

Sterilization of Female Inmates

Some Inmates Were Sterilized Unlawfully, and Safeguards Designed to Limit Occurrences of the Procedure Failed

Report 2013-120

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June 19, 2014

2013-120

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor (state auditor) presents this audit report concerning female inmate sterilizations occurring between fiscal years 2005–06 and 2012–13. The California Department of Corrections and Rehabilitation (Corrections) oversees the inmate population of the State's 33 adult prisons, four of which housed substantially all women. However, for much of our audit period, Corrections' role in providing inmates with medical care was not significant. California Correctional Health Care Services (Receiver's Office) played the more substantial role under the direction of a federal court-appointed receiver who took control of prison medical care in 2006 and will retain control until the court finds Corrections can maintain a constitutionally adequate prison medical care system.

This report concludes that during our eight-year audit period, 144 female inmates were sterilized by a procedure known as bilateral tubal ligation, a surgery generally performed for the sole purpose of sterilization. State regulations impose informed consent requirements that must be met before a woman can be sterilized; however, Corrections and the Receiver's Office sometimes failed to ensure that inmates' consent for sterilization was lawfully obtained. Overall, we noted that 39 inmates were sterilized following deficiencies in the informed consent process. For 27 of the 39 inmates, the physician performing the procedure or an alternate physician failed to sign the inmate's consent form certifying that the inmate appeared mentally competent and understood the lasting effects of the procedure. For 18 of the 39 inmates, we noted potential violations of the waiting period between when the inmate consented to the procedure and when the sterilization surgery actually took place. Finally, among these 39 inmates were six who were sterilized following violations of both these requirements. Although neither Corrections nor the Receiver's Office's employees actually performed the sterilization procedures, we concluded that they had a responsibility to ensure that the informed consent requirements were followed in those instances in which their employees obtained inmates' consent, which was the case for at least 19 of the 39 inmates.

Our audit also noted that prison medical staff infrequently requested approval to sterilize inmates, and when they did so, it was not always clear that these requests were approved. However, since January 2010, medical claims data from the Receiver's Office show that the number of female inmates who have undergone bilateral tubal ligations and other medical procedures that may result in sterilization has greatly decreased.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

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Summary

Results in Brief

The California Department of Corrections and Rehabilitation (Corrections) oversees the inmate population of the State's 33 adult prisons. During our eight-year audit period—which we defined as fiscal years 2005–06 through 2012–13—four of these prisons housed substantially all of the female inmates: California Institution for Women, Central California Women's Facility, Folsom Women's Facility, and Valley State Prison for Women (Valley). Valley no longer houses women since its conversion to a men's prison in January 2013. For much of our audit period, Corrections' role in providing inmates with medical care was not significant; the more substantial role was played by California Correctional Health Care Services (Receiver's Office) under the direction of a federal court-appointed receiver. A receiver took control of prison medical care in 2006 and will retain control until the court finds that Corrections can maintain a constitutionally adequate prison medical care system.

From fiscal years 2005–06 through 2012–13, 144 female inmates were sterilized by a procedure known as a bilateral tubal ligation. The last of these female inmate sterilizations occurred in 2011. Although various surgical procedures may result in a female's sterilization, bilateral tubal ligations are generally surgical procedures that are performed for the sole purpose of sterilization, and state regulations impose certain requirements that must be met before such a procedure is performed. However, the state entities responsible for providing medical care to these inmates—Corrections¹ and the Receiver's Office—sometimes failed to ensure that inmates' consent for sterilization was lawfully obtained. Overall, we noted that 39 inmates² were sterilized following deficiencies in the informed consent process. We found two types of deficiencies. First, we found no evidence that the inmate's physician—the individual who would perform the procedure in a hospital or an alternate physician—signed the consent form as required by state regulations. Second, we noted potential violations of the required waiting period between when the inmate consented

¹ Corrections was responsible for inmate health care between July 1, 2005, and the appointment of the first federal receiver, effective April 2006. During this time period, 15 inmates had tubal ligation procedures, and based on available and potentially incomplete medical records, documentation for at least four of these inmates demonstrated potential violations of informed consent requirements.

² The true number of inmates for whom Corrections or the Receiver's Office did not ensure that lawful consent was obtained before sterilization may be higher. For example, one hospital destroyed seven inmate medical records in accordance with its records retention policy. Five of these seven inmates consented to the sterilization procedure while in prison, and it is unclear—based on available records—whether physicians signed the sterilization consent forms just prior to surgery.

Audit Highlights . . .

Our audit of female inmate sterilizations occurring over an eight-year period revealed the following:

- » *144 female inmates were sterilized through a surgery known as bilateral tubal ligation.*
- » *39 inmates were sterilized following deficiencies in the informed consent process.*
 - *We saw no evidence that the inmate's physician signed the required consent form in 27 cases.*
 - *In 18 cases, we noted potential violations of the required waiting period between when the inmate consented to the procedure and when the sterilization procedure actually took place.*
 - *Among these 39 inmates there were six cases where we noted violations of both consent form and waiting period.*
- » *Neither the California Department of Corrections and Rehabilitation nor the California Correctional Health Care Services ensured that the informed consent requirements were followed in 19 instances in which their employees obtained inmates' consent.*

to the procedure and when the sterilization surgery actually took place. Some inmates were sterilized following violations of both of these requirements. Although neither Corrections nor employees of the Receiver's Office actually performed the sterilization procedures, we concluded that they had a responsibility to ensure that the informed consent requirements were followed in those instances when their employees obtained inmates' consent, which was the case for at least 19 of the 39 inmates. Either the remaining 20 inmates signed their consent to be sterilized at a physical location other than a prison or the Receiver's Office had difficulty determining whether the individual who obtained consent was an employee.

Lawful consent is represented by key steps as defined by the California Code of Regulations, Title 22 (Title 22). For example, the physician or an alternate physician must sign the consent form just before performing the surgery, and a waiting period is required after the patient signs the consent form. The missing physicians' signatures on some of the inmates' consent forms are especially concerning because of what the physician signature certifies: that the required waiting period has been satisfied and that the patient appears mentally competent and understands the lasting effects of sterilization. The physician is the last check in the informed consent process and provides the patient with the final opportunity to change her mind.

All the bilateral tubal ligations we reviewed were performed at general acute care hospitals rather than in prison medical facilities. A lawyer for the Receiver's Office stated that the specific provisions of Title 22 do not apply to prison employees, because Title 22 applies only to general acute care hospitals. Nevertheless, because employees of the Receiver's Office played a significant role in these 19 inmates' care and in obtaining their consent to be sterilized, our legal counsel advised us that a court would likely find that the Receiver's Office had a responsibility to ensure that consent was lawfully obtained from these inmates in accordance with Title 22.

Although the consent forms we were able to review demonstrated that each female inmate signed a consent form, we have concerns about whether the female inmates undergoing bilateral tubal ligations received adequate counseling about their decision to be sterilized. Despite a Receiver's Office policy that prison medical staff must use progress notes—a term for documenting information made in an inmate's medical record—to summarize discussions with inmates, in no instance did we find a female inmate whose progress notes adequately reflected that she had been counseled about her decision to be sterilized. The lack of notes in the inmates' medical records regarding informed consent and sterilization made it impossible for us to reach a conclusion as to the quality

and content of the consultations between prison medical staff and inmates. We were also unable to conclude whether inmates received educational materials, whether prison medical staff answered inmates' questions, or whether these staff provided the inmates with all of the necessary information to make such a sensitive and life-changing decision as sterilization.

The Receiver's Office also failed to ensure that the prison medical staff under its direction followed state regulations requiring specific approvals for bilateral tubal ligation procedures, including approvals by two committees made up of high-ranking prison medical staff and medical executives from the Receiver's Office. The failure to obtain the necessary approvals was systemic; all but one of the 144 bilateral tubal ligation procedures lacked the necessary approvals. Overall, our file review demonstrated that prison medical staff infrequently requested approval to sterilize inmates, and when they did, it was not always clear that these requests were approved. In many cases, prison medical staff simply requested approval for other medical procedures—such as cesarean sections at hospitals—and did not indicate that the inmate was also to be sterilized.

Since January 2010, when the Receiver's Office asserts it became aware of the sterilization procedures—following allegations by a legal advocacy group—its medical claims data show that the number of female inmates who have undergone bilateral tubal ligations and other medical procedures that result in sterilization has greatly decreased. In addition, since that time we found that the Receiver's Office has better adhered to its processes for reviewing medical services for necessity and for obtaining required approvals for medical services. Nevertheless, because the function of approving a medical procedure has been and remains separate from the process for scheduling the procedure at a general acute care hospital or other community medical facility, the opportunity still exists for inmates to receive medical services that are not authorized. Until the Receiver's Office ensures that medical scheduling is driven by authorized requests for service, it risks subjecting inmates to potentially unnecessary medical procedures and cannot demonstrate that it is in full control of the medical care inmates receive.

Recommendations

To ensure that the necessary education and disciplinary action can be taken, the Receiver's Office should report to the California Department of Public Health, which licenses general acute care hospitals, and the Medical Board of California, which licenses physicians, the names of all hospitals and physicians associated with inmates' bilateral tubal ligations during fiscal years 2005–06

through 2012–13 for which consent was unlawfully obtained. The Receiver's Office should make these referrals as soon as is practicable.

To ensure that it can better monitor how its medical staff and contractors adhere to the informed consent requirements of Title 22, sections 70707.1 through 70707.7, the Receiver's Office should develop a plan by August 2014 to implement a process by December 2014 that would include the following:

- Providing additional training to prison medical staff regarding Title 22 requirements for obtaining informed consent for sterilization procedures, including the applicable forms and mandatory waiting period requirements, to ensure that consent is lawfully obtained.
- Developing checklists or other tools that prison medical staff can use to ensure that medical procedures are not scheduled until after the applicable waiting periods for sterilization have been satisfied.
- Periodically reviewing, on a consistent basis, a sample of cases in which inmates received treatment resulting in sterilization at general acute care hospitals, to ensure that all informed consent requirements were satisfied.
- Until such time as the Receiver's Office implements a process for obtaining inmate consent for sterilization under Title 22 that complies with all aspects of the regulations, it should discontinue its practice of facilitating an inmate's consent for sterilization in the prison and allow the general acute care hospital to obtain an inmate's consent.

