HMA

HealthManagement.com

Sacramento County Correctional Facility Master Planning Services

Phase I/II Report: Functional Assessment and Projected Needs

Section 5.0 – Medical Services Assessment

HMA DLRGROUP
Published on October 30, 2026
Prepared at the Direction of Counsel

INTRODUCTION

This section provides a high-level assessment of current medical services, focusing on operational, staffing, care delivery, and infrastructure factors that affect access, quality, and efficiency. The findings below highlight key challenges, county response efforts, and opportunities for improvement across medical service delivery.

In Sacramento County, legally mandated healthcare is provided by the County's Adult Correctional Health Services (ACH), a division of the Department of Health Services. Medical services provided include initial medical screenings at intake, physical health, dental and pharmaceutical services, medication for opiate use disorder (MOUD)/medication-assisted treatment (MAT), and ancillary healthcare services. ACH contracts with hospital systems or other providers for specialty care and inpatient services.

In addition to directly providing healthcare services, ACH oversees the County's contract with Adult Correctional Mental Health (ACMH), operated through the University of California Davis Department of Psychiatry and Behavioral Sciences, for the delivery of mental health services. Although medical and mental health services are administered through separate operational structures, the populations served frequently present with co-occurring physical health, mental health, and substance use disorders that require coordinated assessment, treatment planning, and continuity of care. Effective collaboration between ACH, ACMH, and the Sacramento Sheriff's Office (SSO) custody staff is therefore essential to ensuring timely access to care, management of complex clinical needs, implementation of the Consent Decree, and successful operation of the broader correctional healthcare system.

SUMMARY OF MEDICAL SERVICES ASSESSMENT

Sacramento County's correctional healthcare system is at an important stage in its ongoing effort to achieve sustained compliance with the Consent Decree while planning for the future healthcare needs of an increasingly complex incarcerated population.

ACH provides legally mandated medical care across the Main Jail (MJ) and Rio Cosumnes Correctional Center (RCCC), including screening, primary care, chronic disease management, dental care, pharmacy services, MAT/MOUD, specialty care coordination, and infirmary services. ACH also oversees the County's contract with ACMH, creating shared responsibility for serving a population with high rates of co-occurring medical, mental health, substance use, cognitive, and functional impairments. Findings from court-appointed experts, federal monitors, and County reviews consistently demonstrate that effective healthcare delivery depends upon strong coordination among ACH, ACMH, custody staff, and community providers.

Sacramento County has made meaningful progress in strengthening correctional healthcare services through leadership recruitment, intake process redesign, improved grievance management, expansion of competency review and onboarding programs, enhancement of withdrawal management services, development of provider productivity reporting, and planning for future technology improvements. These efforts reflect significant organizational commitment to improving care quality, enhancing patient safety, and addressing long-standing compliance concerns identified through the Consent Decree monitoring process.

Despite this progress, healthcare operations continue to be affected by several interconnected challenges. Staffing vacancies, recruitment difficulties, provider backlogs, inconsistent clinical workflows, limited productivity and performance data, care coordination barriers, medication administration inefficiencies, specialty care access constraints, and facility limitations collectively affect timely access to care and operational performance. These challenges are particularly important given the growing number of medically fragile, aging, chronically ill, mobility-impaired, and high-utilizer patients who require intensive coordination across multiple clinical disciplines and levels of care.

The assessment finds that future success will depend not only upon filling vacancies but also upon continued evolution toward a team-based, data-informed model of correctional healthcare. This model should emphasize coordinated primary care teams, housing unit-based service delivery where feasible, expanded telehealth capacity, stronger chronic disease management, improved specialty care coordination, integrated behavioral health collaboration, and a robust quality assurance infrastructure capable of demonstrating sustained compliance and measurable performance improvement. As Sacramento County continues to invest in staffing, technology, facility improvements, and treatment capacity, greater emphasis should be placed on performance measurement, proof-of-practice monitoring, and continuous quality improvement to ensure that operational reforms produce measurable improvements in patient care and system outcomes.

Together, these changes should position ACH to move from a primarily reactive model of care delivery toward a more proactive correctional healthcare system that identifies high-risk patients earlier, manages chronic and complex conditions more consistently, reduces preventable delays, and demonstrates through reliable data that required services are being delivered.

Priority Actions for Continued Improvement

- Stabilize staffing and provider coverage through accelerated recruitment, onboarding, retention initiatives, and development of a team-based care model.

- Reduce provider backlogs and improve access to care through workflow redesign, enhanced care coordination, and expanded housing-unit-based and telehealth-enabled services.
- Strengthen chronic disease management, specialty care access, and transition planning for medically complex and high-utilizer patients.
- Develop a comprehensive data-driven quality assurance and performance management program capable of supporting Consent Decree compliance, proof-of-practice reporting, grievance analysis, clinical auditing, and continuous process improvement.
- Improve integration between ACH, ACMH, custody operations, and community providers to promote continuity of care, reduce operational fragmentation, and improve outcomes for individuals with co-occurring medical, mental health, and substance use disorders.
- Continue investing in technology modernization, including medication administration tools, electronic medical record (EMR) enhancements, referral tracking, and performance reporting capabilities.

GENERAL ASSESSMENT OF CURRENT MEDICAL SERVICES: FINDINGS AND RECOMMENDATIONS

Assessment Approach and Methodology

The medical services assessment was informed by site visits, workshops with County stakeholders, interviews with clinical and operational leaders, review of Subject Matter Expert reports, and analysis of documents provided by ACH leadership. Stakeholders included representatives from medical leadership, ACH, ACMH, SSO, line staff, and County leadership.

The HMA team included a licensed internal medicine physician and a licensed registered nurse (RN) with correctional healthcare experience, and also drew on correctional healthcare standards, national best practices, and professional guidance from organizations such as the National Commission on Correctional Health Care and the American Correctional Association.

Key findings and observations from the evaluation of existing medical services are summarized below, organized along major topics currently impacting operations and delivery of services. For a discussion of physical plant and infrastructure-related deficiencies impacting delivery of adequate medical services to the in-custody population, please refer to Section 6.0 Functional/Operational Assessment of this report.

