Farrell v. Hickman
First Report of Consent Decree by the Medical Experts

Based on Site Visits Conducted

August 23, 2006 to February 15, 2007

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FARRELL MEDICAL EXPERTS

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Introduction

In February 2006, the Health Care Services Remedial Plan (Remedial Plan) was accepted by the parties and filed with the Court. During the course of the year, DJJ's Health Care Services staff worked on implementing the Remedial Plan, focusing initially on hiring headquarters staff and developing health care policies and procedures.

Mike Puisis, DO, departed as one of the Farrell medical experts and with agreement of the parties, was replaced by Joe Goldenson, MD, in August 2006. The medical experts drafted a Health Care Audit Instrument based on standards and criteria in the Remedial Plan and in consultation with the parties and Special Master. From August 2006 to January 2007, the medical experts conducted site visits to Health Care Services at headquarters, and to each DJJ youth facility to field test the audit instrument and to generally assess the status of health care delivery in the facilities. Following these site visits, we developed two documents that were circulated to the parties for comment and discussion:

- a draft audit instrument
- detailed instructions for using the audit instrument to conduct audits

This first report includes a summary of our headquarters and facility site visits. We have included initial assessments of compliance for the Headquarters audit tool. However, because the primary purpose of the first round of site visits was to field-test the audit instrument, our facility findings are somewhat general and do not include assessments of compliance. In this report, we have also included recommendations to address identified problems or to improve efficiencies. A draft version of the report was sent to the parties prior to submission. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated August 8, 2007.

We would like to thank DJJ staff for their cooperation and assistance during our site visits.

Methods of Assessment

During our headquarters and facility site visits, our assessment methods including the following:

- Tours of the facility medical units, Correctional Treatment Centers (CTC), housing units and administrative-segregation units
- Interviews with medical, nursing, ancillary, correctional staff, and youth
- Review of tracking logs and medical records
- Observation of selected health services such as medical reception, nursing triage, and medication administration
- Review of documents including policies and procedures, and treatment manuals
- Review of staffing patterns and professional licensure

Glossary of Acronyms

AGPA	Associate Government Program Analyst
BCP	Budget Change Proposal
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
CMO	Chief Medical Officer
CTC	Correctional Treatment Center
DGS	Department of General Services
DON	Director of Nursing
DPA	Department of Personnel Administration
FMLA	Family and Medical Leave Act
HCS	Health Care Services
HCSRP	Health Care Services Remedial Plan
ITP	Intensive Treatment Program
LOC	Loss of Consciousness
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBP	Monthly Budget Plan
MTA	Medical Technical Assistant
NP	Nurse Practitioner
OHU	Outpatient Housing Unit
OT	Office Technician
PCP	Primary Care Provider
PHN	Public Health Nurse
RFB	Request for Bid
RN	Registered Nurse
SCP	Specialized Counseling Program
SRN	Supervising Registered Nurse
SSA	Staff Services Analyst
TDO	Temporary Departmental Orders
UHR	Unified Health Record
YCC	Youth Correctional Counselor

Health Care Organization, Budget, Leadership, and Staffing

The medical experts visited DJJ Health Care Services (HCS) on August 23-24, 2006 to conduct an initial assessment of HCS progress with respect to implementation of the Health Care Services Remedial Plan (HCSRP). We subsequently conducted a follow-up visit on February 14-15, 2007. At that visit, we evaluated the status of health care using the draft Health Care Audit Instrument audit tool entitled "Health Care Organization, Budget, Leadership, and Staffing."

We thank HCS staff for their assistance and cooperation during these visits. Our findings and assessment of compliance with the questions in the audit tool are described below.

Question 1: The Health Care Services Table of Organization is consistent with the HCSRP (pages 9-10).

DJJ has not finalized a table of organization for Health Care Services. DJJ staff has informed the medical experts that in the final version, the Statewide Medical Director/Director of Health Services will report to the Director of Programs. This is not consistent with the Remedial Plan, which requires that the Statewide Medical Director report to the Chief Deputy Secretary.

DJJ staff stated that the reorganization of the California Youth Authority (CYA) into the Department of Corrections and Rehabilitation, Division of Juvenile Justice (CDCR, DJJ) was directed under Senate Bill SB737. Within that piece of legislation, the structure of DJJ was designed as follows: the Chief Deputy Secretary has overall responsibility for the operations of DJJ. Under the direction of the Chief Deputy Secretary there are three Divisions with a Director appointed over each; the Division of Juvenile Facilities, the Division of Juvenile Programs, and the Division of Juvenile Parole Operations. Although not specifically designated by the legislation, DJJ has determined that Health Care Services is one of the entities that reports through the Division of Juvenile Programs. In addition, DJJ holds that the Remedial Plan does not require that the Medical Director reports directly to the Chief Deputy Secretary, and permits and indirect reporting relationship. The medical experts do not agree with this interpretation of the Remedial Plan and believe that the Plan provides for a direct reporting relationship.

The position of Director of Juvenile Programs is currently vacant, so the Medical Director reports directly to the Chief Deputy Secretary at this time. However, when this position is filled, the Medical Director/Health Services Director will report to the Director of Juvenile Programs and not directly to the Chief Deputy Secretary. Thus, while the department is currently compliant with the remedial plan, when the proposed organization is fully implemented, it will no longer be in compliance.

Although SB737 establishes a broad organizational structure, it is unclear that this legislation specifically prevents the Statewide Medical Director from reporting to the Chief Deputy Secretary. The medical experts' concern is that historically, correctional systems underestimate the complexity of health care service delivery, and often treat health care as simply another program. This often results in inadequate support for health care and in avoidable morbidity and mortality. Thus, the Remedial Plan organizational model was proposed to elevate health services in the organizational structure to ensure that health care issues are given adequate voice and weight in the organization. The medical experts agree that the proposed organizational model is

not the only one that can promote success of the health care program. However, we remain concerned that the position of health services in the proposed organizational structure is potentially problematic, particularly if the Director of Programs has no experience in health care administration.

DJJ has informed the experts that a finalized table of organization will be presented at a court hearing in October 2007. After the DJJ table of organization has been finalized and operationalized, the experts will review and monitor the progress of implementation of the health program and determine if the new structure is acceptable.

Assessment: Non-Compliance

<u>Question 2:</u> The DJJ organizational structure has established a centralized model for health care delivery, supervision, and oversight. Health Care Services has authority over facility personnel decisions including decisions to hire and discipline staff.

As noted above, DJJ has not issued a final table of organization.

Interviews with facility staff during the expert's site visits raised a concern related to the current organizational structure at the institutions. According to the Remedial Plan, headquarters clinical staff, (e.g., Medical Director, Chief Psychiatrist, Chief Dentist, and Director of Nurses etc.) provides clinical supervision of their respective counterparts in the field. The facility Chief Medical Officer (CMO) is to provide administrative supervision of all health care services staff. However, staff at the facilities stated that CMOs administratively supervise health administrators, nurses and physicians; but do not administratively supervise dentists and mental health staff. Staff reported that historically the CMOs were not supportive of the needs of the dentists and mental health staff and, rather than address the issue directly with the CMOs, the reporting relationships were changed. During our tours, CMOs reported that they were generally unaware of the activities of the dentists and mental health staff. This practice does not promote administrative accountability or collaboration. The superintendent is administratively responsible for all areas of the facility, and the CMO should be administratively responsible for health care services at each facility.

Assessment: Not evaluated due to lack of a finalized table of organization.

<u>Question 3.</u> Key HCS leadership positions (HCSRP pages 9-12) are budgeted, filled, or being effectively recruited. Pay parity exists with CDCR.

The following key HCS positions are budgeted and filled:

- The Statewide Medical Director position is budgeted and is technically vacant; however, the position is filled through a contract with UCLA.
- Director of Nurses
- Chief Psychiatrist
- Chief Dentist (there are three Chief dentist positions)
- Pharmacy Services Manager

The following key HCS positions are either not budgeted or filled:

- The Health Care Administrator (HCA) position is not a budgeted position. The HCA occupies a Correctional Health Care Administrator II position from Heman G. Stark. Staff reported that the process of establishing a budgeted position is underway.
- At the time of our review, the Standards and Compliance Coordinator position was established and available to be filled. We have been informed that the position was subsequently filled and the coordinator began working in June.
- The Clinical Record Administrator position was filled, but then vacated in August 2006. Staff reported that this it is very difficult to recruit for this position, since statewide salary levels are not competitive with the private sector. In the interim, HCS has developed an RFB to obtain the services of a contractor to provide administrative record oversight until a permanent staff can be recruited.

We were provided a copy of the Department of Personnel Administration (DPA) pay letter 06-46B that was issued on December 15, 2006. This pay letter brings all of the salaries for applicable DJJ health care workers in parity with health care staff working in CDCR Adult Services.

Assessment: Partial Compliance

<u>Question 4.</u> The Statewide Medical Director position is filled or being effectively recruited and provides competent oversight and leadership of DJJ Health Services in compliance with Remedial Plan requirements (page 10). The Medical Director has medical autonomy for the health care program.

Robert Morris, MD, Professor of Pediatrics at UCLA, is the Statewide Medical Director. He is on a contract position, and normally works Tuesday to Thursdays. Dr. Morris reported that he is available when he is not in the office and often works more than 40 hours per week. When Dr. Morris is at headquarters, he often attends meetings that last much of the day, even when the meetings do not directly relate to health care operations.