To improve the quality of the information prison medical staff document in inmate medical records, the Receiver's Office should do the following:

- Train its entire prison medical staff on its policy in the inmate medical procedures related to appropriate documentation in inmates' medical records. This training should be completed by December 31, 2014.
- Either develop or incorporate into an existing process a means by which it evaluates prison medical staffs' documentation in inmate medical records and retrains prison medical staff as necessary. The Receiver's Office should develop and implement this process by June 30, 2015.

To ensure that inmates receive only medical services that are authorized through its utilization management process, the Receiver's Office should do the following:

- Develop processes by August 31, 2014, such that a procedure that may result in sterilization is not scheduled unless the procedure is approved at the necessary level of the utilization management process.
- By October 31, 2014, train its scheduling staff to verify that the appropriate utilization management approvals are documented before they schedule a procedure that may result in sterilization.

Agency Comments

In its response to the audit, the Receiver's Office generally agreed with the report's factual findings, but noted that it reached conclusions about its duty to ensure compliance with the sterilization and consent procedures set forth in Title 22 that differ from the report. Nevertheless, the Receiver's Office pledged to implement all of the recommendations.

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Introduction

Background

The California Department of Corrections and Rehabilitation (Corrections) oversees the State's prison population, which includes 33 adult prisons. Of these, four prisons housed substantially all of the female inmates in the eight years spanning fiscal years 2005–06 through 2012–13. Two of the prisons, California Institution for Women (CIW) and Central California Women's Facility (Central), are designated womens' prisons and continue to house female inmates. In January 2013 Corrections realigned the populations of two prisons, converting Valley State Prison for Women (Valley) to a men's prison and establishing Folsom Women's Facility (Folsom) at Folsom State Prison. As of June 2013 the female inmate populations at the CIW, Central, and Folsom prisons were 2,131; 3,525; and 186 women, respectively. Table 1 lists Corrections' total female inmate population during our audit period, and Figure 1 on the following page indicates the locations of the prisons for women and provides general information. According to Corrections' associate warden of mission for female offender programs and services and special housing, the female inmate population decreased in 2012 because of the 2011 Realignment legislation addressing public safety.

Table 1
Female Inmate Population From 2006 Through 2013

	2006	2007	2008	2009	2010	2011	2012	2013
Female inmate population*	11,749	11,888	11,392	11,027	10,096	9,565	6,409	5,919

Sources: California Department of Corrections and Rehabilitation's monthly population reports (as of June 30th of each year).

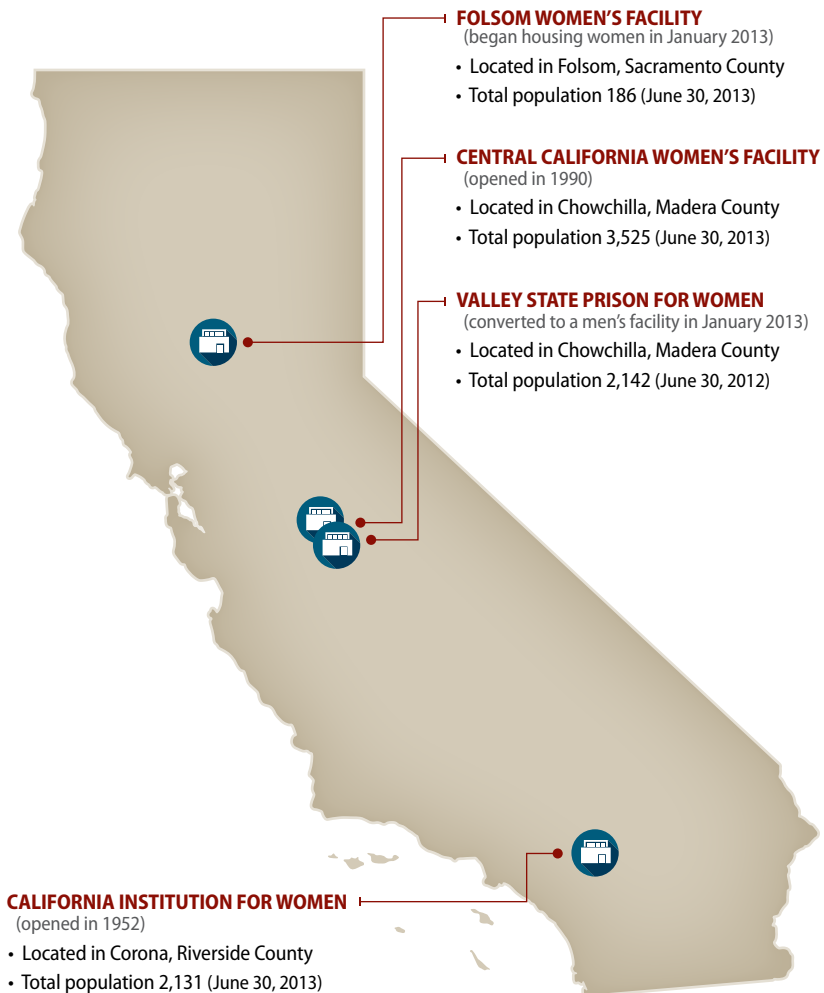
* The female inmate population includes the number of female inmates incarcerated in prisons, camps, community correctional centers, and state hospitals, but excludes females on parole.

Medical Care in Prisons

Multiple entities are involved in providing medical care to inmates or overseeing their medical services, including Corrections, California Correctional Health Care Services (Receiver's Office) under the direction of a federal court-appointed receiver (receiver), and community-based medical providers. Although multiple entities are involved, since 2006 the receiver has been responsible for controlling prison medical services as a result of litigation concerning prison health care. In April 2001 nine inmates filed a class action lawsuit against state officials in federal court (court)

alleging that Corrections was providing constitutionally inadequate medical care. This case resulted in a June 2002 agreement requiring Corrections to improve medical care for prisoners. However, in June 2005, the court determined that the California prison medical care system was broken beyond repair and ruled that it would establish a receivership to control the delivery of medical services to all prisoners confined by Corrections. The court appointed the first receiver effective April 2006, and the current receiver has served in the role since January 2008. Before 2006 Corrections controlled medical care to inmates; now it is responsible for maintaining the custody of inmates as they receive their medical care.

Figure 1
Prisons That Housed Primarily Women During Our Audit Period
Fiscal Years 2005–06 Through 2012–13



Source: California Department of Corrections and Rehabilitation.

The court gave the receiver broad authority to reform the prison medical care system until it finds that state officials are able to maintain a constitutionally adequate prison medical care system. The receiver's authority includes all of the secretary of Corrections' powers for administering, controlling, managing, operating, and financing the prison medical care system. Further, the receiver is required to request that the court waive state laws, regulations, and contractual requirements if they are impediments to reform and other alternatives are inadequate. In executing the authority given by the federal court, the receiver leads and directs the activities of the Receiver's Office. Prison physicians, nurses, and other medical staff now work for the receiver.

Process for Approving Medical Procedures for Inmates

In general, the Receiver's Office must ensure that the care inmates receive is medically necessary. Typically, this is medical care that is necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain and that is supported by health outcome data as being effective. California Code of Regulations, Title 15 (Title 15), specifies requirements related to prison medical care and defines certain medical procedures as "excluded," meaning they are services that cannot be provided to inmates because the services treat conditions that improve on their own, such as the common cold, or treat conditions that are cosmetic or not amenable to treatment, such as tattoo removal or multiple-organ transplants. Title 15 lists tubal ligations and vasectomies that are not medically necessary as excluded services. An inmate's physician may prescribe an excluded service as clinically necessary, in which case the excluded service must be approved by two committees: one based in the prison and the other at the Receiver's Office headquarters.

Title 15 establishes two committees, known as utilization management committees, that convene to approve or deny requests for excluded services. These committees are required to consider available health care outcome data supporting the effectiveness of the excluded service and other factors, such as the severity of the inmate's condition, the length of the inmate's sentence, the availability of the service, and the cost. The first committee is established in each prison and is called the Institutional Utilization Management Committee (institutional committee). An institutional committee consists of at least three staff physicians who vote to approve or deny requests for excluded medical services. Those requests that receive the institutional committee's approval must be forwarded to the Headquarters Utilization Management Committee (headquarters committee). The headquarters committee meets to review excluded services requests approved by each institutional committee. It is required to consider the same

factors as the institutional committees, and only those committee members that are licensed physicians may vote to approve or deny a request for an excluded service. The institutional committee and headquarters committee are depicted as levels 3 and 4 in Figure 2. The figure also depicts that a denied request for an excluded service may be appealed.