Physical Healthcare Model

A reliable physical healthcare model in a jail setting depends on more than access to individual clinical encounters. It requires a system that can quickly and reliably identify medical needs at intake, prioritize patients by clinical acuity, track referrals and follow-up needs to completion, coordinate care across disciplines, and adjust services as patient acuity changes. In Sacramento County, many of the issues identified in this assessment are interconnected: patient tracking affects backlog management; backlog management affects grievances and timely access to care; staffing affects care coordination; and technology limitations affect the County's ability to demonstrate whether services are completed as intended.

Findings

Challenges with Patient Tracking and Waiting List Management

Ongoing challenges have been identified with patient tracking, prioritization, and waiting list management. These issues include difficulty maintaining accurate waiting lists, consistently prioritizing patients based on screening-identified acuity, and ensuring reliable follow-up on needs identified during intake. Collectively, these gaps contribute to delays in care delivery and inconsistent clinical follow-through.

These challenges are significant because intake is the first opportunity to identify urgent medical needs, chronic disease conditions, medication continuity issues, withdrawal risk, mobility limitations, and other clinical vulnerabilities. When follow-up needs identified at intake are not reliably tracked through completion, the system may create delays in care, duplication of work, avoidable patient grievances, and missed opportunities to intervene before conditions worsen. A closed-loop tracking process is therefore essential not only for operational efficiency but also for demonstrating that patients receive timely and clinically appropriate follow-up after intake.

- **Backlogs.** Reported backlogs included 574 provider sick call requests, 206 chronic care cases, 235 history and physical examinations, and 460 pending dental cases at RCCC as of September 2025. These areas reflect core clinical care expectations that must be met under federal law and will continue to be a primary focus of federal monitors assessing physical healthcare delivery. Clinical leadership of ACH is keenly aware of these challenges and attributes the backlogs largely to challenges with staffing and lack of standardized efficient workflows based on a team model. They are developing a model of care based on a medical home model which is evidence-based but must be supported by a full complement of well-trained clinical staff alongside clear policies and procedures facilitated within an efficient electronic health record.

ACH leadership and the medical director highlighted the provider backlog at the MJ as a significant issue affecting multiple aspects of care and patient satisfaction.

- **Specialty care access.** Conversations with ACH leadership (February 2026) included the observation that there is difficulty meeting specialty care timelines due to limited resources and lack of strong affiliation of ACH with any local provider with a deep portfolio of specialists willing to see detainees (ACH is not part of a broader health system as you might see in Los Angeles County, Miami/Dade County, Dallas County, Harris County, Cook County, etc.).

Sacramento County Response

- **Intake process revisions.** Sacramento County is updating its Phase 1 intake workflow to refine fit/unfit determinations, provide clearer officer observation guidance, and establish more consistent documentation standards.
- **Intake tools and EMR guidance.** Leadership is rolling out updated intake tools and EMR guidance to improve consistency in clinical decision-making and communication.
- **Care team preparation.** Care team members are being used more intentionally to prepare patients ahead of visits and support smoother clinic operations.
- **Team-based care.** Clinical leadership is planning to transition toward a team-based primary care medical home model.
- **Nurse-driven processes.** ACH leadership is also exploring nurse-driven histories and physicals, and chronic care processes to better use nursing staff within scope and reduce pressure on limited provider resources.

Recommendations

- **Expand housing unit-based services.** Expand housing unit-based services to reduce the need for escort movement and improve access to care and provider productivity. This will require facility renovations, operational adjustments, and cross-disciplinary training, particularly to support ongoing integration of clinical staff within custody environments.
- **Optimize care team roles.** Define and standardize care team responsibilities. Non-provider staff can complete patient preparation, follow-up, documentation support, and routine care coordination tasks within scope, allowing licensed providers to focus on higher acuity clinical decision making and backlog reduction.
- **Standardize waiting list prioritization.** Establish a consistent process for stratifying patients by acuity, intake findings, chronic disease needs, and time waiting so high-risk patients are identified, prioritized, and scheduled for timely follow-up.

- **Expand telehealth services.** Telehealth services should be expanded to increase access to specialty services and follow-up treatment.
- **Create closed-loop follow-up tracking.** Use the EMR or a standardized tracking tool to confirm that intake-identified needs, sick call requests, chronic care follow-ups, and provider orders are completed, documented, and escalated when overdue.

Grievances

Grievances should be treated not only as individual complaints, but also as a core quality assurance data source. Medication-related grievances, access-to-care grievances, and delays in grievance resolution can help identify recurring workflow problems, staffing constraints, communication gaps, and patient education needs. Regular grievance trend review should therefore be linked to corrective action planning, clinical workflow redesign, and leadership review of whether operational changes are reducing the underlying causes of complaints over time.

During a five-month period in 2025, approximately three-quarters of grievances were related to medical services. The most common issues involved medication requests, including new prescriptions, dosage changes, and other medication adjustments. Access-to-care grievances were driven primarily by delays in primary care, with fewer complaints related to specialty care. The average time to resolve a medical grievance during this period was 24 days. Based on grievance report tracking, several operational challenges contributed to delays in meeting the internal 15-day resolution target, which is more stringent than the SSO's 25-day requirement:

- **Leadership turnover.** Oversight shifted between two nursing directors.
- **Grievance nurse shortage.** The grievance coordinator role was also reduced to one SRN covering two facilities; this is insufficient for grievance processing, documentation, and tracking.

Sacramento County Response

- **Additional grievance support.** A second RN was reassigned to support grievance management, and additional RNs were later assigned to help resolve the backlog.
- **Process improvements.** Leadership developed a collaborative process for scanning, archiving and tracking grievances.
- **Quality monitoring.** The quality improvement team is reviewing monitor reports for consistency with requirements in the Consent Decree. Once that consistency is established, they are prioritizing auditable activities to create reports that reflect major drivers of improvement in quality-of-care services.