With respect to implementing the Remedial Plan, Dr. Morris has:

- Overseen the development and distribution of 29 of 32 initial policies and procedures
- Distributed chronic disease guidelines to the CMOs
- Filled physician vacancies with board-certified or eligible primary care physicians
- Organized and conducted quarterly statewide health care meetings attended by medical, nursing, mental health, and dental staff. The medical experts have attended several of the meetings and found them to be very informative and constructive, encouraging communication and teamwork.
- Medical autonomy over the health care program

In addition, the Remedial Plan calls for the development and implementation of a health care standards and compliance program and a quality management program that includes peer review. According to the plan, both of these programs were due in June. The experts have recently been informed that these programs are currently being developed.

Assessment: Partial Compliance

Question 5. The Statewide Director of Nurses position is filled or being effectively recruited and provides competent leadership and oversight of nursing services in compliance with the Remedial Plan (page 11). The DON has clinical authority for nursing services.

The Statewide Director of Nurses position was vacated on 1/24/07, but filled again in May 2007 by Ms. Cathy Ruebusch, RN. Ms. Louise Allen, RN, previous Director of Nurses, was instrumental in the completion of the initial policies and procedures. However, other aspects of the nursing program, such as training program for nursing physical assessment and protocols, remains to be developed and implemented.

Assessment: Partial Compliance

Question 6. The Health Care Administrator (HCA) position is filled or being effectively recruited and provides competent administrative leadership. The HCA has developed a comprehensive health care budget that includes monthly tracking and reporting for each line item (e.g. pharmacy, hospitalizations, equipment and supplies, etc) per facility. The HCA provides administrative support to clinical staff to ensure that operational systems are functioning smoothly.

The HCA position has been filled since January 2005. Beginning in the 2005-2006 fiscal year, a comprehensive health care budget was established for each facility as well as for headquarters. Also beginning with the 2005-2006 fiscal year, Health Care Services at each facility was required to submit a comprehensive Monthly Budget Plan (MBP) identifying all projected expenditures for each line item. The HCA at headquarters reviews each of these MBPs, and obtains clarification on questionable projections, whether under- or over-projected. The experts will monitor the completeness of the budget tracking process in future visits.

Assessment: Partial Compliance

Question 7. The health care budget is adequate to meet all the requirements of the Health Care Service Remedial Plan. The integrity of the health care budget is maintained (funds are not diverted to other programs except when approved by the Chief Deputy Secretary).

A health care budget has been established. The budget plan provides a detailed chart of accounts for various expenditures. At the time of our review, the health care budget included non-health related expenditures such as Youth Correctional Counselors (YCCs) assigned to specialized treatment programs (e.g., Intensive Treatment Program). This makes it difficult to accurately assess health care expenditures. It is our understanding that as of July 1, 2007, Health Care Services has a completely separate budget that does not include non-health related expenditures. The medical experts will re-evaluate this issue during future visits.

Assessment: Deferred

Question 8. There are job descriptions for each budgeted position in the DJJ Office of Health Services.

We requested and were provided a job description and duty statement for each central office position.

Assessment: Substantial Compliance

Question 9. HCS has developed and implemented a structured, written orientation program for headquarters and field staff. All new headquarters staff is oriented within 30 days of hire. Personnel orientation is documented and maintained in personnel files.

HCS staff has developed a structured, written orientation program for headquarters staff. This is a new program that has not yet been implemented at the time of our visits because no new employees have been hired since its development. The plan is for supervisors to provide specific training to new employees based on their specific assignment. The orientation is to be documented via a checklist that is maintained in the supervisory file.

HCS staff is currently working to develop a standardized health care orientation program for facility staff. For field staff, there is currently a generic 40-hour orientation program at each facility that is mandated for all new employees. The employee then receives specific training based on their assignment. These records are maintained at each facility in the training department (facility orientation) and in the supervisory file (job specific training).

Assessment: Partial Compliance

Question 10. HCS has developed and implemented initial policies and procedures, and health record forms in collaboration with the Medical Experts. These policies are reviewed and updated annually, and as necessary.

The Office of Health Services, in collaboration with the medical experts, has developed an initial set of 29 of 32 policies and procedures and accompanying forms. The Peer Review, Credentialing, and Organizational Structure policies have not been finalized. The remaining policies and procedures are still in draft, pending approval of labor review; however, they have been disseminated to the field as Temporary Departmental Orders (TDOs). Facility staff is in the process of writing local operating procedures to implement the statewide policy.

Assessment: Partial Compliance

Question 11. DJJ Office of Health Services has developed chronic care policies and procedures and clinical guidelines that are consistent with nationally accepted standards of care (e.g., Centers for Disease Control and Prevention, American Diabetes Association, etc.). DJJ has provided appropriate policy and guideline training for the clinicians.

HCS has developed a chronic care policy and procedure, and NCCHC chronic disease guidelines have been distributed to the CMOs with instructions to review the guidelines with the physicians. According to DJJ, small group interactive training on these policies and guidelines has been completed. The medical experts were not aware of these trainings and did not evaluate them. The experts will further evaluate the training during upcoming visits.

Assessment: Deferred

Question 12. HCS has developed and implemented a structured auditing process in compliance with the HCSRP.

The Office of Health Services has not yet developed and implemented a structured auditing process. The absence of a Standards and Compliance Coordinator contributes to the lack of process development.

Assessment: Noncompliance

Question 13. The Clinical Records Administrator monitors health record management at each facility a minimum of once annually to ensure compliance with health record policies and procedures.

The Clinical Records Administrator position is unfilled at this time and monitoring is not occurring.

Assessment: Noncompliance

Statewide Pharmacy Services

As our most recent headquarters visit in February 2007, the Statewide Pharmacy Services Manager position had not been filled and none of the requirements (Questions 1 through 10) for the statewide pharmacy audit tool had been met. Since that time, the position has been filled, but experts have made no further assessment regarding implementation of Remedial Plan requirements.

Assessment: Noncompliance

Other Statewide Health Care Issues

Medical Contracts

A serious issue that was identified during our headquarters and facility site visits was the lack of ability of DJJ to award contracts for the health care services in a timely manner. This is due to the organizational changes that resulted in the transfer of DJJ support staff to CDCR in an effort to become more efficient. However, the result has been a lack of dedicated resources and responsiveness on the part of CDCR Contract Services to DJJ needs, despite multiple efforts on the part of DJJ to resolve the issue. The services for which contracts are necessary are critical to health care delivery in DJJ and include nurse registries, clinical laboratory services, hospital contracts, and psychiatric services. The problems are further described in a June 15, 2007 memorandum from the Special Master to the medical experts (See Appendix A).

In addition to problems with processing of contracts in a timely manner, both headquarters and field staff expressed frustration at their inability to obtain support from CDCR for other support services such as personnel, information technology, etc. Staff reported that they did not have these issues when DJJ had dedicated support services staff.

Staffing

Headquarters and facility staff positions were initially difficult to fill for some job classifications (e.g. nursing, pharmacy) due to lack of timely pay parity with the CDCR adult correctional system. This has, for the most part been corrected.

The experts interviewed staff at the facilities, who stated that a lack of responsiveness at the headquarters and facility personnel level was also responsible for delays in hiring or inability to fill positions because the candidates took another job in the interim period. DJJ asserts that these delays are not due to a lack of responsiveness, but are due to factors that are beyond the control of DJJ management, such as fingerprinting and physicals. In any event, these delays are not acceptable, and CDCR issues which are responsible for these delays need to be addressed.

Staff positions are being added to DJJ as the department considers changing facility missions. During this initial tour of the facilities, the experts did not fully assess the adequacy of staffing but will do so in future visits.

Facility Findings

Facility Leadership, Budget, Staffing, Orientation and Training

At each facility, we used the draft Facility Leadership, Budget, Staffing, Orientation, and Training audit instrument to evaluate the leadership and organizational infrastructure. Below is a brief description of our findings at each facility.

Ventura Youth Correctional Facility

The medical experts visited Ventura Correctional Facility on September 12-14, 2006. At the time of our visit, the population was 210 youth, 140 females, and 70 males at the camp. This is a 39% decrease in population from our last visit in May 2003, when the population was 535 (300 females and 235 males).

All facility leadership positions (CMO, Supervising Nurse, and Pharmacist) were filled. Dr. Mark Hynum is the CMO and is board certified in internal medicine. Although a HCS table of organization has not yet been published, in practice he reports to the Statewide Medical Director on clinical issues and administratively to the Superintendent.

The CMO reported that he did not yet have control over the medical budget because it had not been provided to him. With respect to spending decisions, he believed that he has budget authority; however, technically he had to get signature approval from the business manager.

With respect to clinical staffing, currently the facility has a CMO, 1.0 nurse practitioner, and 1.0 physician and surgeon (although Dr. Hynum has not filled the 1.0 and is using a .5 pediatrician). On-call time is shared by the pediatrician and the nurse practitioner. The CMO stated that 40% of his time is devoted to clinical activities.

In practice, the Supervising Nurse reports clinically to the DON. One issue was that in DJJ, SRN I positions have not been upgraded to SRN II positions, and SRN IIs upgraded to SNR IIIs as has occurred in CDCR. As a result, they were losing SRN IIs to the adult side. We understand that this has been corrected and now SRN's must apply for the upgraded position.

Dr. Hynum reported that it was difficult to hire and retain pharmacists due to salary issues. At the time of our visit, CDCR pharmacy salaries had not been upgraded and therefore, pay parity could not be used as a vehicle to increase DJJ pharmacist salaries. It is our understanding that this has been corrected since our initial round of visits. The CMO plans to upgrade a pharmacist to a pharmacist II position, and hire a pharmacy technician. The CMO believes at this time he has adequate clerical support, recognizing that this may change with the implementation of the new health care programs.

With respect to health care autonomy over the hiring, discipline, and reallocation of health care positions, administrative staff reported that they do not have autonomy in this area. Staff stated that the Superintendent has to sign Letters of Instruction before they can be given to an employee, thus giving the Superintendent control over disciplinary matters. DJJ has stated that this is not the case. The experts will further evaluate this issue on subsequent visits.