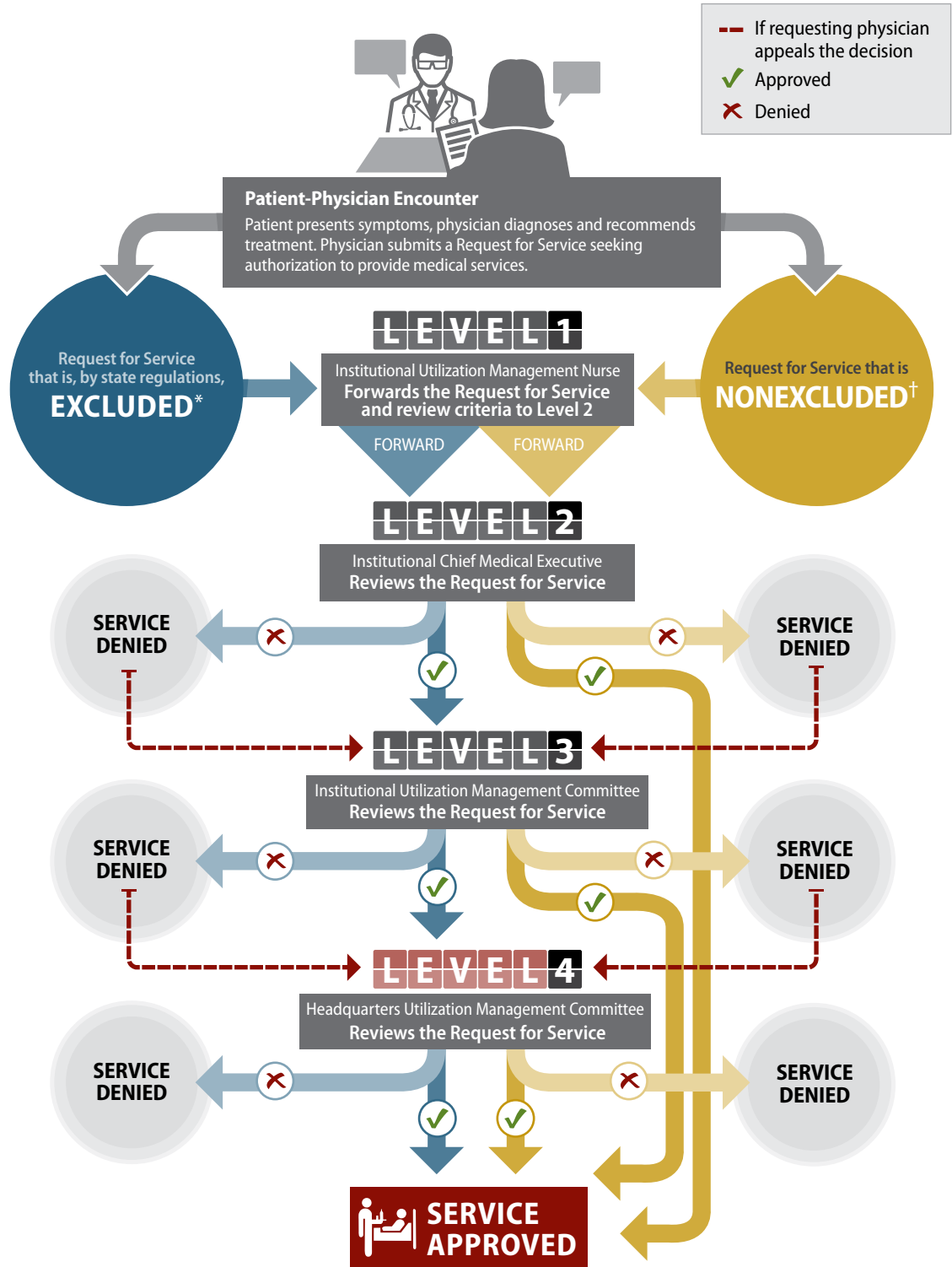
The Receiver's Office maintains and distributes the *Inmate Medical Services Policies and Procedures* (prison medical procedures), which establishes two preliminary levels of review (levels 1 and 2 in Figure 2) before the institutional committee. Level 1 involves a prison nurse reviewing the request for the excluded service and forwarding the request, along with any corresponding statewide program guidelines, to level 2 for this reviewer to approve or deny the request. The level 2 reviewer—a role filled by the prison's chief medical executive or designee—forwards the approved request to the institutional committee.

The approval process for nonexcluded services is slightly different from the approval process for excluded services just discussed. Whereas an inmate's physician seeking approval for an excluded service must ultimately secure approval from both level 3 (the institutional committee) and level 4 (the headquarters committee) before treating the inmate, there is no such requirement for nonexcluded services. Rather, a physician typically needs only level 2 approval from the prison's chief medical executive or designee. Levels 3 and 4 consider requests for nonexcluded services only when the request has been denied at a lower level of review and is then appealed. Thus, for nonexcluded services, Figure 2 shows that a "yes" at level 2 or above results in the service being approved.

Process for Obtaining an Inmate's Informed Consent for Sterilization

State regulations specify the informed consent requirements for sterilizations at general acute care hospitals. Female inmates may have medical needs that the prison-based medical staff are not trained or equipped to address—such as labor and delivery or other surgeries—in which case the Receiver's Office arranges for medical care at general acute care hospitals.

Figure 2
Process for Reviewing a Request for Service



Sources: California Correctional Health Care Services' deputy medical executive of utilization management and California State Auditor's analysis of *Inmate Medical Services Policies and Procedures*.

* Excluded services are not to be provided to inmates unless approved by level 4. Services include surgery, such as tubal ligation.

† Nonexcluded services are medical services not otherwise defined as excluded services in state regulations.

Selected California Code of Regulations, Title 22, Requirements Regarding Informed Consent for Sterilizations

- The patient must be at least 18 years old or independent.
- The patient must consent at least 30 days before the sterilization, but not more than 180 days.

Exceptions: Sterilization may be performed at least 72 hours after consent if the patient either:

- Waives the 30-day waiting period in writing.
- Undergoes emergency abdominal surgery or premature delivery and consent was at least 30 days before the expected date of surgery or delivery.
- The patient must be given an opportunity to have a witness of her choice present at the time of consent.
- The patient must consent by signing the California Department of Public Health form. The following persons must also sign the form certifying that consent was informed:
 - Interpreter, if one was provided.
 - Person who obtained consent.
 - Physician who performed the sterilization, or an alternate physician.

Sources: California Code of Regulations, Title 22, sections 70707.1 through 70707.7.

When sterilization procedures take place in general acute care hospitals, as was the case with the bilateral tubal ligations we reviewed, the California Code of Regulations, Title 22 (Title 22), specifies how informed consent must be obtained and documented. These requirements apply when the purpose of the procedure is to render the patient incapable of reproduction. Title 22 outlines key roles in the consent process and mandates a waiting period—defined as the time between when the inmate signed the consent form and when the procedure may be performed. Selected Title 22 requirements for informed consent are described in the text box.

Title 22 states that the form provided by the California Department of Public Health must be used to document a patient's informed consent for sterilization. Three or four individuals must sign the form certifying their role in the informed consent process for the sterilization procedure. When the patient signs the consent form, she is certifying that she understands that the sterilization procedure must be considered permanent and irreversible. The patient is also certifying that she understands there is a waiting period and that she can change her mind at any time. The form does not include a place for a witness's signature, although Title 22 permits the patient to have a witness of her choice present when she signs the consent form.

The individual obtaining the patient's consent also signs the form, certifying that the patient appears mentally competent and still desires permanent sterilization after receiving counseling on the procedure's effects and a discussion of alternative forms of birth control. If needed, an interpreter will sign the form attesting that he or she has translated to the patient the information and advice that the person obtaining consent presented orally to the individual to be sterilized.

Finally, the physician performing the procedure or an alternate physician must sign the consent form certifying that, just prior to surgery, the patient was again counseled on the procedure and that consent could still be withdrawn. The physician also certifies that the patient appears mentally competent and that at least 30 days have passed since the patient consented to the procedure, except in instances of an emergency abdominal surgery, premature delivery, or when the patient has waived the waiting period. Regardless of these exceptions to the 30-day waiting period, Title 22 prohibits the

sterilization of a patient less than 72 hours after she has signed the consent form. The physician's counseling to the patient is effectively the last opportunity to ensure that all legal requirements for the patient's informed consent have been satisfied.

Title 15 contains requirements that apply to prisons and defines the requirements for an inmate's informed consent for all medical treatments—not just sterilizations. Such requirements generally state that the inmate's informed written consent must be obtained, as circumstances permit, before treatment is undertaken for serious procedures. Title 15 also states that an inmate is capable of giving informed consent if—in the opinion of health care staff—the inmate is aware there is a physiological disorder for which treatment or medication is recommended; able to understand the nature, purpose, and alternatives of the recommended treatment; and able to understand and reasonably discuss the possible side effects and any hazards associated with the recommended treatment.

As shown in the text box, the Receiver's Office has specific policies for its staff to follow to ensure that there is a thorough discussion between the inmate and the physician before the inmate's consent to surgery. As early as January 2002, both before and after inmate medical care was taken over by a receiver, policies contained within the prison medical procedures required that prison medical staff record the essence of their informed consent discussions with inmates about potential procedures. Further, the prison medical procedures explain that documenting the informed consent process protects the medical staff from charges of battery, negligence, and/or unprofessional conduct.

Excluded and Nonexcluded Medical Procedures That Result in Sterilization

A bilateral tubal ligation—which is not medically necessary—is an excluded service as stated previously. The sole purpose of this procedure is to sterilize a woman. In contrast, a procedure such as a hysterectomy intended to treat cancer or address other health problems also results in sterilization, although that was not the procedure's purpose. From fiscal year 2005–06 through 2012–13, claims data from the Receiver's Office show that 794 female inmates had various procedures that could have resulted in sterilization. We determined that 144 of these inmates underwent a bilateral tubal ligation

Prison Medical Policies and Procedures Regarding Informed Consent

Policies

- Medical staff shall document in the patient's health record that the patient has freely given informed consent prior to treatment.
- Informed consent shall be an educational process.
- Documentation shall substantiate that medical staff has provided sufficient information to the patient in language and terms the patient understands.
- Medical staff shall explain the nature of the anticipated treatment, the expected outcomes and risks, and possible alternatives.
- Medical staff shall document an acknowledgment that the patient can withdraw his or her consent at any time.

Procedures

The prison medical staff shall:

- Use medical notes in the inmate's file to record the essence of the informed consent process.
- Enter the times and dates of all discussions with the patient pertinent to proposed treatment, recording sufficient information about the essence of the discussion.
- Sign the medical notes with his or her full name and title.

Source: *Inmate Medical Services Policies and Procedures* (in effect since January 2002).

or similar procedure for the sole purpose of sterilization.³ We focused our audit on the female inmates who underwent a bilateral tubal ligation, given this procedure's classification as an excluded service under Title 15. Additional information about female inmates is in Table A.1 on page 36 in the Appendix, which details the various sterilization procedures inmates underwent by procedure type. For female inmates who underwent a bilateral tubal ligation, Table A.2 on page 37 summarizes other procedures they had during the same hospital stay—for example, a cesarean section—and Table A.3 on page 37 presents selected female inmate demographics.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor (state auditor) to review the Receiver's Office and other responsible entities' policies and procedures related to sterilizations of female inmates. The audit committee approved eight objectives. Table 2 beginning on page 15 lists the objectives that the audit committee approved and the methods we used to address them.

³ Some of the 144 inmates underwent a medical procedure known as salpingectomy, which is the removal of all or a portion of the fallopian tubes. In this report we use the term *bilateral tubal ligation* to describe a bilateral tubal ligation or salpingectomy performed when sterilization was the intent of the surgery; we do not distinguish between these two procedures.