Recommendations

- **Review medication-related grievances.** Conduct a root cause review of medication-related grievances to identify process changes, such as improvements in chronic medication ordering, that could reduce medication-related requests and complaints.
- **Review medical care-related grievances.** Conduct a broader root cause review of medical care-related grievances to identify triage opportunities and flag high-risk grievances for faster resolution.
- **Timeliness.** Focus intensely on improving the speed of review of grievances to assure compliance with the organizational standard of a 15-day response.
- **Hire additional grievance coordinators to allow timely face-to-face interviews**. The exact number of these coordinators needed is unknown, but as noted in the federal monitor report of January 2026, additional nurse coordinators are needed for this function to allow SRNs to prioritize clinical care and operations.

Inconsistent Clinical Practices

Clinical practices remain inconsistent across intake, clinic operations, medication administration, and off-site referral processes. Intake workflows are being revised to clarify fit/unfit criteria, officer observation guidance, and documentation expectations, but successful implementation will require strong frontline training and support. Historically, limited advance scheduling and inconsistent care team coordination have contributed to missed appointments, inefficient provider use, and gaps in follow-up continuity. Medication administration also creates operational burden, with lengthy medication passes, manual workarounds, and limited barcode scanning functionality increasing staff workload and the risk of inefficiency or error.

Case management struggles with the apparent clumsiness of interfaces between the utilization management software and the EMR. This may be a contributing factor to inappropriate referrals, and to significant instances of incomplete/unsuccessful referrals. These include incomplete loop closure on referrals not made or kept, and alternative recommendations by the utilization review physician not reaching the provider who originated the referral.

These same workflow and care coordination challenges also appear to affect off-site medical transport decisions, including:

- Potential overuse of off-site care for urgent issues that could be managed on-site.
- Reliance on outside specialty services that can be reduced through expanded telehealth or on-site capability.

- Unclear, inconsistent or unreliable referral pathways, including concerns about how specialty referrals are being evaluated and the inefficiency of integration of current criteria guidance within the electronic health record.
- Broader care model and workflow gaps that may be contributing to unnecessary movement off-site.

Sacramento County Response

- **Medication administration streamlining.** The team is working to streamline medication administration by limiting intake medication passes to essential medications and reducing unnecessary medication burden.
- **Medication technology improvements.** Clinical leadership is advancing plans for barcode medication scanning and preparing for the transition to the Fusion EMR to reduce manual workarounds and improve efficiency.
- **Infirmary policies and procedures.** Creating policies and procedures regarding infirmary care, including criteria for admission and discharge, and documentation expectations.
- **Adding expertise in withdrawal management.** Clinical leadership deploys addiction medicine specialists to staff the withdrawal and MAT induction unit. These providers are typically primary care clinicians with additional addiction training and are generally not assigned to routine housing-unit care at the MJ. They are directly deployed at the dedicated detoxification/medications for opioid use disorder housing units, allowing them to focus on this high-acuity, high-risk population.

Recommendations

- **Strengthen chronic condition management.** Accelerate adoption of Veterans Administration (VA) guidelines. Consider whether artificial intelligence could support a reliable crosswalk from VA source code to the EMR, with careful review by the chief nursing officer and medical director.
- **Accelerate information technology supports**:
    - **Center for Innovative Pharmacy Solutions (CIPS) pharmacy software/EMR integration.** Improve integration between CIPS and the EMR.
    - **Outside records integration**. Improve reliable incorporation of outside records.
    - **Standardize** the location in the medical record to document the utilization review physician's feedback and the requesting provider's acknowledgement.

- **Assess off-site acute care use**. Evaluate the drivers and timing of off-site acute, unscheduled care to determine whether an on-site urgent care function could reduce avoidable medical transport.
- **Find ways to address unmet specialty options.** This may require improving reimbursement schedules for specialists to meet locoregional healthcare realities.
- **Expand the ability to provide urgent care availability.** With scope to include addressing minor trauma, lacerations, sprains and other common musculoskeletal injuries, and low acuity/complexity infections without referring to off-site care.
- **Improve post-off-site care reconciliation**. Develop a reliable process for medication and medical record reconciliation after off-site care.

Staffing Shortages, Recruitment, and Retention

This section summarizes staffing-related challenges affecting medical service delivery, including vacancies, turnover, provider scheduling complexity, hiring delays, backlogs, and specialty care access.

Clinical Leadership and Staff Turnover

- **Federal monitors.** Federal monitors note challenges with medical leadership, specifically turnover in the medical director role and the absence of assistant medical directors at the MJ and RCCC. During the course of the project, several high-level medical leadership positions changed or remained vacant, creating instability in clinical oversight and slowing efforts to standardize care delivery.
- **Turnover.** Vacancy levels suggest turnover pressure was most acute in late summer 2025 and again in February 2026, with RN and Licensed Vocational Nurse positions accounting for the largest sustained staffing gaps.
- **Assistant medical director vacancies.** Over the last year, ACH has posted physician leadership positions to lead clinical care teams at the MJ and RCCC. These roles should provide on-site direction for licensed care providers and support improvements in care quality, timeliness, and reliability. Strong on-site medical leadership may also improve recruitment, engagement, and retention, particularly for physicians and advanced practice providers with less correctional healthcare experience.
- **Hiring delays.** Clinical leadership reported that slow hiring processes may result in the loss of qualified physician candidates to competing employers before offers can be finalized.
- **Backlogs.** As discussed earlier in the patient tracking and waiting list management section, provider sick call, chronic care, history and physical examinations, and dental

backlogs remain a significant indicator of access-to-care pressure. In the staffing context, these backlogs underscore the need to stabilize provider coverage, strengthen team-based workflows, and ensure sufficient trained clinical staff to support timely follow-up, backlog reduction, and sustained compliance monitoring.

- **Specialty care access.** Conversation with the ACH division manager (February 2026) included the observation that there is difficulty meeting specialty care timelines due to limited resources and lack of strong affiliation of ACH with any local provider with a deep portfolio of specialists willing to see detainees (ACH is not part of a broader health system as you might see in Los Angeles County, Miami/Dade County, Dallas County, Harris County, Cook County, etc.).

