regional Executive Board on a monthly basis for review, comparison and comment.	Budget Analyst/HCCUP analyst/CHSA II/HCM	2-Aug-02	
68	LABORATORY	RESULTS OF ORDERS NOT COMMUNICATED TO PHYSICIANS/PATIENTS	The Laboratory supervisor shall present a report to the medical staff on a weekly basis regarding the requests for laboratory services, the number of labs completed, a listing of tests requested in descending order of volume, the date of the request, the date the request is completed, and the date the lab results were sent to requesting medical staff member. This report shall include a listing of the number of requests made by each medical staff member, types of labs ordered, and percentage of normal results for each lab ordered. This report shall be presented to the regional executive board for review and comment on a Quarterly basis.	Laboratory Supervisor/CHSA II/HCM/Department heads	26-Jul-02	
69	No system to ensure there is follow-up for chronic care inmates	System to be developed according to the Plata guidelines, as stated in chapter 9 of the HCSD policy and procedures. Staff training to be provided by HCSD consultant staff on the specific requirements as oulined in Plata.				In the interm CSATF has implemented auto refills of chronic care medications. A specilized ID card system is being developed to indentify inmates who need life sustaining medications.

Additional Comments:

A memorandum was submitted to Health Care Service Division by the Warden requesting a task force team be assigned to CSATF.
CHSA II office moved to CTC

Senior MTA has been assigned to systemically reorganize clinics and provide training to staff on proper clinic procedures.

Experienced SRN assigned to provide guidance

DR. Bendon, CMO and Dr. Bhatt, Chief Physician and Surgeon assigned to provide assistance.