There are three clinicians (including one part-time) and one clinical examination room. During medication administration that occurs four times per day, no other youth are permitted to be in the medical unit. This creates significant down time and loss of productivity in the clinic. DJJ has recently informed the experts that this issue has been resolved. The experts will re-evaluate this issue on subsequent visits.

Sanitation in the unit was generally good. The facility currently has a janitor and will be hiring a second janitor in the near future. They also have a team of youth who wax and buff the floors under the supervision of a YCC.

A Senior Medical Transcriber tracks staff licensure, DEA, and CPR certification. Our review showed that all RNs are currently certified in CPR. They did not have copies of the dentist's and senior psychologist's license.

The facility does not have a structured, written orientation for health care staff. Currently training consists of a three-day training that includes blood-borne pathogen and first-aid training. The statewide or local health care policies have not yet been developed, finalized, and implemented.

Heman G. Stark Youth Correctional Facility

We visited Heman G. Stark Youth Correctional Facility on September 25-28, 2006. Heman G. Stark's population was 808 youth at the time of our visit. Although Stark is not a reception center, it receives parole revocators and transfers from other DJJ facilities.

At the time of our visit, the facility CMO position was vacant but has since been filled by John Close, MD. Dr. Close is board certified in Family Practice. The Supervising Nurse II position was filled, and the Correctional Health Administrator position was not filled. Dr. Hue Vo, the medical director for the CTC (and acting CMO at the time of our visit), has since departed and been replaced by Gayanni Reynolds, MD, a psychiatrist.

For the main facility, clinical staffing consists of a CMO, three physicians, and a nurse practitioner. The nurse practitioner sees patients but is also responsible for negotiating hospital contracts, and tracking and paying bills. There are three dentists and two registered dental assistants.

The facility's medical mission includes an 11-bed Correctional Treatment Center (CTC) that is licensed for mental health purposes only. During our visit the census was three youth. For the CTC, clinical staffing consists of a full-time medical director, a psychiatrist who works four hours per day, seven days per week, a licensed social worker (who also functions as the standards and compliance coordinator), and a senior psychologist. Nursing staff consists of nine registered nurses (one who functions as an infection control nurse) and five Psychiatric Technicians. The DON considers himself responsible only for the CTC and not the rest of the facility. There are three dietary employees for the CTC. Ms. Louise Allen, RN, Statewide DON reported to us that for the previous month, the CTC census was less than one patient per day.

Health care staff reported a lack of ability to hire personnel in a timely manner and a lack of autonomy with respect to disciplinary matters. The hiring process depends on timely response by

the facility personnel office, which reportedly was not occurring. Also, disciplinary measures such as Letters of Instruction (LOIs) require approval signature of the Superintendent. As noted above, DJJ stated that this was not the case. The experts will further evaluate this issue during subsequent visits.

With the exception of the pharmacy staff, the facility did not have current copies of medical and nursing licenses. According to a roster, all registered nurses, psychiatric technicians, and MTAs were certified in CPR. No information was provided regarding the CPR certification status of the physicians and nurse practitioner.

With respect to coordination of health care services with facility operations, medical staff reported that custody staff cancels specialty appointments without notifying or consulting them. There were also problems reported with custody escorting youth to the medical clinic for evaluation and treatment in a timely manner. A significant concern is that custody staff requires nurses to be on-standby in case chemical agents are used, which occurs frequently at the facility.

Southern Youth Correctional Reception Center and Clinic (SYCRCC)

We visited SYCRCC on November 12-14, 2006. At that time, its population was 270 youth. The facility's medical missions include medical reception and mental health.

All key health care leadership positions were filled. Dr. Do, CMO, is a general practitioner and is not board eligible or certified in a primary care field. He reported that he has not been given a health care budget and it is not under his management control.

The facility has three clinician FTEs (one CMO, one physician, and one nurse practitioner). They reported that they have adequate budgeted RN positions, but they are not all filled and working positions. There is one RN vacancy and the SRN is out on extended Family and Medical Leave Act (FMLA) status. They are not backfilling with registry because Dr. Do has not approved the use of agency staff. There is no centralized system for licensure tracking system at the facility. The nursing licensure file could not be located for our visit; however, copies of nursing staff licensure were printed from the internet and provided for our review. New policies have not yet been implemented and there is no written orientation program for staff.

Custody support is not consistently provided for health care operations, particularly for sick call. Staff makes multiple calls to custody, who report that youth are on their way, and then nothing happens. Often it requires calls to the Lieutenant to order the officers to bring them up.

There is inadequate support for sanitation services. A janitor position has been allocated; but staff reported that there were no candidates on the certification list to be interviewed and hired.

Preston Youth Correctional Facility

We visited Preston Youth Correctional Facility on November 28-30, 2006. The population of Preston was approximately 400 youth. The facility's medical missions include medical reception (added since 2003), an Outpatient Housing Unit (OHU), and mental health.

At the time of our visit health care leadership positions were all filled; however, the Supervising Nurse was on extended vacation. Dr. Evalyn Horowitz is the CMO and is board certified in internal medicine and infectious disease. Although a HCS table of organization had not been published at the time of our visit, in practice she reports to the Statewide Medical Director.

With respect to clinical staffing, the facility has the following budgeted positions: 1.0 CMO and 2.0 physician FTE positions. However, Dr. Horowitz reported insufficient psychiatry hours.

At the time of our visit, DJJ nurses did not have pay parity with CDCR nurses, and the current advertising on the internet stated a difference between what CDCR and DJJ nurses were to be paid that inhibited recruiting for DJJ. Thus, it had been extremely difficult to hire registered nurses. Given this difficulty in hiring nurses, the use of MTAs has been important in health care operations.

Dr. Horowitz indicated that at this time she does not have effective control of the health care budget because of delays at the business office level. Six months ago the nurses had to go to Wal-Mart to buy band-aids because they could not get the purchase order through the business office in a timely manner. Computers and desks had been ordered in September but had not yet arrived at the time of our visit, two months later. Dr. Horowitz had recently gone on vacation and in her absence, had delegated the purchase of drinking cups to other staff. The business manager approved the purchase, but the Superintendent did not approve it until Dr. Horowitz returned from vacation and signed the form. Staff reported that the business office delays orders by holding onto purchase orders for 30 days and then they review it; if it's not perfect, they send it back to medical to be corrected.

Staff reported that there are problems in getting custody escorts to bring youth to physician sick call.

Earlier in the year, there had been conflict between the superintendent and health care leadership with respect to the primary role of the MTAs and whether their duties were primarily medical or custody. The Remedial Plan is clear that the primary duties of the MTAs are medical. Only registered nurses and licensed vocational nurses can be MTAs. This requirement for health care licensure should place them under the direction of the health care leadership with respect to scheduling and assignment of duties. If there are insufficient numbers of custody staff at a given facility, this should be resolved through normal channels of obtaining additional custody staff.

Dr. Horowitz's biggest concerns were about the purchasing and contracting process.

She expressed her concerns regarding inadequate psychiatry hours. Specifically, she expressed concern that she will not have a psychiatrist at the end of December and has 180 youth who routinely need to be seen. Moreover, due to its reception mission, the facility is receiving 6 - 15 youth per week, some who need long-term services. The existing psychiatrist is not seeing all the youth. Dr. Horowitz has 17 different psychiatry registry contracts and she has to call each one to get candidates. She has pursued individual references and all the psychiatrists she has contacted have turned her down. Our discussion raised the question of whether the psychiatrist or psychologist was the director of the mental health program at the facility. The absence of a departmental table of organization contributes to the lack of clarity.

With respect to hiring, staff reported that the personnel process is a nightmare. The personnel officer is retiring and only present half-time.

Staff reported that currently they do not have adequate clerical support but expect to receive two additional Office Technician (OT) positions. They will then have a total of 4.5 positions, which should be adequate.

Staff reported that the facility does not have adequate sanitation resources to ensure a clean and sanitary environment. Currently they have a ward allocated to the health care unit for three hours a day under supervision of an MTA. (DJJ recently informed the experts that this problem has been resolved and the MTA now only performs nursing duties. The experts will validate this on subsequent visits). The sanitation in the housing unit medication rooms was extremely poor. This is ironic since there is a janitorial vocational program for youth at the facility. A janitor position is being hired in the health care budget.

Dr. Horowitz tracks licensure for the physicians. The acting Supervising Nurse tracks licensure for the nurses.

There is no written health care orientation program at the facility.

Northern California Youth Correctional Complex (NCYCC)

NCYCC consists of three facilities: NA Chaderjian (Chad), OH Close, and Dewitt Nelson. The populations of the three facilities totaled 810 in November 2006. The medical missions include an OHU that serves the complex, an Intensive Treatment Program (ITP), and a Specialized Counseling Program (SCP) at Chad. Chad also has two administrative segregation units of 50 beds each and OH Close has an 18-bed segregation unit. Dewitt Nelson has ad-seg rooms scattered throughout the facility.

Health care leadership positions are filled with the exception of the Pharmacy II supervisor. Dr. Gabriel Tanson is the CMO and is board certified in family practice. Dr. Tanson clinically reports to Dr. Morris, although this is not reflected in an organizational chart. Although the CMO is administratively responsible for health services at the facility, the dental staff does not administratively report to the CMO at any facility. As a result, the CMOs are not responsible and do not know of the activities of the dental staff. He stated that the same is true of mental health staff. Dr. Tanson indicated that this is problematic, since decisions are made regarding mental health staff and he is not informed until after the fact. An example of fragmentation is that when we requested staff licensure, licenses for two dentists and two psychologists were not available for review. Dr. Morris and Dr. Morales later informed us that the CMO does administratively supervise the mental health staff. The CMOs, however, did not appear to be aware of this, and in most of the facilities, such supervision was not occurring.