Table 2
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules and regulations significant to the audit objectives.	Reviewed relevant state laws, regulations, and other background materials.
2 Determine what entities are involved in providing medical services to inmates and identify the roles and responsibilities California Correctional Health Care Services (Receiver’s Office) and other entities, such as the California Department of Corrections and Rehabilitation (Corrections), may have in overseeing medical services and sterilization procedures for female inmates.	<ul style="list-style-type: none"> • Reviewed pertinent state laws, regulations, and federal court documents. • Interviewed key officials.
3 Review and assess policies and procedures used by the Receiver’s Office and other entities that may be involved for handling sterilization procedures for female inmates, including informed consent procedures, and determine whether they are consistent with applicable laws and regulations. <p>a. Identify any changes to the regulations or laws relating to the sterilization of female inmates over the past eight years and determine whether the Receiver’s Office or any other oversight entity’s policies and procedures reflect such changes.</p>	<ul style="list-style-type: none"> • Reviewed laws, regulations, federal court documents, and the Receiver’s Office policies and procedures for utilization management and informed consent in effect during our audit period, including any changes to these documents. • Interviewed key officials. • Compared the laws and regulations to the policies and procedures to determine whether the policies and procedures were consistent with key requirements.
4 Determine how the Receiver’s Office or any other entity monitors to ensure compliance with policies and procedures related to sterilization of female inmates.	<ul style="list-style-type: none"> • Reviewed laws, regulations, policies and procedures, medical records, and other documents. • Interviewed key officials. • Assessed whether sterilization procedures were requested and approved in accordance with pertinent requirements for the following inmates: <ul style="list-style-type: none"> – All females we identified that underwent a bilateral tubal ligation during fiscal years 2005–06 through 2012–13. – Twenty females we haphazardly selected from those females we identified who had a sterilization procedure other than a bilateral tubal ligation during April 2010 through June 2013.
5 Identify protocols and practices relating to obtaining the informed consent authorizing the sterilization of female inmates, including any recent changes in the past eight years. <p>a. Identify any changes to protocols or practices over the past eight years that clarify the circumstances under which a sterilization procedure can be suggested to a female inmate.</p>	<ul style="list-style-type: none"> • Interviewed key officials. • Reviewed policies and procedures, and documents communicating procedure changes.

AUDIT OBJECTIVE	METHOD
<p>6 For the most recent eight-year period, determine the number of sterilization procedures performed each year, and to the extent possible, for each sterilization procedure perform the following:</p> <ul style="list-style-type: none"> • Determine whether the inmate was pregnant, why the procedure was performed, whether the procedure was deemed medically necessary, and whether the process for obtaining approval complied with applicable policies and laws. • Identify the demographics of each inmate, including economic status, ethnicity, race, number of prison terms, number of pregnancies, and number of child births. Determine whether there are any trends in the data. • Determine whether the inmate consented to authorize the procedure and whether such consent was lawfully obtained. Determine when, where, and how the consent was obtained. • Determine whether the sterilizations were performed in conjunction with other medical procedures and, if so, identify those procedures. • To the extent possible, determine whether the inmate was informed about the procedure and whether she filed a complaint about the procedures. 	<ul style="list-style-type: none"> • Reviewed pertinent laws, regulations, policies and procedures, and other documents. • Utilized a certified medical coder to identify Current Procedural Terminology (CPT) codes associated with medical procedures that result in female sterilization. • Using medical claims data that the Receiver's Office supplied and that included CPT codes, we identified all female inmates that underwent a medical procedure that could result in sterilization, including a bilateral tubal ligation, during fiscal years 2005–06 through 2012–13. • For inmates receiving bilateral tubal ligations, we reviewed inmate medical records from the Receiver's Office, from the hospital where the sterilization procedure was performed, and, in some instances, from the physician that performed the sterilization procedure. However, our review was limited because the Receiver's Office and one hospital could not provide us with all inmate health records we requested. We used available records to determine, to the extent possible, the following: <ul style="list-style-type: none"> – Whether the inmate was pregnant, why the physician performed the sterilization procedure, and whether the procedure was deemed medically necessary. – Whether the inmate's sterilization consent complied with applicable laws. – When, where, and how the inmate's consent to sterilization was obtained. – The number of pregnancies and child births for each inmate as well as whether English was her primary language and other selected demographic information. • We reviewed the CPT codes associated with the bilateral tubal ligations to understand how often these procedures took place while at a hospital for child birth. • We reviewed the extent to which inmate medical records documented discussions between the physician and the inmate about the sterilization procedure. We also accessed databases of complaints Corrections and the Receiver's Office each maintain and searched the records for inmates who underwent a bilateral tubal ligation. For these inmates, we did not identify any complaints regarding this procedure.
<p>7 Determine funding sources for the sterilization procedures and whether the expense for such procedures was appropriate and allowable. If not, identify any consequences.</p>	<p>We identified one inmate for whom we determined that the Receiver's Office received Medi-Cal federal reimbursement for the inmate's pregnancy-related hospital services, which included a bilateral tubal ligation. Both state and federal regulations prohibit the use of Medi-Cal funds for the sterilization of institutionalized individuals. Although the Receiver's Office did not seek reimbursement for the bilateral tubal ligation procedure directly, we determined that it was performed in conjunction with a cesarean section surgery. Medi-Cal reimbursed the Receiver's Office for a portion of the inmate's hospitalization costs including use of the surgical room; the reimbursement included federal funds. We notified the Receiver's Office and the California Department of Health Care Services—which administers Medi-Cal—and directed these entities to evaluate the appropriateness of the Medi-Cal reimbursement for this inmate. In order to identify the Medi-Cal reimbursement, in addition to some of the methods noted above, we performed the following steps:</p> <ul style="list-style-type: none"> • Reviewed budget documents showing federal reimbursements for inmates receiving medical care at off-site facilities. • For inmates receiving tubal ligation procedures during the time when the State was receiving federal reimbursement, we researched whether the Receiver's Office submitted reimbursement claims for these inmates.
<p>8 Review and assess any other issues that are significant to the policies and procedures of the Receiver's Office or other responsible entities related to the sterilization of female inmates.</p>	<p>Our review of medical claims data and inmate health files at times raised concerns about the accuracy of the medical claims the Receiver's Office may have paid. We provided the Receiver's Office with the information necessary for it to research these claims.</p>

Assessment of Data Reliability

In performing this audit, we relied upon electronic data files extracted from various information systems. The U.S. Government Accountability Office (GAO), whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Table 3 shows the results of this analysis for data obtained from the Receiver’s Office and Corrections.

Table 3
Methods Used to Assess Data Reliability

INFORMATION SYSTEM	PURPOSE	METHODS AND RESULTS	CONCLUSION
California Correctional Health Care Services (Receiver’s Office) Contract Medical Database (CMD) CMD Access Version CMD Web Version CMD Interface Data as of November 2013	To determine the number and type of sterilization procedures by fiscal year performed on female inmates for the period of July 1, 2005, through June 30, 2013.	<ul style="list-style-type: none"> We performed data-set verification procedures and electronic testing of key data elements and did not identify any issues. We performed manual review of medical records for all 148 inmates electronically identified as having undergone a bilateral tubal ligation procedure. As a result of this review, we identified four inmates whose CMD records showed that they had undergone a bilateral tubal ligation, but review of the inmates’ hardcopy medical files showed that the procedure was not performed. We did not perform completeness testing due to a variety of factors that make it difficult to determine definitively how often female inmates received medical procedures resulting in sterilization when sterilization was the sole purpose for the surgery, as we describe in the Appendix. 	Undetermined reliability for the purposes of this audit.
California Department of Corrections and Rehabilitation (Corrections) Strategic Offender Management System (SOMS) Data as of December 2013	To identify the demographics of each female inmate who we identified as having undergone a bilateral tubal ligation procedure between July 1, 2005, and June 30, 2013.	<ul style="list-style-type: none"> We performed data-set verification procedures and electronic testing of key data elements and did not identify any issues. In April 2012 we issued a confidential management letter to Corrections that detailed our review of selected information system controls, which included general and business process application controls. During this review, we identified significant weaknesses in Corrections’ general controls over its information systems. General controls support the functioning of business process application controls; both are needed to ensure complete and accurate information processing. If the general controls are inadequate, the business process application controls are unlikely to function properly and could be overridden. Due to pervasive weaknesses in Corrections’ general controls, we did not perform any testing of the business process application controls. Because our audit period covers inmates who underwent a sterilization procedure between July 1, 2005, and June 30, 2013, and we performed our control review in April 2012, the majority of our audit period occurred prior to the issuance of our control review. 	Not sufficiently reliable for the purposes of this audit.
Corrections Tests of Adult Basic Education (TABE) Master File Access Database Data as of January 2014	To identify the TABE reading test score closest to a female inmate’s bilateral tubal ligation procedure date for those inmates who underwent the procedure between July 1, 2005, and June 30, 2013.	(This cell is merged with the previous row's methods and results.)	(This cell is merged with the previous row's conclusion.)

Source: California State Auditor’s analysis of various documents, interviews, and data obtained from the entities listed in the table.

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Audit Results

California Correctional Health Care Services Failed to Ensure That Its Staff and Others Always Obtained an Inmate's Informed Consent Lawfully Prior to Sterilization

Between fiscal years 2005–06 and 2012–13, 144 female inmates underwent medical procedures that were intended to result in permanent sterilization. These medical procedures—which were bilateral tubal ligations or comparable procedures in which the fallopian tubes are cut to prevent conception—were sometimes performed without satisfying the legal requirements for obtaining inmates' informed consent for sterilization. Overall, we noted that 39 inmates were sterilized following certain deficiencies in the informed consent process. For 27 consent forms, we saw no evidence that the inmate's physician—the individual who would perform the procedure in a hospital or an alternate physician—signed the required consent form. For 18 consent forms, we noted potential violations of the required waiting period between when the inmate consented to the procedure and when the sterilization surgery actually took place.⁴ Some inmates were sterilized even though their consent form reflected violations of both of these requirements. Our legal counsel has advised us that, based on these facts, a court would likely conclude that these 39 inmates' consent was not lawfully obtained. Moreover, although neither the California Department of Corrections and Rehabilitation (Corrections) nor employees of California Correctional Health Care Services (Receiver's Office) actually performed the sterilization procedures themselves, our legal counsel advised us that Corrections and the Receiver's Office nevertheless have a responsibility to ensure that the informed consent requirements were followed in those instances when their employees obtained inmates' consent, which was the case for at least 19 of the 39 inmates.

The missing physicians' signatures on the consent forms are particularly concerning because each physician must certify, by signing the form shortly before the sterilization procedure, that the required waiting period has been satisfied and that the patient appears mentally competent and understands the lasting effects of the procedure. The physician is the last check in the informed consent process and provides the patient with the final opportunity

⁴ In early June 2014, one hospital informed us that it had found one consent form that was unavailable during our audit fieldwork. The consent form lacked a physician's signature but was signed by the inmate more than 30 days before the sterilization procedure. We have not modified the numbers in our report since the hospital recently made this information available to us and since we characterize such instances in our report as potential violations of the waiting period. We have shared our evidence with the Receiver's Office so that it may refer such cases to the proper authorities for review.