Sacramento County Response

Sacramento County is actively trying to improve staffing and care access. These changes suggest the County recognizes staffing instability as a major driver of care access issues. County leadership has already started several improvement efforts, including:

- **Transition to county positions.** The ACH division manager is overseeing the conversion of registry roles to county-employed full-time positions as budget permits.
- **Medical leadership positions (medical director and assistant medical directors for the MJ and RCCC) have been posted.**
- **Provider recruitment.** Posting multiple licensed provider positions to strengthen clinical capacity.
- **Scheduling changes**. Adjusting physician and advanced practice provider schedules to improve continuity and coverage, including a transition from four 10-hour shifts per week to a two-week schedule of nine eight-hour clinical days.
- **Additional grievance support.** A second RN was reassigned to support grievance management, and additional RNs were later assigned to help resolve the backlog.
- **Process improvements.** Leadership developed a collaborative process for scanning, archiving, and tracking grievances.

Recommendations

- **Track vacancy duration.** Track how long critical positions remain vacant and assess how hiring delays affect continuity, backlog reduction, and staff morale.
- **Assess staff mix and role alignment.** Assess whether the current mix of physicians, APPs, RNs, LVNs, MAs, and support staff aligns with patient needs and the intended care model.
- **Optimize care team roles.** Define and standardize care team responsibilities. Non-provider staff can complete patient preparation, follow-up, documentation support,

and routine care coordination tasks within scope, allowing licensed providers to focus on higher-acuity clinical decision-making and backlog reduction.

- **Protect leadership and training time.** Assess whether clinical leaders and experienced staff have sufficient protected time for onboarding, competency review, workflow redesign, grievance response, quality improvement, and documentation oversight.
- **Implement a workforce strategy.** Implement a comprehensive workforce strategy that includes competitive compensation, loan repayment incentives, professional development, and onboarding with trauma-informed training.
- **Build academic partnerships.** Partner with regional health professional schools and graduate medical education programs to create clinical experiences that expose trainees to correctional healthcare and support future recruitment.
- **Pursue loan repayment site status.** Work with the National Association of Counties (NACo), sheriffs' associations, and elected officials to pursue National Health Service Corps loan repayment site status to the county jail. The National Health Service Corps (NHSC) loan repayment program allows licensed primary care providers in eligible disciplines who serve in Health Professional Shortage Area loan repayment assistance. Federal and state correctional facilities are eligible for the scholarship and loan repayment incentives afforded by the NHSC, but a 1989 federal regulation narrowed eligibility to exclude county jails. The Health Resources and Services Administration, which oversees the NHSC acknowledges that facilities serving major metropolitan areas often operate with a role and scale similar to that of state facilities and has stated that they will consider case-by-case exceptions for large correctional facilities in major metropolitan areas.

Limited Productivity Data

Available data does not yet provide actionable insight into physician and advanced practice provider productivity, limiting leadership's ability to determine whether current staffing levels, role mix, and hiring priorities are aligned with patient demand and backlog reduction needs.

Sacramento County Response

Sacramento County is developing provider reporting tools to better understand licensed provider presence, activity, and productivity. These efforts are intended to give leadership more reliable data to guide staffing assignments, hiring priorities, accountability for care delivery, and backlog reduction.

- **Provider reporting.** ACH leadership is working with the Sacramento County Department of Technology to develop automated reports on licensed provider

presence and productivity. These reports are expected to improve visibility into provider availability, clinical activity, and workload distribution. Improved productivity data should help leadership align staffing levels and role mix with patient demand, support more informed hiring decisions, and target backlog reduction efforts.

Recommendations

- **Define provider productivity measures**. Establish standard productivity metrics for physicians and advanced practice providers, including provider presence, completed encounters, follow-up visits, backlog volume, and time to completion for key clinical tasks.
- **Use data to guide staffing and hiring**. Review productivity and demand data regularly to determine whether staffing levels, role mix, scheduling patterns, and hiring priorities are sufficient to support timely access, chronic care management, and backlog reduction.
- **Link productivity reporting to backlog management**. Use provider reporting to identify where backlogs are growing, which visit types are delayed, and whether care team preparation or task redistribution could improve throughput without compromising quality.
- **Establish routine leadership review**. Incorporate provider productivity, vacancy, scheduling, and backlog reports into regular medical leadership meetings so trends are reviewed consistently and operational adjustments are made in a timely manner.

Complex Provider Scheduling

Significant vacancies and additional staffing needs among physicians and advanced practice providers have created a complicated mix of role types, including full-time, part-time, standby, on-call, and medication-only coverage.

Sacramento County Response

Sacramento County recognizes that the current mix of full-time, part-time, standby, on-call, and medication-only provider coverage complicates scheduling and contributes to inconsistent care continuity. County leadership is prioritizing recruitment of qualified full-time ACH providers to stabilize coverage, improve care delivery, and reduce related backlogs and grievances.

Recommendations

- **Establish core provider coverage standards**. Define minimum on-site physician and advanced practice provider coverage by facility, shift, and clinical function to support

intake, sick call, chronic care, medication-related needs, and urgent clinical decision-making.

- **Prioritize stable full-time coverage.** Reduce reliance on standby, on-call, and medication-only coverage where possible by prioritizing full-time provider recruitment, consistent site assignment, and predictable clinic schedules.
- **Build backup coverage protocols**. Develop clear contingency plans for provider absences, vacancies, surges in intake volume, high-acuity medical needs, and backlog reduction efforts to prevent gaps in access to care.
- **Monitor schedule effectiveness**. Review provider availability, backlog trends, off-site transfers, grievances, and custody escort constraints to determine whether scheduling changes are improving timely access and continuity of care.