In addition to the CMO, there are 3 physician FTEs and 1.7 nurse practitioner FTEs. Lisa Pacheco, RN, is the Supervising Nurse II; there are two additional Supervising Nurse 1 positions for the complex.

The facility has four budgeted psychiatrist positions but none of these are filled. They are using registry to fill two days per week.

NCYCC is unique in that there is a unified administrative unit that oversees the budget for the three facilities. The CMO reported that there was a health care budget but he did not know how much money was assigned to medical. Staff also reported that purchases were being held up, pending review by the Superintendent.

Staff reported not having adequate office or clinic space and that some staff is assigned to office space that does not have adequate heating or air conditioning. We did not fully assess this during this visit, but will in subsequent visits.

The procurement and contracting processes are problematic. To better understand the budget and contracting process, we met with the institutional business manager. He indicated that the new CDCR contracting process has greatly slowed things down. Contracts submitted for approval six months ago have still not been approved by CDCR. In the past, approval took three weeks. Staff reported that they have tried to call someone in CDCR personnel or contracts. They've called numerous individuals trying to get answers to questions, without success.

Staff reported significant issues with procurement of medical supplies and services. They still have to put three bids on every purchase over $100. (While the experts recognize that this policy applies to all state agencies, it, nevertheless, makes it difficult for staff to obtain needed supplies and services.) The staff ordered sharps containers for disposal of used needles and syringes and waited months for them to arrive. Once items arrive at the facility, staff has difficulty getting possession of the items because they sit in the warehouse for weeks because procurement hasn't inventoried them or has not sent the truck driver to bring the items to the medical unit. If a piece of furniture is in the warehouse, they might wait months.

With respect to the hiring process, there are significant delays due to the administrative process that includes obtaining Live Scan (fingerprint) results. One nurse who wanted to transfer from Avenal in the adult system to DJJ had applied three months before our visit, and they only received the clearance the week before we arrived. She turned down the job the day prior to our arrival. An Office Assistant who was interviewed on 11/29/06 called on 12/13/06 to say she had taken another job in the intervening period.

Staff reported that they do not have adequate custody support to carry out health care operations. Of particular concern is that a correctional officer is only assigned to the OHU Monday through Friday from 6 am to 2 pm. Thus, there is no correctional staff in the OHU during the afternoons, nights, and weekends, even when there are patients in the OHU. Nurses cannot open the doors without custody staff, who then must be paged if a nurse wants to administer treatment. If there was an emergency, nurses would not be able to respond appropriately.

Staff also reported inadequate support for sanitation and housekeeping. This was reflected by poor cleanliness in the OHU. Staff reported that they have requested a sanitation schedule but have not been given one. Trash is collected in the medical hallway because the custody staff won't open the dumpster lock more than once a day. The medical unit in Chad had not been cleaned in a year. In terms of cooperation with custody, one clinical staff reported that "We are literally a millstone around their neck until there is a crisis."

With respect to orientation, a new employee could be at the facility seven months before receiving facility orientation. Non-peace officer employees used to go to the ancillary new employee orientation that lasted five days. This training is no longer conducted.

El Paso de Robles

We visited the El Paso de Robles Youth Correctional Facility (EPDRYCF) on January 23-25, 2007. At that time its population was 194 males, a 49% decrease from a population of 400 youth in June 2003.

The CMO is Dr. Clemente Rodriguez. Dr. Rodriguez is board eligible in general surgery. He clinically reports to Dr. Morris. Dr. Rodriguez stated that although he is the CMO and administratively responsible for health care delivery, he does not believe he administratively supervises mental health or dental staff. He does not conduct staff meetings and believes that everyone does their own thing. Drs. Morris and Morales were at the facility during our visit and stated that the CMOs are administratively responsible for mental health staff, but not dental staff.

The CMO is the only physician at the facility. Although that is adequate to serve the medical needs of the population, there are issues related to his being the only clinician on call. Given that several facilities have more than one clinician and this is not a medically complicated population, consideration should be given to having a statewide call-sharing system.

All staff has a current and valid professional license. The CHSA is going to assume responsibility for tracking all licensure.

The CMO does not have control over the health care budget and expenditures. Staff reported that they don't yet know how much money is assigned to the budget or how many positions they have. Non-health care expenditures are charged to the medical budget, such as YCC positions assigned to the ITP and accompanying overtime. For example, recently the health care budget was charged $49,000 in overtime due to YCCs. Staff also reported that overtime for correctional officers assigned to the OHU was charged to the medical budget. The CHSA, who is new and learning about the budget process, indicated that overtime charges have been assigned to the medical budget but she was not always aware of where the expense was coming from. She said she believes that any custody staff assigned to medical functions are charged back to medical. There were no problems with ordering medical supplies. The business office was helpful to them.

Staff reported contract issues. They used to have an optometrist on site but because of contract issues they are sending all youth out for optometry examinations. They even have the equipment on-site. The CHSA was not aware of what the specific contract issues were.

Also, the Business Manager negotiated contract terms with Tenant Hospital and it was forwarded through channels to the Department of General Services (DGS). DGS did not like the contract and sent it back to Tenant, who did not agree with the changes. Now the facility has no contract with Tenant Hospital.

Staff reported no significant problems with custody support, although they indicated that access to youth would be more efficient if the facility assigned designated correctional officers to escort and transport duties.

The facility does not have a structured, written orientation for health care staff. The statewide or local health care policies have not yet been developed, finalized, and implemented.

Medical Reception

We reviewed the medical reception process at Ventura Youth Correctional Facility, Southern Youth Correctional Reception Center and Clinic, and Preston Youth Correctional Facility. In general, we found that facilities are in the early phases of implementing the new policies. The medical reception process is not being performed with auditory and visual privacy at all facilities. Staff has not uniformly implemented the new medical reception forms. The quality of the medical history, physical examinations, and treatment plans is generally poor.

Neither Heman G. Stark YCF nor the Northern California Youth Correctional Complex have a medical reception mission; however, parole violators are admitted to both facilities without going through the medical reception process. Thus, these youth are not receiving the medical reception evaluation, as required by the Remedial Plan. This presents a risk that youth with acute, chronic, and infectious diseases will not be diagnosed and treated in a timely manner. Moreover, parole violators may be at risk of alcohol and drug withdrawal. The National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health, in its April 2006 issue of Alcohol Alert stated, "Young adults are particularly likely to binge drink and to suffer repeated bouts of withdrawal from alcohol." Health Care Services should develop and implement protocols for the appropriate management of alcohol and drug withdrawal.

At Ventura YCF, staff reported that the medical reception process is conducted in a private and confidential manner. We did not observe the process during this visit. There were no signs in English and Spanish in the medical area reminding staff of the need to maintain confidentiality. Staff currently provide a verbal orientation to youths, but do not provide written instructions for accessing health care. It was reported that several staff members are fluent in Spanish and staff with sign language skills are at the facility five days a week.

With respect to monitoring the medical reception process to ensure that all components are completed in a timely manner, the staff developed their own medical reception tracking system. However, no one is currently monitoring the log. They plan to implement the headquarters tracking system when the policies are implemented.

At Preston YCF, a registered nurse was in charge of the medical reception/intrasystem transfer process. From May to October 2006 the facility averaged 37 admissions and seven transfers per month, respectively. Preston normally receives new intakes three days a week (Tuesday, Wednesday, and Thursday), and occasionally on Monday and Friday. The nurse uses a tracking book to document both new intakes and transfers into the facility, not the new medical reception tracking log.

Staff reported that youth arrive for medical reception after they undergo security processing, usually 2-3 hours after arrival. The nurse performs an initial interview and indicated that the

counties sometimes send medical information but often do not. The nurse added that it was particularly difficult to get immunization information. The nurse administers immunizations as needed and a TB skin test unless the youth was previously positive. In these cases, the nurse documents the history and obtains a chest x-ray. The nurse also administers a health questionnaire, performs HIV pre-test counseling, and obtains lab tests. The physician performs the physical examination. If the youth has a positive mental health history or is on medications, the youth is referred to a psychiatrist or psychologist. The policy is now that the psychologist has ten days to see the youth. Dental staff usually sees the youth within three or four days. The nurse schedules the youth to read the PPD and perform HIV post-test counseling. The facility does not yet have a chronic disease management program but the nurses schedule youth with chronic diseases to see the physician.

At SCYRCC, the new tracking log is in place but the dental portion of the log is not filled out. The medical reception process is performed in a manner that does not assure auditory confidentiality since other youth may overhear interviews. Staff is transitioning in the new medical reception forms. Our record review showed that the Problem List is not visible when opening the record. The documentation of the medical history, physical examinations, and treatment plans was inadequate.

Intrasystem Transfer

The intrasystem transfer process is taking place at all the facilities. The old forms are still in use. Newly arriving youth with chronic diseases are not consistently referred to a physician upon arrival.

At SYCRCC, there are problems with custody staff not bringing youth to the medical unit for health screening upon arrival.

At NCYCC, staff reported that not many youth transfer into the facility; however, they do receive parole revocators. They are not undergoing the medical reception process as required by the Remedial Plan. Staff also report that newly arriving youth are not brought to the medical unit in a timely manner for health screening.

Nursing Sick Call

Although nurses triage health care requests at all the facilities, the nursing sick call program has not been fully implemented at any facility. HCS has not yet developed Nursing Protocols and staff training has not been conducted. Therefore, nurses lack guidance on performing adequate assessments. At several institutions, nurses simply conduct a paper triage of health services request forms and then arrange to have the clinician see the patient.