The true number of cases in which Corrections or the Receiver's Office did not ensure that consent was lawfully obtained prior to sterilization may be higher.

to withdraw her consent to having the procedure. Our legal counsel advises us that without such a certification from the physician or an alternate physician, the inmate's consent was not lawfully obtained under state regulations. Given the importance of the physician's role in the informed consent process, we have asked the Receiver's Office—under the direction of the federal receiver—to refer these questionable cases to the Medical Board of California and the California Department of Public Health, which have the enforcement authority to investigate physician and hospital practices, respectively.

The true number of cases in which Corrections or the Receiver's Office did not ensure that consent was lawfully obtained prior to sterilization may be higher. For example, in accordance with its records retention policy, one hospital destroyed seven inmates' medical records, leaving it unclear—based on other health records available from the Receiver's Office—whether the physicians performing these seven sterilization procedures had signed the necessary consent forms. In at least five of these seven cases, the inmate consented to the procedure while in prison. If Corrections or Receiver's Office employees obtained consent from these inmates, Corrections or the Receiver's Office is responsible for ensuring that consent was lawfully obtained prior to surgery.

Since the appointment of the first receiver, effective in April 2006, the Receiver's Office has had ultimate responsibility for ensuring adequate medical care for the State's inmate population. During our review, it became apparent that the Receiver's Office lacks a process to ensure that its prison-based medical staff and others follow the informed consent requirements under the California Code of Regulations, Title 22 (Title 22). The Receiver's Office confirmed that its own employees were the individuals obtaining the inmates' consent in 15 of the 27 instances in which physicians did not sign the consent forms and in 7 of the 18 instances in which the criteria for the waiting period was potentially not met.

We asked the deputy director of medical services to explain why the Receiver's Office did not ensure that an inmate's informed consent for sterilization was obtained lawfully in those cases in which its employees were the persons obtaining consent. A Receiver's Office attorney responded to our inquiry, stating that the specific provisions of Title 22 do not apply to prison employees because Title 22 applies to general acute care hospitals. Further, the attorney stated that the Receiver's Office is not in a position to ensure compliance by staff outside of the prison because it does not have prison clinical staff present at the hospital to observe the final signature process every time an inmate undergoes a procedure. Finally, the attorney stated that the Receiver's Office does not believe that the inmates' consent was unlawful, providing no further explanation for such a conclusion.

Contrary to the belief expressed by the attorney for the Receiver's Office, our legal counsel advised us that a court would likely conclude Corrections⁵ and the Receiver's Office had a responsibility to ensure that informed consent for sterilization was lawfully obtained from female inmates when their employees were the persons obtaining the inmates' consent. California courts have held that a physician who did not perform a medical procedure may be responsible for obtaining informed consent from the patient if the doctor performing the procedure fails to do so. In reaching these decisions, the courts focused on the high level of involvement by the physician in providing care to the patient before the procedure was performed by a different doctor. In this regard, Corrections and the Receiver's Office are legally responsible for providing medical treatment to inmates and for obtaining the inmate's written informed consent for serious medical procedures. Moreover, at times the inmates' medical records show that employees of Corrections or the Receiver's Office provided prenatal care to these patients and arranged for the sterilization procedures to be performed outside of the prison in a general acute care hospital. In addition, employees for Corrections and the Receiver's Office were the persons obtaining the inmates' consent to sterilization for at least 19 of the 39 inmates for whom we noted problems. Given these legal authorities and facts, our legal counsel determined that a court would likely conclude that prison health authorities were responsible for ensuring that these inmates' informed consent met legal requirements because a physician at a hospital failed to sign the consent form or failed to ensure that the requirements for a waiting period had been satisfied.

Employees for Corrections and the Receiver's Office were the persons obtaining the inmates' consent to sterilization for at least 19 of the 39 inmates for whom we noted problems.

Physicians Sometimes Sterilized Inmates When Available Health Records Cast Doubt on Whether the Required Waiting Period Was Observed

If the Receiver's Office had a process to review the informed consent forms signed by inmates prior to sterilization, it would have noted not just the absence of the physician's signature on some of the consent forms, but also potential violations of the required waiting period between the date of the inmate's consent and the date of sterilization. Although we could not definitively conclude whether timing violations had occurred, given that some inmates' medical records were incomplete, we nevertheless identified 18 cases in which we have concerns that inmates may have been sterilized without complying with the necessary waiting period.

⁵ Corrections was responsible for inmate health care between July 1, 2005, and the appointment of the first federal receiver, effective April 2006. During this time period, 15 inmates had tubal ligation procedures. Documentation in the available and potentially incomplete medical records demonstrated that for at least four of these inmates, potential violations of the informed consent requirements occurred.

In 17 of the 18 cases for which we have concerns, inmates were sterilized less than 30 days after signing a consent form even though the law requires patients to have at least 30 days between the date of consent and the date of sterilization.

With some exceptions, Title 22 requires that patients who are to be sterilized in a general acute care hospital have at least 30 days (and no more than 180 days) between the date of consent and the date of sterilization. In 17 of the 18 cases for which we have concerns, inmates were sterilized less than 30 days after signing a consent form, and in the remaining case the inmate was sterilized more than 180 days after consent was obtained. In 12 of these 18 cases, the inmates provided consent to sterilization while in prison, and the Receiver's Office confirmed that its employees—or Corrections' employees—obtained consent in seven of the 12 cases. Title 22 generally prohibits sterilizing a patient unless she has had a specific period of time to consider this permanent and life-changing decision, and prohibits sterilizing a patient once this time has elapsed, after which consent must be renewed to be effective.

Under Title 22, sterilization may occur sooner than 30 days when a patient voluntarily requests in writing that it be performed in less time or when the procedure is performed at the time of emergency abdominal surgery or premature delivery.⁶ However, in all cases 72 hours must have passed after written informed consent is given. Our review of available medical records found instances in which we question the application of these exceptions to the 30-day waiting period. For example, the hospital physician for Inmate A from Valley State Prison for Women (Valley) cited emergency abdominal surgery as a justification for sterilizing the inmate before the end of the 30-day waiting period. Inmate A signed her consent for sterilization on November 27, 2007, at Valley prison. The inmate's expected delivery date was January 3, 2008 (more than 30 days after her consent). However, on December 18, 2007, the prison scheduled Inmate A for a cesarean section—a type of abdominal surgery—and a bilateral tubal ligation procedure to take place on December 21, 2007. When scheduling the procedures to take place, prison medical staff noted that the cesarean section procedure was “routine” as opposed to “urgent” or “emergent,” and we saw no indication in the inmate's medical record to indicate an emergency medical condition. Inmate A was sterilized on December 21, 2007, 24 days after she consented to the procedure and 13 days before her expected delivery date.

In another example, we are skeptical as to how a scheduled cesarean section procedure would constitute premature delivery when the procedure was planned to take place on a date before the inmate's expected delivery date. Specifically, on June 23, 2009, Inmate T from the California Institution for Women (CIW)

⁶ When a patient is sterilized prior to expiration of the 30-day waiting period due to premature labor or emergency abdominal surgery, Title 22 still requires the patient to consent at least 30 days before her expected delivery date or 30 days before she intended to be sterilized.

signed her consent for sterilization, with the signing occurring at the prison and the person obtaining consent being an employee of the Receiver's Office. Inmate T's expected delivery date was July 30, 2009, or more than 30 days after her consent. However, on July 12, 2009, the prison scheduled Inmate T for a cesarean section procedure on the following day, July 13, 2009, 17 days before her expected delivery date and only 20 days after she had consented to sterilization. A review of her medical record did not indicate any emergency conditions that necessitated an earlier delivery.

In other cases, physicians signed consent forms indicating that 30 days had passed when this clearly was not the case. For example, Inmate K from Valley signed her consent for a bilateral tubal ligation on January 12, 2010, and was sterilized on February 3, 2010, only 22 days later. For another inmate at Valley, the physician correctly claimed that 30 days had passed but failed to realize that more than 180 days had elapsed. Specifically, Inmate D from Valley signed her consent for sterilization in prison on June 20, 2006, and was sterilized on January 2, 2007, or roughly 196 days after consent.

One of the reasons for waiting at least 30 days before sterilization is to provide the patient with enough time to reflect on her choice and to make sure she desires sterilization. During our review we came across one inmate who may not have desired to be sterilized and, in our opinion, for whom there was no valid consent form. Inmate X from Valley initially consented to sterilization via bilateral tubal ligation on June 20, 2008; the person obtaining consent was an employee of the Receiver's Office. However, about three weeks later, on July 10, 2008, Inmate X changed her mind. Medical notes in the inmate's medical record confirm that she changed her mind and indicate that the signed consent form was returned to the inmate. Then on August 12, 2008, prison medical staff scheduled the inmate for a cesarean section at a general acute care hospital on September 17, 2008. The inmate's prison medical records do not indicate that she was also being scheduled for a sterilization procedure, and there are no other medical notes reflecting that the inmate again chose to be sterilized. Nevertheless, when the inmate arrived at the hospital on September 17, 2008, she signed a standard hospital-developed consent form for surgery, documenting her consent to a cesarean section and bilateral tubal ligation. However, the hospital consent form did not recognize the 30-day requirement for sterilization. We also noted that the physician performing the surgery somehow obtained the sterilization consent form that had been returned to the inmate in July and signed it. Given that Inmate X had previously withdrawn her consent to be sterilized—which was her right—we question the lawfulness of Inmate X's consent to sterilization, because the necessary waiting period was not observed. In our opinion, prison medical staff and

Physicians signed consent forms indicating that 30 days had passed when this clearly was not the case.

the hospital physician were obligated to ensure that Inmate X had signed another sterilization consent form that allowed for a lawful waiting period.

Inmates Who Consented to Sterilization While in Prison Likely Did So Without a Witness of Their Choice

The problems associated with the lack of physician signatures on the consent forms and potential waiting period violations are compounded by the fact that inmates have little or no opportunity to have a witness of their choice present when they sign the sterilization consent form in prison. Inmates frequently signed these forms in prison, accounting for at least 110 of the 144 inmates whose records we reviewed. An attorney from the Receiver's Office explained that allowing inmates to have a witness of their choosing during the consent process is practically unworkable in a prison setting. If an inmate wanted anyone from anywhere as a witness, according to the staff counsel, the Receiver's Office could not accommodate such a request for logistical reasons and for institutional safety and security concerns.