Specialty Care Access and Workforce Capacity Constraints

Specialty care access challenges appear closely tied to broader staffing, recruitment, and provider coverage limitations. ACH has reported difficulty meeting specialty care timelines due to limited internal resources and the absence of a strong affiliation with a local health system or specialty provider network willing to routinely serve detainees. These constraints are compounded by provider vacancies, scheduling complexity, and limited data on specialty referral demand, which make it harder to determine which needs require off-site specialty care versus those that could be managed through expanded on-site capacity, telehealth, or more formal specialty partnerships.

Although specialty care records can be located through a search, many referrals to non-ACH specialists are not automatically added to the jail's EMR. This limits access to complete specialty care information and increases the risk that clinically important recommendations may be overlooked.

Sacramento County Response

Sacramento County is actively trying to improve staffing and care access. County leadership has already started several improvement efforts, including posting multiple licensed provider positions to strengthen clinical capacity.

Recommendations

- **Assess specialty referral demand and delays.** Track referral volume, specialty type, wait times, completion rates, and post-visit follow-up needs to identify the highest-priority access gaps.
- **Use telehealth to expand specialty access.** Prioritize telehealth for specialties with high referral volume or delays, where clinically appropriate.

- **Develop formal specialty partnerships.** Pursue agreements with regional health systems, federally qualified health centers, academic medical centers, or specialty groups willing to serve the jail population.
- **Build internal capacity where feasible.** Identify specialty-related needs that could be managed on-site through protocols, provider training, chronic care workflows, or targeted recruitment.
- **Link specialty access planning to staffing strategy.** Use specialty referral data to inform provider recruitment, role mix, scheduling, and partnership priorities.
- **Strengthen reliable information transfer.** Develop roles and responsibilities on the care team for requesting, tracking to effective receipt, and uploading of outside specialty notes into the EMR. For commonly used specialty providers (e.g., University of California Davis, Sutter Health, Kaiser Permanente), develop business associate agreements or other arrangements to allow jail clinicians limited viewing access into those systems' electronic records to view notes from specialty providers.
- **Standardize the location in the medical record to document the utilization review physician's feedback and the requesting provider's acknowledgement.**

Proposed Medical Staffing Plan

There are no defined national staffing ratios or regulatory standards that prescribe a specific number of medical staff by role in correctional facilities. For that reason, the proposed medical staffing plan should be understood as a functional planning framework rather than a fixed detainee to staff ratio. HMA's review considered ACH budgeted staffing, comparison data from three other large municipal jail systems, documents shared by County leadership, healthcare leadership interviews, federal monitor reports, quality reports, and expectations reflected in correctional healthcare standards and best-practice guidance, including the American Correctional Association and National Commission on Correctional Health Care references included in this report. These comparisons must be interpreted with caution, given the high variability in the Average Daily Population, physical spaces, clinical models of care, detainee complexity, and the use of ancillary (e.g. registry) staff across these different environments. The staffing numbers presented in this section reflect information available at the time of the February 2026 evaluation and should be understood as a point-in-time assessment rather than a current staffing census.

The comparison data indicates that ACH's total budgeted staffing is closer to the lower-to-middle portion of the range reported by other large municipal jail systems reviewed. ACH's total budgeted staffing was approximately 83 full-time equivalents per 1,000 detainees, compared with a range of approximately 60 to 150 full-time equivalents per 1,000 detainees in the comparison systems. Given Sacramento County's population complexity, dual-site

operations, Consent Decree requirements, existing backlogs, vacancy levels, and physical plant constraints, the County should plan toward the higher end of the applicable comparison staffing range. This planning position should not be treated as a fixed ratio; staffing levels and role mix should continue to be monitored and adjusted based on patient volume and acuity, access-to-care measures, backlog trends, grievances, staff productivity, and demonstrated progress toward Consent Decree compliance.

ACH's physician staffing was approximately three full-time equivalents per 1,000 detainees, compared with a range of 1 to 7 in the comparison systems. When physicians and licensed advanced practice providers are considered together, ACH budgeted approximately five full-time equivalents per 1,000 detainees, compared with a range of 3 to 12 in the comparison systems. In both of these important clinical categories, Sacramento County's budgeted staffing is at the low end of the comparison range.

ACH's RN staffing was approximately 30 full-time equivalents per 1,000 detainees, compared with a range of 15 to 35, and its licensed vocational nurse staffing was approximately nine full-time equivalents per 1,000 detainees, compared with a range of 6 to 11. ACH also budgeted approximately 16 full-time equivalents per 1,000 detainees for licensed vocational nurses and other clinical support roles, including emergency medical technicians, patient care assistants, and medical assistants, compared with a range of 11 to 18 in the comparison systems. Sacramento County has had a particular challenge with filling the licensed vocational nurse role, and this often results in registered nurses performing duties of the licensed vocational nurse, drawing down from time available for exercising the enhanced critical assessment skills characteristic of the registered nurse.

This comparison should be interpreted cautiously because the comparison systems define staffing categories differently, and in some examples the totals may include mental health, dental, pharmacy, administrative support, or other correctional healthcare positions. Sacramento County's current budgeted staffing structure must be interpreted in light of the many physical space, operational, and detainee complexity challenges present at the Main Jail and RCCC. The current physical plant and operational environment limit the effectiveness of available staff. In addition, the significant number of vacant positions contributes to uneven service delivery, inefficiency, and reduced reliability. Even when contracted or registry personnel are used to meet targeted staffing numbers on a given shift or assignment, their relative unfamiliarity with the jail environment, workflows, documentation expectations, and local practice standards can reduce clinical effectiveness.

The staffing model should be organized around the functions necessary to support timely access to care, consistent chronic disease management, intake follow-up, specialty referral

coordination, medication management, grievance response, training, and performance monitoring. The County should initially plan toward the higher end of the applicable staffing range while continuing to monitor staffing through key performance indicators and periodically adjusting position counts, role mix, and coverage patterns based on actual care demands and results.