When nurses do conduct assessments, the quality of the assessments is generally poor with minimal history and physical examinations performed. Vital signs are not routinely being measured for sick call encounters. In some cases, the nurse did not address the complaint on the request form; instead, the nurse addressed a new problem presented on the day the youth was seen.

At Heman G. Stark YCF, nursing and physician sick call was being conducted in the day rooms of the housing units, even though medically equipped clinics rooms were nearby. Youth submitting health service requests were not consistently seen in a timely manner, reportedly due to custody issues. For example, a 20-year-old submitted a sick call request form dated 9/18/06 complaining of severe abdominal cramping and pain that he thought was related to food. The form was dated as being received on 9/21/06. A note by the physician indicated that the youth was not available to be seen per unit staff. Another physician note on 9/27/06 indicated that the youth was seen on 9/26/06; however, there was no note in the record to support this.

At SYCRCC, the old forms are in use. The nurses collect health care services request forms five days a week rather than seven days per week. Therefore, nurses were not triaging health requests on the weekends to identify patients with urgent complaints that should be seen the same day, including dental and mental health complaints. From our review, it was not clear that youth are being seen within one business day of submitting their requests. The satellite clinics are inadequately equipped and supplied with no access to a sink for handwashing. The nurses often simply triage the request, and refer the youth directly to the physician.

At NCYCC, the nurses conduct a paper triage and arrange for the clinician to see the patient.

At EPDRYCF, nursing sick call is conducted five days a week and scheduled to occur at 2-3 scheduled intervals throughout the day to accommodate youth's schedules. There is signage in the medical areas with respect to maintaining patient confidentiality. A review of seven records showed that nursing assessments are not adequate with respect to the history, physical examination, and nursing diagnosis.

Medical Care

At all the facilities, we found few numbers of youth with acute, chronic disease or communicable diseases. The medical acuity of DJJ's population is low due to the age of the population and the agency's policy to defer admission of youth with high acuity medical and mental health conditions.

In general, we found that clinicians often are not documenting appropriate histories for sick call or chronic care visits. Clinicians do not ensure that vital signs are measured for sick call encounters. In most cases, education is not documented as occurring during sick call and chronic care visits. Furthermore, in our limited review of the facilities, we found cases of patients with serious medical conditions whose medical care was not appropriately managed. These cases are described below.

Patient 1: This patient underwent an appendectomy at a local hospital for a perforated appendix on 7/24/06. He returned to the facility on 7/29/06 and was housed in the OHU. On 8/8/06, at 10 pm, a nurse noted that the patient was complaining of a severe headache, had vomited, and had a temperature of 103.2 degrees. The nurse did not contact the physician on call. The nurse re-checked the patient a couple of hours later and noted that he was feeling better and was afebrile. The next morning, at 5:30 a.m., a nurse noted that the patient had a temperature of 102.1 degrees and was complaining of severe (10 on a scale of 10) right sided abdominal pain. The nurse contacted the physician who gave a telephone order for Vicodin. The patient stated that he could

not take Vicodin and the physician changed the order to Tylenol. The physician evaluated the patient in the OHU at 8:10 a.m. and sent him to the emergency department (ED) for further evaluation. The patient was diagnosed with an intra-abdominal abscess for which he underwent surgery that morning.

Assessment: The patient did not receive timely or appropriate care.

- A fever of 103.2 degrees and vomiting are very worrisome symptoms in a patient who has recently had abdominal surgery. The nurse should have contacted the physician on call, who should have either come in to evaluate the patient or sent him to the hospital for further evaluation.
- On 8/9/06, when the nurse notified the physician at 5:30 a.m. that the patient had a high fever and was complaining of severe abdominal pain, he should have transferred the patient to the ED for further evaluation.

Patient 2: This patient is a 16-year-old youth with a history of asthma who arrived at the facility on 11/1/06. The nurse noted that he was using an Albuterol inhaler and that he had been hospitalized two times. She did not obtain any further history. The physician performed a physical examination, but did not obtain any further history related to the patient's asthma. In his assessment, the physician did not note that the patient had asthma, and he did not order any medication.

On 11/11/06, a nurse saw the patient because he was complaining of shortness of breath. The nurse contacted the physician who gave a verbal order for an Albuterol inhaler. The physician did not order follow-up. As of 11/30/06, the patient had not been enrolled in the chronic disease program.

In addition, the patient had a 7-mm tuberculin skin test (TST) on 11/6/06. The nurse referred the patient to the physician who ordered a chest x-ray and INH for treatment of tuberculosis infection. The chest x-ray was performed on 11/10/06 and was normal.

Assessment: The patient did not receive timely or appropriate care for his asthma.

- Neither the nurse nor the physician obtained an appropriate history for a patient with asthma and two prior hospitalizations.
- The patient did not receive his medication in a timely manner.
- The patient was not enrolled in the chronic disease program.

The patient's TST was not managed appropriately. The patient did not have any of the medical conditions for which a 7 mm TST would be indicative of tuberculosis infection. Furthermore, even if treatment was indicated, it should not be initiated prior to ensuring that the patient did not have active tuberculosis disease. This case was referred to the CMO for follow-up.

Patient 3: On the evening of 9/20/06, a nurse noted that the patient was complaining of pain in his right hand. She noted that he had decreased range of motion and swelling in the area of his right fifth metacarpal bone. The nurse contacted the physician who gave a verbal order for ice, ibuprofen, and for the patient to be seen the next day. On 9/21/06, a nurse noted that the patient's hand was very swollen and that he was unable to move his fingers without pain. The nurse noted

that the patient stated that his pain was 10 on scale of 1-10. Later that day, the physician noted that the patient's hand was tender, with decreased range of motion. He ordered an x-ray. On 10/4/06, there was an entry from another physician noting that the x-ray revealed a fracture. (The results of the x-ray were not in the medical record and it is not clear when the x-ray was performed).

The second physician referred the patient to the orthopedic surgeon for further care. The consultation request stated that the injury occurred on 9/28/06 (not 9/21). The orthopedic surgeon did not see the patient until 10/6/06. He stated, "This is an 8-day-old fracture [it was actually 15 days old]. We will accept the position of this fracture. He will lose knuckle contour but will not have functional deficit, as the fifth metacarpal is quite mobile. Closed manipulation would be impossible at 8 days post injury in a patient of this age. He would require an open reduction, which is not warranted. A 4-5 gauntlet cast was applied today."

Assessment: The patient did not receive timely care for his hand injury.

Patient 4: A nurse saw the patient at 6:15 p.m. on Saturday, 7/8/06, and noted that he stated that his stomach was hurting and that he had vomited his lunch. The nurse noted that the patient was pointing to his upper and lower abdomen and stated that the pain was 10 on a scale of 1 to 10. The nurse did not examine the patient's abdomen and did not obtain vital signs. Her assessment was "alteration in comfort due to abdominal pain." She noted that she reassured the patient, advised him to increase fluids, and ordered Pepto-Bismol. She also advised the patient to notify the staff if he was not better in two hours.

A nurse saw the patient again at 8:20 p.m. and noted that he stated that the medication had not provided relief. The nurse further noted that the patient had vomited blood, had continuous pain in the stomach, and sat on the floor outside the control center due to the pain. She sent the patient to the medical clinic for further assessment and treatment.

At 8:45 p.m., a nurse saw the patient in the medical clinic. She noted that the patient had had pain and vomiting since the morning, that the pain was 10 on a scale of 1 to 10, that he did not have any urinary symptoms, and that his vital signs were normal. She further noted, "walking upright without restriction of movement or guarding, abdomen distended, o/w [otherwise] normal exam (no rebound or tenderness, soft)." The patient was unable to urinate and the nurse hydrated him with 1 liter of fluid. She subsequently obtained a urine sample and performed a urinalysis, which revealed trace white blood cells, nitrates, protein, and large ketones (all of which are non-specific abnormalities). The nurse contacted a physician who gave a verbal order for antibiotics for treatment of a urinary tract infection. The nurse noted that the patient was observed for an hour and given more oral fluids, which he tolerated. The nurse then sent him back to his housing unit with instructions to report any continued problems, and scheduled him to see the physician the next day.

Early Sunday morning, at 2:10 a.m., the nurse called the housing area for an update. The custody staff informed her that the patient had come back, eaten, and gone to sleep, and that he had not reported any further nausea or vomiting. At 7:30 a.m., a nurse noted that the patient was not complaining of nausea or vomiting.

At 11:30 a.m., a nurse noted that when she saw the patient at pill call, he stated that he had vomited five times. The nurse further noted that the patient was able to walk from his room to the control room with a steady gait. She did not obtain any further history or examine the patient at that time.

The patient was subsequently seen in the clinic at 1:15 p.m. He was complaining of right lower quadrant pain and vomiting at that time, and had a low grade fever and increased pulse. The nurse noted that he was warm to touch, that his abdomen was tender with rebound, and that his bowel sounds were decreased. (These signs and symptoms are indicative of an acute abdominal problem.) The nurse's assessment was "alteration of comfort secondary to vomiting." She contacted the physician who advised her to observe the patient.

At 1:45 p.m., a nurse noted that while awaiting the physician's arrival, the patient was in a "comfortable position" and moaning. At 1:50 p.m., the nurse contacted the physician to advise him of the patient's pain and increased vomiting. The physician advised the nurse to send the patient to the hospital via ambulance. The patient was subsequently diagnosed with an acute perforated appendix, for which he underwent surgery.

Assessment: The patient did not receive timely or appropriate care for his acute abdominal pain and vomiting. Furthermore, it was not appropriate for the physician to order antibiotics for a urinary tract infection without having evaluated the patient.