Nevertheless, Title 22 is very clear in stating that an individual has given informed consent to sterilization "only if" certain requirements are met. One of these requirements is being permitted to have a witness of the patient's choice present when consent is obtained. Although the witness is not required to sign the consent form, and no place on the form is provided for a witness's signature, having a witness of the patient's choice present—who presumably knows the patient well—serves as a safeguard to help ensure that the patient understands the procedure and truly desires to be permanently sterilized. A witness of the inmate's choice can also help protect the State from allegations that the inmate was coerced into her decision to be sterilized. The unwillingness or inability of the Receiver's Office to provide inmates with the opportunity to have a witness of their choice—as required by Title 22—serves to reinforce and highlight the problematic process that prison medical staff followed when obtaining inmates' consent for sterilization.

The unwillingness or inability of the Receiver's Office to provide inmates with the opportunity to have a witness of their choice highlights the problematic process that prison staff followed when obtaining inmates' consent for sterilization.

Prison Medical Staff Did Not Document Their Discussions With Inmates Regarding Sterilization Procedures

Finally, our review of consent practices of the Receiver's Office related to sterilization uncovered another systemic deficiency in how prison medical staff adhere to informed consent requirements. As discussed in the Introduction, the *Inmate Medical Services Policies and Procedures* (prison medical procedures)

establishes expectations for how inmates are to be counseled and how informed consent is to be obtained in a prison setting. Since January 2002 prison medical procedures have required that informed consent be a process to educate the inmate and that prison medical staff document in the inmate's health file the date, time, and essence of the discussion about a potential procedure and its risks and alternatives. For the 144 inmates we reviewed, we looked for documentation in each inmate's medical record that would allow us to evaluate how inmates were counseled on the proposed sterilization procedure and what information they were provided about the procedure beforehand. However, for all 144 cases we reviewed, prison medical staff failed to document what was discussed with the inmate, as required by prison medical procedures. Sometimes, prison medical staff simply noted that the inmate signed the consent form or that the inmate "desires sterilization."

The lack of notes in each inmate's medical record regarding informed consent and sterilization made it impossible for us to conclude on the quality and the content of the consultation between prison medical staff and each inmate. We were also unable to reach a conclusion as to whether inmates received information about the procedure and whether prison medical staff answered inmates' questions prior to their making this sensitive and life-changing decision. We shared our observations about the lack of notes in the inmate medical records with the deputy director of medical services at the Receiver's Office, asking for his perspective on why we saw such limited information in the inmates' medical records regarding the informed consent discussion. In response, the Receiver's Office stated—through an attorney—that it is at a disadvantage in replying to our question because Corrections initiated the policies and training describing how informed consent was to be documented in an inmate's health record. The attorney for the Receiver's Office stated that although his explanation was probably correct, it was speculative. The attorney stated that the procedure has a statutory form that covers all the elements of consent, and in cases where the Receiver's Office physicians started the consent process, they likely assumed that the form would serve as the required documentation, obviating the need to prepare a separate, duplicate progress note. The attorney noted that sterilization represents a rare instance where a procedure carries with it a mandated consent form. Although much time has passed, the Receiver's Office has not eliminated the policy governing documentation of informed consent, and if, in fact, the consent form was a proxy for a progress note, we are surprised by the fact that we did not find consent forms in all the inmate health records we reviewed.

For all 144 cases we reviewed, prison medical staff failed to document what was discussed with the inmate, as required by prison medical procedures.

Protocols Designed to Ensure That Sterilization Is Medically Necessary Failed

As described in the Introduction, Title 15 of the California Code of Regulations (Title 15) requires a review and approval process for certain medical procedures, referred to as excluded services, that generally cannot be provided to inmates. The regulations include sterilization procedures, such as tubal ligations, as an example of excluded services that, if provided, must be approved by the Headquarters Utilization Management Committee (headquarters committee) beforehand. However, Corrections and the Receiver's Office failed to ensure that the prison medical staff under their direction followed state regulations requiring the proper approval of sterilization procedures.

Prison medical staff may have been confused or misinformed about the need to obtain headquarters committee approval prior to an inmate's sterilization. An October 1999 memo to prison medical staff from Corrections—which was the state agency in control of inmate health care at that time—stated that postpartum tubal ligation procedures would be offered to inmates as part of obstetrical care. In our opinion, the 1999 memo appears to move bilateral tubal ligations from excluded services to nonexcluded services when performed as part of obstetrical care, without acknowledging the required approval process mandated in regulations. Officials at Corrections could not further explain the purpose of the 1999 memo and how it was intended to affect the approval process, if at all, for sterilization procedures.

As shown in Figure 2 in the Introduction, prison medical procedures allow the Receiver's Office to provide excluded services to inmates if utilization management committees at the prison (level 3) and at headquarters (level 4) approve the requested service. These committees are made up of physicians and other correctional officials who evaluate the merits of a medical procedure the inmate's physician has proposed. The inmate's physician makes his or her request by completing a paper form called a Request for Service, which includes spaces to list both the requested procedure and the reason why it is medically necessary. The Request for Service form also has a location to note whether the service has been approved or denied. If the procedure is approved, the form is forwarded to other prison medical staff to schedule the patient for treatment. In the case of a bilateral tubal ligation, the procedure would be scheduled at a hospital with a local physician who works on behalf of the Receiver's Office.

During our review we saw no evidence that the bilateral tubal ligation procedures, with one exception in 2011, received all the required levels of approval.

During our review we saw no evidence that the bilateral tubal ligation procedures, with one exception in 2011, received all the required levels of approval. This may partially explain why

the Receiver's Office asserted that it was not aware that these sterilization procedures were taking place until January 2010, when a legal advocacy group called Justice Now began alleging that medically unnecessary sterilization procedures had been performed. Overall, our file review demonstrated that prison medical staff infrequently requested approval to sterilize inmates, and when they did, it was not always clear that these requests were approved. In many cases, prison medical staff simply requested approval for other medical procedures—such as cesarean sections at hospitals—and did not also indicate that the inmate was to be sterilized. Of the 144 inmates whose records we reviewed, we found only 56 Request for Service forms that gave some indication that inmates were to be sterilized. In 27 of these 56 cases, we did not see any evidence of prior review or approval of the sterilizations. We also did not find a consent form in the inmate's file for one of these 27 inmates; thus, for one inmate the medical records from the Receiver's Office did not contain a sterilization consent or a required medical request and approval.

Shedding further light on how prison medical staff failed to adhere to the utilization management process, we saw that in some instances the time elapsing between when the prison physician requested approval for inmate sterilization and when the procedure was performed was so short that we question how feasible it would have been for utilization management review committees—both at the prison and at headquarters—to review and consider the sterilization procedure before the inmate's surgery. Specifically, we noted that less than a week elapsed between the date of the request and the date of the surgery in 12 instances in which medical staff sought approval for sterilization procedures. For example, we reviewed the medical record for Inmate G, who had been an inmate at CIW. Inmate G's physician submitted a Request for Service form asking for "L+D," meaning labor and delivery, clarifying on the form that the inmate also desired a tubal ligation. The Request for Service form—dated August 10, 2009—lacked any evidence of review and approval. Following a cesarean section in the hospital, Inmate G had a sterilization procedure two days later on August 12, 2009. It is unlikely that the two days between the signing of the form and the surgery were sufficient for both a level 3 and level 4 review of the requested sterilization procedure.

Our audit also noted 18 cases in which prison medical staff requested approval for medical procedures with no mention of sterilization, and yet the inmate was sterilized within one to three days of the request. In a particularly egregious case, the physician for Inmate T at CIW submitted a Request for Service form dated July 12, 2009, requesting approval for "pregnant evaluation/treatment" services, with no additional information on the form to indicate that the physician was requesting a sterilization

Our file review demonstrated that prison medical staff infrequently requested approval to sterilize inmates, and when they did, it was not always clear that these requests were approved.

The Receiver's Office did not adequately monitor and control the sterilization procedures being performed on inmates, and prison medical staff did not always request approval before inmates were sterilized.

procedure for which the inmate had signed a consent form. After having a normal delivery of her child in a local hospital, Inmate T was sterilized the following day, on July 13, 2009.

Overall, our review of available inmate medical records indicates that the Receiver's Office did not adequately monitor and control the sterilization procedures being performed on inmates, and prison medical staff did not always request approval before inmates were sterilized. In light of the 1999 memo that appeared to make certain sterilization procedures an acceptable form of treatment, it is unclear whether prison medical staff thought approval from headquarters was unnecessary before arranging for the sterilization of inmates under their care.

We asked the deputy medical executive at the Receiver's Office (deputy medical executive)—who has been in charge of the utilization management process since July 2008—to explain how bilateral tubal ligations could have been performed without the necessary approvals from headquarters. In response, she explained that female prisons required extensive one-on-one, verbal, telephonic, and other education between 2008 and 2010 to develop both the institutional utilization management committees and the processes for referring cases to headquarters for review. The deputy medical executive also stated that the authorization system is currently paper based, explaining that if an electronic authorization system existed to block the local approval of excluded services, forcing the routing of requests to headquarters for review, inadvertent scheduling of excluded services by institutions could, hypothetically, be decreased. According to the deputy medical executive, an electronic authorization system could allow headquarters staff to review, in real time, which procedures have been authorized in the prisons and generate an alert when proposed medical services require headquarters' review. However, the deputy medical executive acknowledged that the Receiver's Office lacks such an electronic authorization system. With the Receiver's Office relying on prisons to consistently forward paper-based requests for sterilizations to headquarters for approval, coupled with its inability to block prisons from scheduling sterilization procedures without its approval, the Receiver's Office was not well positioned to monitor and control how often inmates were sterilized and whether such sterilizations were appropriate.

The Receiver's Office Must Take Additional Steps to Rectify Failures That Led to Inmates Being Sterilized by Bilateral Tubal Ligation

In 2010, after it became aware that the sterilization procedures were taking place, the Receiver's Office conducted a review that identified weaknesses in the way that the medical staff in the female prisons processed and considered sterilization requests. According

to an internal report the deputy medical executive issued to an executive at the Receiver's Office following a review of Valley and other female prisons, she concluded, "Despite language in Title 15 and the Department Operations Manual restricting the use of sterilizations, [bilateral] tubal ligations, and hysterectomies that are intended to provide sterilization, the leadership teams at [certain female prisons] could not document that an oversight program had been developed to consistently review requests for sterilization, or hysterectomy that would result in sterilization, to determine if they were medically necessary, and that all other conservative measures commonly attempted in the community had failed." In the internal report, the deputy medical executive also commented specifically about problems at Valley, stating that "both the [prison] based OB-GYN physician at Valley and [community-based physicians] do not, to me, appear capable of objective oversight of their utilization, and community-institutional personal and professional familiarity is so high and complex, that [headquarters] oversight of these cases will be necessary to ensure compliance."