HMA recommends the County support a medical staffing plan with sufficient capacity in several core service areas: stable medical leadership at both facilities; team-based primary care capacity that includes physicians or advanced practice providers, RNs, licensed vocational nurses, medical assistants, and care coordination support; dedicated intake and receiving screening resources; chronic disease management capacity; specialty care coordination and outside-record reconciliation support; substance use disorder treatment capacity; training and competency infrastructure; and a dedicated quality assurance and performance management function. In particular, stable county-employed physicians and advanced practice providers are needed to anchor team-based care, supervise clinical decision-making, reduce backlogs, support chronic care management, and provide consistent medical leadership across both facilities. These staffing objectives are consistent with best-practice expectations for correctional healthcare systems serving medically complex populations and are necessary to move from a reactive, encounter-based model toward a more proactive, coordinated, accountable care delivery system.

Sacramento County should invest in a future-state medical staffing model that is organized and adequately staffed to address core service functions, including intake and receiving screening, primary care, chronic disease management, urgent and infirmary-level care, medication management, substance use disorder treatment, specialty care coordination, reentry and transition planning, training and competency support, and quality assurance. Each function should have defined staffing expectations, role responsibilities, coverage standards, and performance measures. The proposed staffing model should meet all required elements of the Consent Decree, reduce existing backlogs, provide evidence-based care for chronic and complex conditions, coordinate specialty and off-site services, support medication continuity, strengthen staff training and competency, and establish a dedicated quality assurance infrastructure. While final position counts should be refined as facility design, housing plans, population projections, and service delivery models, and performance data are finalized, HMA recommends that the County plan toward the higher end of the applicable staffing range and continue to monitor and adjust staffing based on workload, patient acuity, access, backlogs, quality measures, and Consent Decree requirements.

Team-based primary care should be organized around physicians or advanced practice providers, RNs, licensed vocational nurses, medical assistants, and care coordination support.

These teams should be responsible for timely sick call response, follow-up care, chronic disease management, and backlog reduction. Second, chronic disease management capacity should include dedicated responsibility for tracking and managing patients with chronic conditions, including follow-up intervals, laboratory monitoring, medication continuity, and escalation when patients miss appointments or clinical indicators worsen. Third, medical leadership should remain stable and site-based, including a medical director structure, an assistant medical director role, and continued professional development of lead physicians at the MJ and RCCC, allowing clinical leaders to provide supervision, provider support, evidence-based practice guidance, and workflow accountability.

The staffing model should also include dedicated intake support with adequate nursing and licensed clinician capacity for intake screening, urgent medical review, medication verification, withdrawal identification, chronic disease identification, and follow-up scheduling. Intake-related data should be monitored closely to determine whether process changes are producing the intended results and whether staffing levels remain appropriate based on patient volume, acuity, and follow-up needs. Specialty care coordination should maximize currently budgeted capacity for referral tracking, outside record retrieval, incorporation into the EMR, telehealth coordination, post-visit medication and treatment reconciliation, and communication of specialist recommendations to ACH providers. Substance use disorder treatment should maintain dedicated addiction medicine and nursing capacity for withdrawal management, MOUD/MAT induction, follow-up, and coordination with behavioral health and reentry services.

A central goal of the staffing plan should be to reduce Sacramento County's reliance on registry and temporary clinical coverage, including registry nurses and temporary or contract physicians, and transition toward a more stable county-employed workforce. Registry and temporary staff can help cover immediate vacancies, but they are not a durable substitute for permanent staff who understand the jail environment, local workflows, documentation expectations, EMR practices, custody coordination requirements, and Consent Decree-related performance expectations. Heavy reliance on temporary coverage also limits continuity of care, weakens accountability for follow-up, increases onboarding burden, and makes it harder to implement standardized clinical workflows.

Finally, the future-state model should include a stronger quality assurance and performance management function, with staff trained in clinical auditing, performance monitoring, grievance trend analysis, data validation, and corrective action planning. ACH should establish a clearly defined quality assurance program with standardized processes, roles, measures, and feedback loops to support consistent, high-quality clinical care and demonstrate sustained performance improvement. Training and competency support should also be built

into the staffing model, with designated staff, tools, protected time, onboarding capacity, annual competency validation, new workflow implementation support, high-risk clinical practice review, and timely feedback to staff and supervisors. Ongoing monitoring of training completion, competency validation, and practice patterns should be used to confirm that process changes are producing the intended results and that staffing levels remain appropriate based on workload, patient acuity, and operational needs.

Training and Competency

This section highlights training, onboarding, documentation, and competency challenges that affect practice standardization, staff readiness, and the consistency of medical services.

Findings

Training and Competency Gaps

There continues to be concerns about training and ongoing competencies needed to deliver high-quality, standardized correctional healthcare. Key challenges include:

- Turnover
- Need for stronger onboarding and competency assessment

These concerns are compounded by staffing shortages and operational pressures, which limit the time available for training and make it harder to ensure consistent adoption of new practices across the care team.

Sacramento County Response

In response, leadership is expanding onboarding, direct training, and competency review, while working to standardize nursing documentation in the EMR.

Recommendations

- **Strengthen onboarding for licensed providers**. Develop specific onboarding for licensed clinical providers who lack correctional healthcare experience, along with a process for ongoing - especially early-employment - review, problem solving, support, and development. This could include a mentoring approach and will likely be strengthened further when on-site assistant medical directors are in place to provide consistent leadership and experience for licensed providers.
- **Develop role-specific competency pathways**. Create separate competency expectations for RNs, LVNs, providers, supervisors, and support staff so training reflects each role's scope, daily responsibilities, and correctional health risks.

- **Create a structured preceptor model**. Assign experienced staff as preceptors for new hires and staff transitioning into new roles, with defined checklists, observation requirements, and sign-off before independent practice.
- **Establish annual competency validation**. Require recurring competency review for high-risk workflows, including intake screening, sick call triage, medication administration, emergency response, withdrawal monitoring, chronic care, and documentation.
- **Build a training dashboard.** Track onboarding completion, competency validation, overdue training, remediation needs, and staff participation by role and facility to give leadership better visibility into readiness and compliance.