Patient 5: The patient injured his hand on 11/7/06. His right thumb was noted to be tender and swollen. An x-ray was ordered, but not performed until 11/30. The x-ray did not reveal a fracture.

Assessment: The patient did not receive timely care.

Chronic Disease Management

The new chronic disease management program is in its early phases of implementation at some facilities and has not been implemented at others. The tracking system has not been implemented in any of the facilities. Staff is using the medication list to track youth with chronic diseases, but reported that the facilities do not have an automated way to remove the names of youth who have left the facility and have to do this manually. This is not happening routinely at any of the facilities. As a result, the lists are not useful for tracking youth who have chronic diseases and many patients with chronic illnesses are not being seen within the timeframes specified by the Remedial Plan.

With respect to those patients who are being seen in the program, our record review showed that clinicians often are not documenting appropriate histories, obtaining vital signs, or documenting education for patients with chronic diseases.

At Ventura, the chronic disease management program has not been fully implemented. Patients are being seen for acute problems, not routine care.

At Preston YCF, youth with chronic diseases are not routinely receiving appropriate intake evaluations and are not routinely being seen for their chronic diseases.

At NCYCC, youth are often not being seen every three months as required by the Remedial Plan. The name of one patient with diabetes did not appear on the chronic disease list and did not show up on the pharmacy profile. Dr. Goldenson noted that the patient had diabetes when he was reviewing the medical record for another issue.

Other problems at NCYCC related to chronic disease were noted, including:

- Two patients had recently been started on medications for hypertension despite the fact that there was no clear indication that they actually had this problem. They had each had only one elevated blood pressure reading, and prior ones had all been normal.

- A physician increased a patient's (Patient 4) medication for diabetes despite the fact that he appeared to be well controlled. He had had one increased blood sugar reading, but the others had been within the normal range and his HgbA1c (5.5), which is a test that reflects glucose control, over a three month period was normal.

We discussed these cases with Dr. Tanson, who stated that he would provide training in chronic disease management to the physicians.

Infection Control

At most facilities, infection control programs are in early phases of development. DJJ does not have an adequate program to offer hepatitis B vaccination to health care or custody staff, or to obtain consent and declination forms as required by OSHA guidelines.

Most of the facilities have rooms designated as respiratory isolation rooms, but not all rooms were functional. Dr. Morris indicated to the medical experts that he wants all TB suspects sent out to local hospitals, but his staff was not aware of this. They advised the experts that they planned to use the respiratory isolation room should they identify a TB suspect.

At Ventura, the infection control nurse has worked at the facility for five years and has been the Infection Control/Staff Development Nurse for two months. He will be responsible for the annual TB skin testing for the youth and staff, in April and May of each year, respectively. He also manages the Hepatitis B vaccination program for staff. However, at the time of our visit, there was no local operating procedure for implementation of the infection control program. The nurse has not received formal training in infection control, just on the job training. He stated that he reported all reportable diseases and TB skin test conversions to the local health department and to Brenda Green, RN, in headquarters.

At EPDRYCF, the infection control program is further along and staff has developed a Blood-Borne Pathogen Exposure Control Packet that is to be used when a staff member is exposed to blood or other potentially infectious body fluids.

Pharmacy Services

With the exception of Quality Management activities, the pharmacy activities are consistent with the Remedial Plan.

Medication Administration Process

We reviewed the medication process at each of the facilities.

The medication rooms we inspected were generally clean and well organized. Most, but not all facilities had night locker accountability systems. Nurses at several facilities are routinely crushing narcotics for patients, which is not in compliance with the Remedial Plan. At several facilities, nurses are administering hour of sleep (HS) medications as early as 7:30 pm, which is not in compliance with the Remedial Plan. The Remedial Plan requirement advises not administering HS medications before 2100 hours (one hour window on either side permitted).

Individual facility findings are described below.

At Ventura, the medication room was clean and well-organized. The nurse demonstrated how she administered medications and followed the proper procedure. All medications in the storage bins were in unit dose packaging. The cabinet did not, however, designate separate storage areas for external and internal medications, as required by the Remedial Plan.

At Heman G. Stark YCF, the medication room was relatively clean and well organized. There was a night locker that contained prescription medications. There was no accountability system for the medications. A random review of two medications showed that they would expire within the week. The facility is crushing all psychotropic medications against Remedial Plan requirements. In the main clinic treatment room, there were expired medications in the refrigerator. There was a tray with frozen water in it with suppositories boxes frozen in the water. It had not been cleaned in some time.

At SCYRCC, there have been improvements since our initial visit. The medication room is cleaner; however, it still contains old cabinetry and medication carts. Stock medication bottles have been removed and a pharmacist is filling all prescriptions. There is a night locker with a medication accountability system, which includes narcotics. A random sample check showed that narcotics were accounted for. Unfortunately, the nurse prepoured her medications and was crushing all psychotropics. These actions are not in compliance with the Remedial Plan and new policies. Youth did not present identification cards as required by the Remedial Plan. The nurse attempted to verify identity by asking the patient's name, but not the ID number. The nurse did not consistently check the MAR before administering medications.

At NCYCC, staff indicated that policy requires that youth have ID's to be identified for medication administration but that youth come to pill call without the ID cards. When staff sends them back to the housing unit to get them, they often do not return. There are many no shows for medications. Medical staff request that youth refuse medication in person to ensure access to care, but custody is not consistently supportive of this. Staff also reported that when pill call is being conducted, security will not bring youth to the clinic to receive other services.

At EPDRYC, there are no local policies and procedures for medication administration. Medications that are to be administered at the hours of sleep (HS) are being administered as early as 7:30 pm, which is not in compliance with the Remedial Plan.

Urgent/Emergent Services

We found that none of the facilities had local operating policies and procedures or conducted quarterly emergency drills. All the facilities had at least one automatic emergency defibrillator that was checked daily. Emergency response bags were not checked daily at each facility and in some cases contained nonfunctional equipment or outdated medications. Individual site visit findings are described below.

At Heman G. Stark YCF, there is no urgent emergent log in use. There is a mace log. Staff reported that custody calls them and requires them to be present in advance of using chemical agents, and that nurses are required to triage youth at the scene and wash them down with a hose, instead of custody showering the youth and escorting them to medical as required by policy. This is an inappropriate use of medical personnel.

At SYCRCC there are two Automatic External Defibrillators (AEDs) that are checked daily. Emergency equipment was in proper working order; however, the emergency response bag is not checked daily.

At EPDRYCF, the Urgent/Emergent Tracking Log is in use. Most, but not all health care providers have current CPR certification. The facility has an automatic emergency defibrillator and emergency medications. The emergency response bag is not checked along with other emergency equipment. A review of the bag showed that the flashlight was broken and the glucagon medication had expired.

Outpatient Housing Unit

In general we found that the OHU environments are dismal, often dirty, and generally nontherapeutic. Local policies and procedures are not yet in place. Patients are not always within sight or sound of a licensed health care provider. Patients are not being admitted, monitored, and discharged in compliance with the Remedial Plan. At NCYCC, there are serious issues related to staff access to patients due to lack of custody staff assigned to the OHU. Individual facility findings are described below.

At Ventura, there was no local operating procedure related to operation of the OHU. There was a tracking log that listed all youth placed in the OHU. The OHU is located along a long corridor that is parallel to another hallway where clinical exams rooms are located. There are 5 beds plus a post-partum bed that was clean and warmly decorated. The OHU has one respiratory isolation room that was not working. Engineers had checked it the week prior to our visit and ordered a new motor for it.

Neither an officer nor nurse was consistently present when youth were in the OHU. There is a call system that rings to a non-staffed nurse's station. Thus, youth are not always within sight or sound of a licensed health care provider. During our visit, on 9/13/06 at approximately 1400, a youth was admitted to the OHU. There was no officer or nurse at the nurse's station. A nurse was to document 15 minute checks but did not document the 1500 and 1515 hour checks.

At Heman G. Stark YCF, there is no OHU, only an 11-bed CTC that is used for mental health purposes. They transfer any youth requiring OHU care for medical reasons to SYCRCC.

At SYCRCC, the OHU environment is dismal and nontherapeutic. There was no patient call system. Patients were not within sight or sound of a licensed health care provider. Clinicians did not write complete admission and discharge orders. Physician orders were not consistently implemented.

At EPDRYCF, the OHU patient call light was not functioning properly but was repaired during our visit.

At NCYCC, there was no local policy and procedure related to operation of the OHU. There was a tracking log that listed all youth placed in the OHU for the past 180 days. The log contained the youth name, ID number, diagnosis, and discharge dates. There was no standardized nursing procedure manual in the OHU. The OHU was under the supervision of an RN 24 hours per day, and a physician was on call 24 hours per day, 7 days per week. Youth are within sight or sound of licensed health care staff at all times; however, there are serious access issues.

Only correctional staff has keys to the infirmary rooms, yet the only correctional officer coverage in the OHU is from 6 am to 2 pm, Monday through Friday. There are no correctional officers assigned to the OHU from 2 pm until 6 am the following morning, and none on the weekends. If a nurse needs to get into a room to provide nursing treatment for a youth, they must call perimeter security staff who may take ten minutes or longer to come to the OHU. Thus, if a youth was hanging in a cell, health care staff would have to call security to open the door. This is unacceptable. It was also reported that there were officers allocated to the medical unit when it was to be a CTC; however, those officers were removed from the OHU and now staff the front gate. The medical budget is still charged for these correctional officers.