The deputy medical executive's comments were well founded regarding the need for oversight from headquarters, as her observations were confirmed by our own. However, we note that the Receiver's Office has since taken some steps to further limit how often sterilization procedures take place, including training medical staff and changing its medical claims system. Our analysis of medical claims data since 2010 from the Receiver's Office shows that the number of female inmates undergoing bilateral tubal ligations and other medical procedures that result in sterilization has greatly decreased. For the eight-year audit period we reviewed, Table A.1 in the Appendix summarizes the medical procedures that had the potential to sterilize the female inmate. Although it is still possible for an inmate to be scheduled for and undergo medical procedures resulting in sterilization without medical staff obtaining all of the necessary approvals, our review of procedures inmates underwent in 2010 and later that resulted in sterilization found that adherence to the utilization management review process improved.

The Receiver's Office Still Must Prevent Staff From Scheduling Unauthorized Procedures

As discussed earlier in this report, just one of the 144 inmates we reviewed had a bilateral tubal ligation that was scheduled and performed with documented utilization management approval. Because the functions of approving a medical procedure and scheduling it are separate, prison medical staff are able to schedule procedures without necessary utilization management review, meaning that inmates could still receive medical services that are not authorized. When we asked the deputy medical executive

Our analysis of medical claims data since 2010 from the Receiver's Office shows that the number of female inmates undergoing bilateral tubal ligations and other medical procedures that result in sterilization has greatly decreased.

Until the Receiver's Office can link medical scheduling with utilization management authorization, it risks inmates being scheduled for and receiving medical procedures that are not authorized as medically necessary.

over utilization management why this weakness has not been addressed, she responded that utilization management has done its best to communicate to scheduling staff that an authorized procedure request is needed, but that utilization management has no authority over the scheduling unit. When we inquired whether the director of health care operations, who is responsible for utilization management and the nursing unit, could give the nursing unit direction to stop scheduling unapproved medical services, the deputy medical executive agreed that this would be a feasible alternative to utilization management needing to acquire scheduling authority. Further, the deputy medical executive noted that a method to electronically block the scheduling of medical services until they receive utilization management approval currently does not exist. However, the deputy medical executive stated that the Receiver's Office is procuring a new computer system that will require prior authorization before scheduling, which should be available in fall 2015. Until the Receiver's Office can link medical scheduling with utilization management authorization, it risks inmates being scheduled for and receiving medical procedures that are not authorized as medically necessary, such as bilateral tubal ligations.

The Receiver's Office Has Taken Steps to Improve Adherence to Its Utilization Management Process

The level of adherence to the Receiver's Office utilization management process may correlate to the level of staff and management training about the process. We believe that it is essential to train prison-based medical staff because they are responsible for ensuring that their institutions provide necessary care. As Figure 2 on page 11 depicts, each institution's utilization management nurse and medical executives play important roles in implementing the utilization management process. The Receiver's Office trains medical staff on the utilization management process in formal and informal ways, including classroom-based coursework, technical assistance, and utilization process monitoring. We found that the 2013 training content was sufficiently comprehensive to ensure that prison-based medical staff understood the utilization management process. Courses for utilization management nurses and prison-based medical executives covered three key components: the utilization management review process, the application of medical decision support criteria, and Title 15 service exclusions and committee reviews.

According to the deputy medical executive, the nurses' training has occurred each year from 2010 through 2013, but the trainings before 2013 focused on the medical decision support criteria and did not include utilization management. She also stated that the medical executives' training is part of a pilot program that began in 2012. The 2014 utilization management work plan—which

outlines quantitative performance objectives for the delivery of health care under state law—indicates that the nurses’ and medical executives’ training is scheduled to run through the end of 2014.

Our review of medical files also revealed better adherence to utilization management requirements since 2010. Specifically, we reviewed medical records for 20 female inmates who underwent nonexcluded medical procedures, such as hysterectomies, between April 1, 2010, and June 30, 2013. For 19 of these inmates—or 95 percent of the cases reviewed—the Request for Service reflected utilization management reviews and approvals. In contrast, utilization management reviews and approvals were found in less than 1 percent of all bilateral tubal ligation cases we reviewed for the eight fiscal years beginning in 2005–06 through 2012–13. For example, Inmate N from CIW had a hysterectomy in 2012 to treat what her medical progress notes cite as uterine fibroids and heavy bleeding. The Request for Service for the inmate’s procedure reflected utilization management review at levels 1, 2, and 3 (refer to Figure 2 on page 11 for information on the levels of review). Although a nonexcluded procedure can be approved at level 2, the Request for Service reflected that the level 2 reviewer deferred the decision and the request went to level 3 (the institution’s utilization management committee), where it was approved. For one inmate we found no Request for Service, and thus we could not determine whether the hysterectomy she underwent was reviewed and approved as required. Despite this lapse, since 2010 the Receiver’s Office is better able to ensure that the treatment inmates are prescribed is scrutinized and deemed medically necessary.

Finally, the Receiver’s Office also made changes to its medical billing system in the fall of 2010 to flag medical claims for certain sterilization procedures and delay the payment of these claims until headquarters could review and approve the procedure. Although the change to its billing system would not prevent sterilizations from taking place, since it focuses on stopping payment for the procedure rather than stopping the procedure itself, this step and the increased trainings appear to have been effective.

Recommendations

To ensure that the necessary education and disciplinary action can be taken, the Receiver’s Office should report to the California Department of Public Health, which licenses general acute care hospitals, and the Medical Board of California, which licenses physicians, the names of all hospitals and physicians associated with inmates’ bilateral tubal ligations during fiscal years 2005–06 through 2012–13 for which consent was unlawfully obtained. The Receiver’s Office should make these referrals as soon as is practicable.

To ensure that it can better monitor how its medical staff and contractors adhere to the informed consent requirements of Title 22, sections 70707.1 through 70707.7, the Receiver's Office should develop a plan by August 2014 to implement a process by December 2014 that would include the following:

- Providing additional training to prison medical staff regarding Title 22 requirements for obtaining informed consent for sterilization procedures, including the applicable forms and mandatory waiting period requirements to ensure that consent is lawfully obtained.
- Developing checklists or other tools that prison medical staff can use to ensure that medical procedures are not scheduled until after the applicable waiting periods for sterilization have been satisfied.
- Periodically reviewing, on a consistent basis, a sample of cases in which inmates received treatment resulting in sterilization at general acute care hospitals, to ensure that all informed consent requirements were satisfied.
- Working with Corrections to establish a process whereby inmates can have witnesses of their choice when consenting to sterilization, as required by Title 22, or working to revise such requirements so that there is an appropriate balance between the need for secure custody and the inmate's ability to have a witness of her choice.
- Until such time as the Receiver's Office implements a process for obtaining inmate consent for sterilization under Title 22 that complies with all aspects of the regulations, it should discontinue its practice of facilitating an inmate's consent for sterilization in the prison and allow the general acute care hospital to obtain an inmate's consent.

To improve the quality of the information prison medical staff document in inmate medical records, the Receiver's Office should do the following:

- Train its entire medical staff on its policy in the inmate medical procedures related to appropriate documentation in inmates' medical records. This training should be completed by December 31, 2014.
- Either develop or incorporate into an existing process a means by which it evaluates prison medical staffs' documentation in inmates' medical records and retrains medical staff as necessary. The Receiver's Office should develop and implement this process by June 30, 2015.

To ensure that inmates receive only medical services that are authorized through its utilization management process, the Receiver's Office should do the following:

- Develop processes by August 31, 2014, such that a procedure that may result in sterilization is not scheduled unless the procedure is approved at the necessary level of the utilization management process.
- By October 31, 2014, train its scheduling staff to verify that the appropriate utilization management approvals are documented before they schedule a procedure that may result in sterilization.
- Ensure that the computer system it procures includes functionality to electronically link medical scheduling with authorization through the utilization management process to prevent all unauthorized procedures, regardless of whether they may result in sterilization, from being scheduled.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Date: June 19, 2014

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

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Appendix

STATISTICAL AND DEMOGRAPHIC INFORMATION ABOUT FEMALE INMATES WHO RECEIVED MEDICAL TREATMENT POTENTIALLY CAUSING STERILIZATION BETWEEN FISCAL YEARS 2005–06 THROUGH 2012–13

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor (state auditor) to determine the number of sterilization procedures performed on female inmates over the most recent eight-year period. The audit committee also asked the state auditor to determine what other procedures, if any, were performed along with these sterilizations and to provide demographic information for the inmates affected.

A variety of factors make it difficult to determine definitively how often female inmates received medical procedures for which sterilization was the sole purpose for the surgery. For example, a woman being treated for uterine cancer may need to have a hysterectomy, resulting in sterilization, even though that was not the stated purpose for the procedure. Complicating matters even further, it is possible that certain inmates were sterilized before our audit period and then subsequently received a hysterectomy or other procedure that commonly results in sterilization. In such circumstances, the hysterectomy or other procedure would appear in our data set, and yet those surgeries did not actually cause the inmate's sterilization.

With these challenges in mind, we addressed the audit committee's request by analyzing California Correctional Health Care Services (Receiver's Office) inmate medical claims data. Table A.1 on the following page provides counts of medical procedures that had the potential to cause the sterilization of female inmates between fiscal years 2005–06 and 2012–13. The table also shows that medical providers submitted claims pertaining to 794 unique inmates for medical procedures that could have caused their sterilization. The procedure groupings in Table A.1 show the number and frequency in which bilateral tubal ligations occurred. According to our medical consultant, the Receiver's Office, and our own file review for each inmate affected, these procedures were performed solely for the purpose of sterilization. We also selected a total of 26 files from the other two categories shown in Table A.1 and concluded that these procedures were performed in response to specific medical conditions and that sterilization was not mentioned as an explanation for the surgery.