Assessment and Documentation Inconsistency

The January 2026 SME report emphasized continued inconsistency in nursing assessment and documentation, reflecting broader training, competency, and practice standardization gaps that affect the reliability and quality of medical services.

Sacramento County Response

- Expanded onboarding and competency review. In response, leadership is expanding onboarding, direct training, and competency review, while working to standardize assessment, documentation, and adherence to best practices.
- Standardized nursing documentation. ACH leadership is developing a standardized nursing documentation system in Athena (the jail's EMR platform), modeled in part on Kaiser's approach, to guide assessments and treatments. Progress has been slowed by resource constraints, as the Department of Technology is managing multiple competing priorities.

Recommendations

- **Implement structured clinical review.** Develop a process for random but standardized assessment of clinical care, including evaluation of assessment quality, evidence-based care, and clinical documentation. This would align with the prevailing model of ongoing professional performance evaluation used in high-performing healthcare settings.
- **Standardize documentation templates.** Finalize and implement standardized nursing documentation templates in the EMR to guide assessment elements, required follow-up actions, escalation criteria, and treatment documentation.
- **Validate competency through chart review.** Use routine chart audits and direct observation to confirm that staff are completing assessments, documenting clinical reasoning, and following escalation pathways consistently.

- **Provide timely coaching feedback.** Create a feedback loop so nurse educators and supervisors can review documentation findings with staff promptly, reinforce expectations, and address recurring gaps before they become entrenched practice patterns.
- **Build EMR-based prompts and guidance.** Where feasible, incorporate prompts, required fields, and decision-support guidance into the EMR to reinforce complete assessments, consistent documentation, and appropriate referral or escalation decisions.

Strengthen Implementation Support for New Clinical Workflows

New clinical workflows, policies, and EMR changes require structured implementation support beyond online competency modules. Staff need hands-on coaching, real-time troubleshooting, direct observation, and protected practice time in high-pressure settings such as intake, clinic operations, medication administration, and housing-unit care. Without this support, new expectations may be adopted inconsistently, limiting the County's ability to standardize practice, sustain workflow improvements, and demonstrate reliable implementation of Consent Decree-related reforms.

Sacramento County Response

- **Operational prioritization.** The division manager reviews and prioritizes recommendations from Consent Decree reports during weekly medical operations meetings and assigns subgroup follow-up as needed. To avoid overwhelming staff with premature or conflicting information, the division manager coordinates with leadership to communicate only finalized changes.

Recommendations

- **Provide hands-on go-live support.** Pair new workflows, policies, and EMR changes with in-person support during initial implementation, including leadership rounding, real-time troubleshooting, and direct observation in intake, clinic, medication administration, and housing-unit settings.
- **Use scenario-based practice**. Incorporate case-based drills, simulations, and tabletop exercises so staff can apply new expectations to common jail scenarios, such as intake acuity decisions, sick call triage, medication refusals, withdrawal monitoring, emergency response, and escalation to providers.
- **Build unit-level super user support.** Identify and train super users by facility, shift, and role to reinforce new workflows, answer frontline questions, and help supervisors identify early implementation barriers.

- **Protect time for implementation training.** Build training and practice time into staffing plans so implementation support is not deferred because of vacancies, backlogs, or daily operational demands.
- **Monitor sustainment after rollout.** Track adoption of new workflows through chart audits, supervisor observation, staff feedback, grievance trends, and backlog measures, then use findings to refine training and coaching.

CLINICAL AND TREATMENT PROGRAMMING SPACE FOR MEDICAL

High-Need, High-Use Medical Population

In response to the consultant team's analysis of high-use populations, healthcare and custody staff described in detail how a relatively small group of medically fragile, mobility impaired, and functionally limited individuals consume a large share of higher acuity beds.

They confirmed that many of these individuals are booked on violation-type offenses and return frequently for short stays that accumulate into significant bed day use. We also heard consistent observations about an aging population, an increase in wheelchair users, and limited housing that is truly appropriate for older adults, including women. This discussion gave us a clearer, fact-based picture of a defined high-need, high-use segment that must be explicitly planned for rather than treated as an anomaly.

This population should be treated as a defined planning population for medical services, housing, staffing, and facility design. Medically fragile and functionally limited patients, including those with intellectual or developmental disabilities, often require more frequent nursing contact, provider follow-up, medication support, assistance with activities of daily living, mobility accommodations, specialty care coordination, and discharge planning. When appropriate housing, clinical space, and care coordination resources are limited, these patients may remain in higher-acuity beds longer than clinically necessary or may require workarounds that increase demand on custody and healthcare staff. Future medical planning should therefore include explicit assumptions for the volume, acuity, housing needs, and staffing impact of high-need, high-use patients.

Physical Plant Limitations and Medical Care Delivery

Finding

Physical Plant Limitations Constrain Medical Access, Workflow, and Care Delivery

Existing medical and housing spaces do not appear sufficient to support the level of clinical access, privacy, mobility accommodation, treatment capacity, and team-based workflow required for the current and future population. These limitations affect the County's ability to

provide timely sick call, chronic care follow-up, urgent evaluation, medication administration, specialty consultation, telehealth, and care coordination. Space constraints are not merely infrastructure issues; they directly affect staffing efficiency, patient movement, provider productivity, timely access to care, and the County's ability to sustain compliance with required medical care standards.

Recommendation

- **Incorporate medical space requirements into facility planning.** Future facility planning should define the clinical spaces necessary to support the proposed medical care model, including sufficient exam and treatment rooms, accessible clinical areas for mobility-impaired patients, medication administration space, telehealth rooms, urgent care and observation capacity, clinical teamwork areas, confidential care coordination space, and appropriate housing adjacencies for medically fragile and high-utilizer patients. These requirements should be linked to projected population acuity, staffing plans, workflow redesign, and Consent Decree compliance monitoring.