The OHU area in general was unsanitary. The floors were dirty and the walls of some of the rooms were splattered with unknown matter. The nurse's station was cluttered. Staff reported that there was no hot water for youth and sometimes no heat. On a positive note, the refrigerators were clean and appropriately labeled and used. There was an orientation manual that was somewhat outdated. Narcotics were kept in the refrigerator under a single lock and were accounted for. There was an AED and other emergency equipment that was checked daily.

Utilization of the OHU is infrequent. According to the tracking log for the period of 5/5/06 to 11/27/06, 235 youth were placed in the OHU, averaging 34 patients per month or approximately one per day. The majority of admissions were orthopedic/injury related (25%), dermatological (22%), and mental health (12%).

Patient Record Review

We reviewed records that showed clinical and nursing issues with respect to OHU Care. They are briefly described below. A concern is that in some records, nurses recorded that the physician saw the patient; however, there was no corresponding physician note.

Patient 1. This 17-year-old youth submitted a sick call request form on 9/18/06 for a twisted ankle. On 9/9/06 at 1515, the nurse documented in the unified health record (UHR) that the youth fell down while hiking the day before. He was unable to stand without significant pain. His left foot was swollen. She called the nurse practitioner who instructed that the youth be sent to the local emergency department (ED). He returned at 1845 and was admitted to the OHU. The

nurse did not document the medical diagnosis made at the ED. The physician was at the facility upon his return, and although he did not write a progress note, he wrote orders to send the patient to orthopedics and for primary care follow-up on Monday. This did not take place.

Assessment: The patient did not receive the ordered follow-up with the primary care physician or orthopedics as requested by the physician

Patient 2. This 16-year-old arrived at the facility on 10/30/06. On 11/27/06, he requested to be seen complaining of an insect bite. The nurse saw the youth the same day, took vital signs, and referred the youth to a physician. The primary care physician noted a 2 cm diameter area of induration on the right lower leg. He prescribed warm compresses and Bactrim and put him in the OHU. Daily physician and nursing rounds were made. The youth remained in the OHU until 11/29/06 and was sent back to his housing unit. However, later that day he returned to the OHU with increasing pain and the lesion had increased to 4 cm sign with slight drainage. The wound was never cultured.

Assessment: Although the clinician monitored this youth with a skin infection on a daily basis, on the day he discharged him from the OHU, the youth was readmitted with an increasing area of induration and drainage, suggesting the infection was worse. This raises questions as to whether physical examinations were actually performed while the patient was in the OHU. Also, a wound culture and sensitivity was not performed for this patient. In this era of increasing antibiotic resistance, performing wound cultures is important to guide antibiotic choice.

Patient 3. On 12/9/06 at 2000, an MTA saw this 20-year-old patient for blood in his urine (hematuria). The MTA did not take vital signs. At 2050, a note by the OHU nurse indicated that she took vital signs and stated that the physician was coming in to see the patient. The physician evaluated the patient at 2130. The physician suspected and treated the patient for a urinary tract infection but did not obtain a urine culture to confirm this.

Assessment: The diagnosis was not confirmed.

Patient 4. This 19-year-old complained of chest pain and shortness of breath on 9/23/06. He was taken to the OHU where a nurse assessed his condition and called the physician. He told the nurse to place the youth in the OHU until the morning. The physician did not give orders to the nurse for monitoring the patient. The nurse took initial vital signs, which showed his BP was 158/104 mm/hg and pulse was 67 beats/minute. The nurse did not repeat vital signs from 0120 until 0750. The physician saw him the next morning and released him to his housing unit.

Assessment: The purpose of OHU placement is monitoring and treatment, however the physician gave no orders for monitoring and the nurse did not repeatedly measure the patient's vital signs. Note: there is no custody staff in the OHU in the afternoon or night shift.

Patient 5. On 9/22/06 a nurse saw the youth who complained of upper abdominal pain. The nurse notified the physician who ordered Maalox and Donnatal. He complained again at 1720 and the nurse called the physician who ordered the youth sent to the OHU. The OHU nurse performed an assessment and called a physician who ordered a stat CBC. The youth requested to go back to the dorm about 1900 hours. The nurse notified the MD and the patient was released.

The CBC was collected on 9/22, received on 9/22, and reported on 9/29. The physician initialed it on 10/3.

Assessment: Ordering a stat blood count, but not getting the results for ten days is not an adequate system for evaluating acute abdominal pain.

Patient 6. On 10/23/06, a nurse saw this 20-year-old parole violator upon arrival. His vital signs were: pulse = 44 beats/minute and irregular, BP =137/65 mm/hg, respirations =18/minute and Temp = 98.4°. A physician saw him the same day at 1237, but did not take a cardiac history. He documented that the youth had a history of alcohol use the preceding night, and a history of cocaine and methamphetamine use, but did not document the date of his most recent use. The physician noted that his heart rate was 45-50 beats/minute and irregular. His assessment was bradyarrhythmia and probable hangover from alcohol overdose. He sent him to the OHU for observation and an EKG. The orders did not include vital signs. The youth arrived at the OHU at 1300. The nurse repeated the vital signs that were essentially unchanged.

The nurse documented that the OHU physician saw the patient but he did not write a note. He wrote no further orders. At 1438, the nurse measured the patient's vital signs, which were markedly changed (Pulse = 115 beats/minute and BP 134/77 mm/hg). At 1452, an EKG showed the patient's heart rate was 78 beats/minute with sinus arrhythmia with frequent PVCs.

The physician saw the patient the next day at 0825 and did not evaluate the patient's vital signs. He ordered a chest x-ray, CBC, and cardiology consult, and discharged the patient to the dorm. A part-time physician (who happened to be a cardiologist but not practicing in that capacity at the facility) saw the patient on 10/26 and determined that he had benign PVCs arising from right ventricle and reassured the patient, recommended avoiding alcohol use, a light potassium diet, and no physical limitation. His chest x-ray, CBC, serum chemistry, electrolytes, liver panel, and drug screen were all normal.

Assessment: Alcohol withdrawal is a concern for youth who may enter directly off the street. The physician noted that the youth had been drinking the previous night, but did not obtain a history related to the amount or extent of his alcohol consumption. Furthermore, the facility did not have an appropriate protocol for monitoring youth at risk for alcohol withdrawal. The patient's vital signs were not closely monitored. The on-site physician happened to be a cardiologist but was not acting in a consultant capacity; however, his evaluation was performed in lieu of a requested cardiology consultation. This was not clear in the health record documentation.

Health Records

New health record forms have not been implemented. The Problem List was often not completed and filed where it could be readily seen when the medical record was opened. In addition, information, such as normal physical examinations, the preparation of parole meds, and eyeglasses was sometimes documented on the Problem List. Such information does not belong there and makes the list less functional.

Information in the medical records was often not filed chronologically. Some forms and other papers were filed in different sections of the medical records in the different facilities. For

example, some facilities file HIV results in the laboratory results section, and others file them in the public health section.

Preventive Services

The preventive services program has not been implemented in any of the facilities.

- Most youth with chronic illnesses are being offered flu vaccines.
- In most cases, youth with chronic disease are not being offered pneumococcal vaccine.
- Yearly visits for weight and blood pressure checks, as well as for education, are not occurring. Blood pressure and weight are only documented for those youth who have been seen by the nurses for another problem.
- In most cases, tetanus-diphtheria boosters are not offered to youth who have not received one in 10 years.
- Most youth have been offered hepatitis A and B vaccines.

Dental Services

In anticipation of a dental expert being hired, the medical experts did not review dental services.

Consultation and Specialty Services

We found that in general, clinicians do not see patients within 5 business days following their specialty appointments to review consultant findings and recommendations with the patient and develop an appropriate treatment plan. Consequently youth are not receiving medical care in a timely manner. At most facilities there are significant issues with establishing contracts. A brief description of facility findings are described below.

At Ventura YCF, patients are not being seen by the medical staff within five days of their specialty appointments. Thus, there is no discussion to assess the youths' understanding of the consultant's findings and recommendations or the youth's willingness to follow the consultant's recommendations. In addition, while the consultant's reports are usually being signed off by the physicians or nurse practitioner, there often is no accompanying progress note.

At HGSYCF, patients were not routinely seen upon their return from specialty clinics. This results in similar problems as described above.

At SYCRCC, the contract with USC/LAC requires that when a clinician wants to refer a youth to a consultant, the youth must be evaluated in the emergency room before the hospital will schedule the appointment. This results in added cost and unnecessary transportation. Staff also reported that USC/LAC Hospital does not schedule appointments in a timely manner.

SYCRCC does not have a tracking system for specialty consultations and physicians are not following up with youth to ensure that the appropriate care is being provided. As a result, consultations are not consistently occurring within the required time frames. These issues should be addressed in contract negotiations. When consultations do take place, clinicians are not consistently seeing patients within five days of their specialty clinic visits.

At Preston, there was no x-ray technician from July 2006 until November 30, 2006. According to Dr. Horowitz, x-rays were only performed sporadically during that period, and she had advised the medical staff to send patient's who needed urgent x-rays to SJGH. This resulted in delays in obtaining and reading x-ray reports with resulting delays in referrals to the orthopedist or other specialists.

At NCYCC, primary care physicians do not fill out a consultation request form for on-site consultants. Thus, these consultants (e.g., dermatology) document their findings in the progress notes, rather than documenting on a consultation form. In addition, the primary care physicians were not following up either with patients who were being seen by on-site or off-site consultants.

We recommend that primary care providers request all consultations through use of the consultation referral form, and that results are documented and filed in the section for consultation reports.

During record review, examples of the problems we found included the following:

Patient 1: This patient was seen in surgery clinic at USC/LAC Hospital on 3/30/06 for evaluation of gall stones. The surgeon referred the patient for surgery. The surgery did not occur and he was sent back to surgery clinic for further evaluation on 9/19/06. The surgeon noted that the patient was a "candidate for surgery." There was no follow-up when the patient returned to SYCRCC. As of 11/14/06, the surgery had not been scheduled.