Table A.1
Inmate Medical Procedures Potentially Resulting in Sterilization
Fiscal Years 2005–06 Through 2012–13

	FISCAL YEAR								TOTAL NUMBER OF INDIVIDUAL INMATES
	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	
Number of inmates per year	101	154	218	153	100	50	27	18	794*
GENERAL PROCEDURE	NUMBER OF PROCEDURES PERFORMED PER YEAR								TOTAL NUMBER OF PROCEDURES PERFORMED
Bilateral tubal ligation	26	28	37	29	19	4	1	0	144
Hysterectomy	67	104	147	97	70	28	13	13	539
Other	12	27	43	36	13	19	13	6	169
Totals	105	159	227	162	102	51	27	19	852

Sources: California State Auditor's analysis of data obtained from California Correctional Health Care Services (Receiver's Office) Contract Medical Database (CMD), CMD Access Version, CMD Web Version, and CMD Interface Version.

Notes: The data presented in this table are of undetermined reliability for the purpose of reporting medical procedures that could result in sterilization; however, it was the most accessible information. Further, our audit noted four instances in which tubal ligation procedures recorded in CMD did not take place, based on our review of documentation obtained from hospitals, physicians, and the Receiver's Office. As a result, we have adjusted the total number of tubal ligation procedures shown in the table to 144; however, similar errors may exist in other procedure categories.

* 794 is a count of unique inmates that received at least one medical procedure that could have resulted in sterilization. This amount is not a sum of the other data in this row, since some inmates received multiple procedures over the fiscal years shown.

Further, the procedures counted in the table may not always have caused an inmate's sterilization, because the inmate may have undergone a sterilization procedure before our audit period. We grouped inmate medical procedures—as recorded in the Contract Medical Database—based on their Current Procedural Terminology codes.

Because the audit request seemed most focused on inmates who had procedures for which sterilization was the intent of the procedure, we obtained additional data on medical procedures that were performed during the same hospital stay as the bilateral tubal ligation. As shown in Table A.2, the 144 inmates most frequently had bilateral tubal ligations when also having a cesarean section.

Table A.2
Number of Inmates Sterilized at Hospitals During Their Stay for Child Birth
Fiscal Years 2005–06 Through 2012–13

	POSTPARTUM STERILIZATION	PROCEDURE OCCURRED AS PART OF A CESAREAN SECTION	TOTAL FEMALE INMATES
Total	22	122	144

Sources: California State Auditor’s analysis of data obtained from the California Correctional Health Care Services Contract Medical Database (CMD), CMD Access Version, CMD Web Version, and CMD Interface Version.

Note: For the 144 inmates who were sterilized by bilateral tubal ligation during our audit period, we reviewed the Current Procedural Terminology (CPT) codes physicians used to bill the Receiver’s Office for these services. CMD billing records revealed that 22 inmates had CPT Code 58605 (postpartum tubal ligation), while 122 inmates had CPT Code 58611 (tubal ligation at time of cesarean section).

Table A.3 shows selected demographics by fiscal year for the 144 inmates who had a bilateral tubal ligation. The female inmates were typically young when they had their bilateral tubal ligation, mostly between 26 and 40 years of age, and had been pregnant five or more times with at least three childbirths, not counting the child delivered at the time of the sterilization procedure. The inmates generally tested at less than a high school level of reading proficiency and were predominately of the white, Hispanic, and black races. In addition, English was the primary language for the majority of the inmates and most were incarcerated for the first time.

Table A.3
Demographics for Female Inmates Having Bilateral Tubal Ligation Surgery
Fiscal Years 2005–06 Through 2012–13

DEMOGRAPHIC CATEGORY	FISCAL YEAR								TOTAL
	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	
Age at sterilization									
21–25	5	1	5	1	2	0	0	0	14
26–30	4	8	12	11	8	1	0	0	44
31–35	9	10	9	7	8	1	0	0	44
36–40	7	9	9	7	1	1	1	0	35
41–45	1	0	2	3	0	1	0	0	7
Number of pregnancies									
0–4	6	8	6	6	5	0	0	0	31
5–6	12	7	12	10	6	1	0	0	48
7–8	5	7	10	11	7	1	0	0	41
9–21	3	6	9	2	1	2	1	0	24

continued on next page . . .

DEMOGRAPHIC CATEGORY	FISCAL YEAR								TOTAL
	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	
Number of live children									
0-2	4	8	8	4	4	1	0	0	29
3-4	13	11	12	15	7	1	0	0	59
5-6	7	4	14	7	6	2	0	0	40
7-11	2	5	3	3	2	0	1	0	16
Education* (reading grade level)									
Beginning literacy (0-3.9)	4	3	1	3	3	1	0	0	15
Intermediate literacy (4-6.9)	5	9	7	8	5	0	0	0	34
Advanced literacy (7-8.9)	4	2	8	6	3	0	0	0	23
High school level literacy (9-12.9)	12	11	15	12	6	3	1	0	60
No scores available	1	3	6	0	2	0	0	0	12
Ethnicity / race†									
Black	8	9	6	8	3	1	0	0	35
Hispanic	10	9	10	7	10	0	1	0	47
Mexican	1	0	3	1	1	0	0	0	6
White	6	10	16	12	3	3	0	0	50
Other	1	0	2	1	2	0	0	0	6
Primary language									
English	18	8	16	21	14	4	1	0	82
Spanish	1	3	1	0	0	0	0	0	5
Unknown	7	17	20	8	5	0	0	0	57
Number of incarceration periods									
1 period	15	23	27	21	13	2	0	0	101
2 periods	9	2	6	5	5	2	1	0	30
3 periods	2	3	4	3	1	0	0	0	13

Sources: California State Auditor's analysis of inmate health records and data obtained from California Correctional Health Care Services Contract Medical Database (CMD), CMD Access Version, CMD Web Version, and CMD Interface Version; California Department of Corrections and Rehabilitation's (Corrections) Strategic Offender Management System; and Corrections' Tests of Adult Basic Education Master File Access database.

* The groupings are from Corrections' categorization of the inmate's reading ability score on the Tests of Adult Basic Education. The data in this table are the test scores that the inmates received closest to the tubal ligation procedure date, regardless of whether the inmate took the test before or after the procedure.

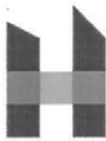
† Race and ethnicity are reported based on Corrections' categories for inmates.

May 30, 2014

Ms. Elaine M. Howle, State Auditor*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Correctional Health Care Services (CCHCS) submits this letter in response to the California State Auditor (CSA) draft audit report titled "Sterilization of Female Inmates: Some Inmates Were Sterilized Unlawfully, and Safeguards Designed to Limit Occurrences of the Procedure Failed." We sincerely appreciate the work of CSA managers, legal office, and audit team members in their development of the audit findings and recommendations.



CCHCS continually strives for improvement and excellence in our business and clinical processes to achieve and meet our mission and goals in order to restore the prison medical services to a constitutionally acceptable level. CCHCS shares the Legislature's commitment and concern to ensuring the quality and medical necessity of health services for our female patient-inmates.

Except as noted below, CCHCS agrees with the basic factual findings set forth in the audit report. The findings described in the audit report date back to policy that was in effect in 1999, or possibly even before. On being made aware of the practices in question, CCHCS took steps to address those concerns, a point that the audit report recognizes.

One issue, which the audit report addresses, is whether CCHCS' duty is to ensure compliance with the sterilization and consent procedures set forth in Section 70707.1, and following, of Title 22 of the California Code of Regulations. CCHCS acknowledges that CSA attorneys have reached different conclusions than those reached by CCHCS attorneys. However, regardless of that disagreement, CCHCS does not discount the prudence of all of CSA's recommendations, and CCHCS will take steps to implement those recommendations.

We should also clarify that no Medi-Cal reimbursement was received related to sterilizations. Although CCHCS had received reimbursement from Medi-Cal for hospital services, such reimbursement did not include any services or procedures specifically related to bilateral tubal ligation.

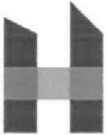
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* California State Auditor's comment appears on page 43.

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Many of the concerns addressed in the audit report will be addressed by CCHCS' adoption of CSA's recommendation that CCHCS discontinue the practice of either obtaining or facilitating a female inmate's consent for sterilization and rather defer to the general acute care hospital to secure that consent. The two-step consent process itself and the waiting period set forth in that process have generated problems, and CCHCS' migration away from involvement in the consent process will avoid many of these issues.

As the audit report also notes, CCHCS' existing paper-based process for review of requests for otherwise excluded services limits its ability to ensure that excluded services, such as female inmate sterilizations, are not scheduled without having received the prior approval of the Headquarters' Utilization Management (UM) Committee. CCHCS' migration to an electronic prospective authorization process will provide better control over this problem.



CCHCS will make appropriate referrals of cases to the Department of Public Health and the Medical Board of California. However, CCHCS must necessarily defer to those entities the determination of whether "consent was lawfully obtained," and CCHCS' referrals will simply be for those entities to investigate, as they may deem appropriate.

It should be noted that, even without the above measures having yet been implemented, CCHCS has made significant strides toward the avoidance of sterilization of female patient-inmates. CCHCS has invested substantial resources and anticipates positive impacts concerning the following:

- UM has developed evidence-based decision support processes using the InterQual library of evidence-based literature to monitor referral requests and approval.
- We are currently developing an electronic prospective authorization process that will preclude entry of any pre-determined "excluded" services through pre-programmed business rules. Scheduling system workflows that will be developed in the future Electronic Medical Record should also supplement exclusion of scheduled excluded services.

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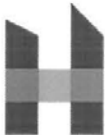
CCHCS would like to thank the California State Auditor for the opportunity to respond to the draft report.

Sincerely,



R. CLARK KELSO
Receiver

cc: Richard Kirkland, Chief Deputy Receiver
R. Steven Tharratt, MD, MPVM, FACP, Director, Health Care Operations
Mitzi Higashidani, Director, Health Care Policy and Administration
Joyce Hayhoe, Director, Office of Communications, Outreach, and Legislation
Janet Lewis, Deputy Director, Policy and Risk Management Services
Johnny Hui, Chief, Internal Audit Program



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Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the California Correctional Health Care Services' (Receiver's Office) response to our audit. The number below corresponds to the number we have placed in the margin of the Receiver's Office response.

We question the assertion made by the Receiver's Office that it received no Medi-Cal reimbursement related to sterilizations. As we state in Table 2, objective 7, on page 16, we identified one inmate for whom we determined that the Receiver's Office received Medi-Cal federal reimbursement for pregnancy-related hospital services. We describe the circumstances of that reimbursement, which include the fact that it covered hospital costs including the use of the surgical room for the inmate's sterilization procedure. We directed the Receiver's Office to work with the California Department of Health Care Services to ascertain the appropriateness of the Medi-Cal reimbursement for this inmate. Until the Receiver's Office has done so, the conclusion the Receiver's Office has drawn is premature.

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