Collaboration and Teamwork to Improve Medical Care Delivery

Finding

Caring for Complex Transient Populations Requires Multidisciplinary Collaboration

Correctional care is by definition a high-risk, high-complexity endeavor. The Sacramento County Jail detains a complex adult population with a high prevalence of physical, mental health, and substance use disorders. A striking proportion of the detainees are unhoused when out of the carceral setting. The physical environment of the jail is inherently stressful. While healthcare systems strive for the quadruple aim of improved patient outcomes, with a good patient experience, lower overall costs, and healthcare professional fulfillment, jail and prison settings should aim for the same.

Unique to carceral healthcare is the intersection of goals of healthcare provision (the objective of the healthcare team) and physical safety and security (the primary objective of the custody team). For optimal outcomes and professional engagement and fulfilment, collaboration in many dimensions is critical. In addition, collaboration between the caregivers providing mental health services and those providing physical health services is necessary for optimal outcomes.

The trend in most American primary care settings is toward team-based care, which at minimum includes a licensed clinical provider (physician or advanced practice provider), an RN, and a medical assistant. In the setting of the jail, this type of team can be deployed to address the spectrum of needs of a general population, from intake to chronic care, to follow-

up of action-requiring abnormal test results, to coordination of specialty care off-site, to transitions of care at discharge.

Sacramento County Response

- **Physical health/mental health integration.** The division manager oversees the mental health team's contract and has implemented various integration methods to align the care given by physical and mental health team members, including monthly multidisciplinary team meetings and joint quality improvement meetings.
- **Medical operations.** The division manager also chairs weekly medical operations meetings. These serve as a driver for broader discussions with decision-makers when physical healthcare provision overlaps with other areas like mental health or dental care. Presently, custody is not part of the medical operations meetings.
- **Team-based care.** The medical director and the nursing director are working to establish care teams where practical and possible but have been hampered by a high number of vacant positions.

Recommendations

Regular huddles involving custody and healthcare:

- Daily:
    - At intake, including booking leadership and nursing leadership-for communication and real-time problem solving
    - At the MJ and RCCC: Operational, with shift supervisors, medical leads, and mental health clinicians, to review any medical emergencies, uses of force, and behavioral health crises; to identify detainees requiring close observation (e.g., for suicidal ideation, signs and symptoms of acute withdrawal), to communicate logistical constraints (e.g., staffing shortages, external hospital transport); and most importantly, to share on-the-fly modifications and adaptations needed to meet identified challenges
    - Safety huddle (separately at MJ and RCCC) involving physician, nursing, healthcare operations, and custody leadership. Discussion should include any identified issues, opportunities for improvement to patient safety or staff safety, grievances at the intersection of custody and care team
- Weekly:
    - Multidisciplinary clinical leadership meeting to:
        - Discuss high-risk inmates with complex medical, mental health, or behavioral needs

        - Align housing, classification, and treatment plans to prevent system failures such as might happen with housing a vulnerable inmate in proximity to an aggressive detainee
        - Plan warm handoffs and continuity of care for inmates nearing release to prevent recidivism
- Monthly:
    - Leadership (at both the MJ and RCCC) to include the custody leadership, division manager, medical director, nursing director to discuss incident reports, grievances, and adverse events, with a goal of identifying systemic solutions and monitoring progress toward shared goals
        - This should include shared objectives such as development of policies and procedures that comply with national standards, federal monitors, and other organizational priorities
        - This may be a venue to also discuss cross-training such as having medical staff train custody on recognizing withdrawal symptoms, legal leadership to train all on shared requirements such as privacy of personal health information, and custody training medical staff on facility security protocols
- As needed:
    - **Critical Incident Debriefs,** which should include all staff involved in a specific event (e.g., suicide attempt, contraband overdose). These should be convened within 24–48 hours of an incident and need to be facilitated by individuals skilled in safety culture, to ensure a blame-free review of what occurred to identify gaps in communication, policy, or response and to determine whether immediate corrective actions are needed to prevent recurrence

REFERENCES

- American Correctional Association. (n.d.). *Standards and accreditation*. American Correctional Association. https://www.aca.org/standards
- Board of State and Community Corrections. (2019). *Title 15: Minimum standards for local detention facilities* (Adult Title 15, effective January 1, 2019). California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 4.
- Budget FY 2025. Maricopa County. https://www.maricopa.gov/ArchiveCenter/ViewFile/Item/5877
- Bureau of Justice Assistance. (2023). *Guidelines for managing substance withdrawal in jails*. U.S. Department of Justice, Office of Justice Programs.
- California Department of Health Care Services. (2023). *CalAIM Justice-Involved Initiative: Policy and operations guide* (October 2023). https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf
- Cook County Health Proposed Budget FY 2026. https://cookcountyhealth.org/wp-content/uploads/FY26-Budget-Presentation_CCH-Finance-08-05-25.pdf
- Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines. https://www.healthquality.va.gov/guidelines/
- Eighth Medical Care Expert Report. (January 13, 2026). https://prisonlaw.com/s/235-1.pdf
- Grievance Report July 2025-December 8, 2025 Final. Provided by County Kitchell, county project managers on the master plan project, via email 3/9/2026. Authorship unknown.
- National Commission on Correctional Health Care. (2026). *Standards for health services in jails (overview)*. NCCHC.
- National Commission on Correctional Health Care. (n.d.). *NCCHC position statements*. https://www.ncchc.org/position-statements/
- National Commission on Correctional Health Care. The importance of custody-health care collaboration, part 1. https://ncchc.org/the-importance-of-custody-health-care-collaboration-part-1/
- NYC Health + Hospitals / Correctional Health Services Service Providers Staffing Report: January 2026. https://council.nyc.gov/budget/wp-content/uploads/sites/54/2026/02/CHS-Service-Providers-Staffing-TC.pdf

- Rosen, D. L., Carda-Auten, J., DiRosa, E., & Travers, D. (2023). Jail healthcare staffing in the U.S. Southeast: A cross-sectional survey. *Journal of General Internal Medicine, 39*(4), 603-610. https://doi.org/10.1007/s11606-023-08454-3
- Sacramento County Department of Health Services Primary Health Division Organizational Chart. "Adopted Budget CURRENT" Correctional Health Services. (November 21, 2025).