Patient 2: The patient was seen 8/25/06 in surgery clinic at USC/LAC Hospital for evaluation of an inguinal hernia. The surgeon noted that the patient needed a surgical repair. There was no follow-up upon the patient's return to the facility. The patient was sent to the emergency room at USC/LAC Hospital on 10/6/06 for evaluation of abdominal pain. The physician noted, "surgery pending, no date yet." As of 11/14/06, the surgery had not been scheduled.

Patient 3: The patient was seen at surgery clinic at USC/LAC Hospital on 4/18/06 for evaluation of a hernia. The surgeon noted that an elective procedure to repair the hernia would be scheduled. The patient was seen again at the clinic on 5/16/06 and the surgeon noted that he would place the patient on the elective list. The patient was sent to the USC/LAC Hospital emergency room on 10/24 for evaluation of abdominal pain. The physician noted that the patient had been seen by general surgery for his hernia. As of 11/14/06, the surgery had not been scheduled.

Patient 4: The patient had a history of hyperthyroidism. He saw an endocrinologist on 4/3/06. The endocrinologist noted that the patient did not exhibit signs or symptoms of hyperthyroidism and stated that his disease could be in remission. The endocrinologist recommended discontinuing the patient's medication and monitoring him. He recommended repeating laboratory tests in two weeks and again in one month to confirm remission. The tests were performed on 4/19 and 4/28/06, and indicated that the patient was still hyperthyroid. On 5/1/06, the physician reviewed the laboratory tests. He did not evaluate the patient, but instead ordered repeat laboratory tests in three months.

On 5/18/06, the patient submitted a health care request stating that he needed his medication. The physician saw the patient, but did not obtain a history or perform a physical examination related

to his thyroid status, and did not reorder his medication. He referred the patient back to the endocrinologist. The endocrinologist saw the patient on 8/21/06 and restarted his medications.

The patient did not receive timely or appropriate care for his hyperthyroidism.

Patient 5: The patient had a history of recurrent shoulder dislocations. The orthopedic surgeon saw the patient on 8/23/06 and recommended follow-up on 9/8/06 to discuss surgical options. On 8/28/06, a physician submitted a request for this consultation. The appointment was not scheduled as of 9/27/06. As a result, the patient has not received timely care.

Credentialing, Peer Review and Quality Management

Credentialing, peer review, and quality management programs have not been implemented at any of the facilities.

Recommendations

Headquarters

1. Finalize the Department, Headquarters and Field tables of organization and include all key positions. Adopt a uniform model for clinical and administrative supervision and oversight from headquarters to the facility level. The CMO should have administrative supervision over all health care operations in the facility.

2. Continue to work with CDCR Contracts Section to develop an efficient process for establishing and executing health care contracts in a timely manner.

3. Develop and implement a nursing health assessment and protocol program.

4. Finalize all initial policies and identify other health care policies to be developed in the next 12 months.

5. Develop and implement a clinical auditing program.

6. Finalize and implement the peer review, credentialing and organizational structure policies.

7. Once institutional missions have been determined and programs implemented, conduct a staffing assessment to determine staffing needs.

8. Develop and implement a plan to evaluate the cost effectiveness of pharmacy services. Consider establishing Licensed Vocational Nurse positions in DJJ as has been done in CDCR.

Facility

10. Increase collaboration between health care and custody staff to eliminate barriers to health care access.

11. Improve sanitation of the health care units and satellite sick call areas.

12. Improve communication and collaboration between facility and medical administration regarding budget and personnel issues.

13. Implement the newly published health care policies.

14. Nurses and clinicians should improve the quality of clinical assessments and documentation.

Dated: September 13, 2007

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Madeleine LaMarre, MN, APRN, BC

Dated: September 13, 2007

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Joe Goldenson, MD

Appendix A – Medical Contracts Memorandum

MEMORANDUM

TO: Joe Goldenson, Madie LaMarre, *Farrell* Medical Experts
FROM: Donna Brorby, *Farrell* Special Master
RE: Medical contracting (revised)
DATE: June 15, 2007

* *

I requested from DJJ the following information about health services contract requests made this fiscal year (2006-07):

Dates sent to CDCR
Dates contracts executed
Proposed or actual contractor
Current status.

As I continue to monitor the contracts issue, I will request the dates contracts awarded also. (Award is done by CDCR, essentially naming the potential contractor whose bid is accepted. The contract then must be approved by DGS in order to be executed.) I will also try to get information about the status of CDCR processing of DJJ's contract requests (what happens between DJJ's contract request and award of a contract).

DJJ provided an excel report tracking about 18 Health Services headquarters requests and about 36 DJJ facilities contract requests. I sent that to you by email. The tracking document shows long lapses of time from contract request to execution of contract (and many requests pending for a year or longer without contracts being executed).

After I received the tracking document, I met with Dave Gransee, DJJ Health Care Administrator, Nick Burgeson, DJJ's point person on medical contracts requests, Katie Riley, CDCR attorney, and Doug Ugarkovich, Farrell Litigation Coordinator, on June 4, 2006. Then, on June 13, 2006, I met with the same four individuals plus
Robert Morris, Medical Director, David Hale, DJJ Business/Contract Services Manager (on a 24 months assignment from CDCR to assist with contracting issues), Karen V. Smith, Deputy Director CDCR Office of Business Services, Debra Jones, Associate Director CDCR Office of Business Services and Joseph Watkins, CDCR Manager DJJ Contracts Unit.

In the two meetings, we reviewed the tracking document and discussed DJJ's contract requests. I will not review all of them here, but the following are exemplary:

DJJ requested contracts for dentist and dental hygienist services in May 2006. It had no response until December 2006, when CDCR said that DJJ would be covered in CDCR master service contracts for these services. As of June 4, DJJ (Nick Burgeson and Dave Gransee) had heard that the master contracts have been

awarded for dentists and dental hygienists, but they did not know if DJJ was included in the contracts. At the June 13 meeting, we all learned that DJJ was not included. DJJ's next step would be to resurrect the May 2006 requests.

DJJ similarly request contracts for psychiatry, psychology, psychiatric technicians, nurse practitioners, and nursing services in May and June 2006. It had been told it would be covered by CDCR master contracts. At the June 13 meeting, DJJ learned that it was not and would not be included in those master contracts. The communication disconnect was partly due to the fact that the *Plata* federal court receiver had taken over CDCR's medical contracting function for the adult prison system in December 2006. The 34 or so CDCR medical contracts staff reported to the receiver since then. They did not communicate with CDCR or DJJ when they removed references to DJJ in the medical contracts.

DJJ requested a contract for acute psychiatric hospital services from Sierra Vista Hospital in September 2005. That contract has NOT been awarded yet. First, there was a mistake in how the contract was drawn up (single provider instead of multiple provider). Sierra Vista bid, but the contract had to be redone and rebid. The second time, there were no bids at all. DJJ investigated to determine why expected bidders had not bid, and then made another request for contract to CDCR. DJJ does not know its status. In the meantime, DJJ has entered numerous emergency contracts/amendments under which Sierra Vista has provided emergency psychiatric services.

DJJ requested a clinical laboratory services contract in July 2006. The contract was awarded "last week" (end of May 2007). It has to be approved by DGS still to be executed. The contractor Latara Enterprises dba Foundation Enterprises will take over from Unilab Corp./Quest Diagnostics which did not bid this year. The Unilab contract expires June 30. There is a question whether there will be a disruption in lab services during the change over, especially if execution of the contract is close to the end of June.

DJJ requested a contract for a HQ Pharmacy Manager in July 2006. It was never awarded. DJJ finally hired a Pharmacy Manager after salaries were raised in about May 2007.

DJJ requested a contract for Clinical Records Administrator (headquarters) in December 2006. (The position then had been vacant since the beginning of September 2006.) DJJ does not know the status of the request. This was one of DJJ's highest priority requests. Lesser priority requests have been processed to completion while this one has languished.

The June 13 meeting that was arranged at my request was *not* the first between many of the same people. There was a similar meeting in August 2006. At that time, CDCR's two top administrators in the contracts function, Director Steve Alton and Deputy Director Karen Smith, took notes and promised to improve service to DJJ. From then until January 2007, DJJ staff had

regular meetings with the CDCR business office DJJ contracts manager (Karen Dolan until December 2006, then Kathy Gilpin, now Joseph Watkins). From DJJ's perspective, DJJ would provide information to CDCR at the meetings, but CDCR never had information to give DJJ information about the progress towards awarding and executing contracts. DJJ discontinued the meetings as a result.

As I have told you, there was a large meeting of *Farrell* counsel, DJJ staff and CDCR secretary Jim Tilton on October 20, 2006. Secretary Tilton promised to create a team of liaisons from CDCR to DJJ to solve the problems of the interface between DJJ and CDCR for purposes of improving CDCR's services to DJJ, including contracts services. In about May 2007, CDCR did temporarily transfer a number of staff to make the relationship between CDCR and DJJ work to meet DJJ's legitimate needs. David Hale is on a 24 month assignment from CDCR. He seemed very knowledgeable about contracts issues and the CDCR process. He said he would have a staff, probably of five. This is a step beyond anything that has happened before in the area of efforts to create a working system for DJJ to develop and enter into contracts.

At the June 13 meeting, CDCR and DJJ agreed to a work plan for getting the most important contracts in place and improving the system for processing DJJ contract requests, and they promised to meet again in a month.

I will continue to monitor the progress and report to you.

Appendix B – Patient ID Numbers

Medical Care:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		
Patient 6		

OHU:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		
Patient 6		

Consultations:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		