FINAL REPORT

PERFORMANCE AUDIT
OF
HCA/CORRECTIONAL MEDICAL SERVICES

OFFICE OF THE
PERFORMANCE AUDIT DIRECTOR

MARCH 2009

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Executive Summary

Preface

The Orange County Board of Supervisors' (Board) decision to conduct a performance audit of the Health Care Agency's Correctional Medical Services (CMS) program affords an important opportunity to address an inherently high-risk function that has received significant public attention over the past several years. The audit team wishes to thank both the Health Care Agency (HCA) and the Orange County Sheriff-Coroner Department (OCSD) for their cooperation during this audit and their willingness to address the issues identified.

HCA has been delegated the responsibility by OCSD and the Board for providing County inmates with adequate and timely medical care. HCA fulfills this responsibility through its CMS program, a large, highly complex and multi-faceted operation. Since the 2002 State budget deficit, which resulted in significant program reductions, CMS has had difficulty fulfilling its mission in an efficient and effective manner. This conclusion has been documented in various internal and external studies. Quality inmate health care is generally achieved, however, it is provided in an environment laden with management, operational, and administrative deficiencies, the cumulative effect of which increases risk exposure to the County. These issues need to be sufficiently addressed before any significant staffing resource decisions, such as those requested in the 2008 Strategic Financial Plan, can be made.

On the positive side, recent leadership and operational changes at both CMS and OCSD have opened the door for improvement. At strategic points during the course of this review, the audit team met with both HCA and OCSD Executive staff to inform them of our findings and recommendations. As a result, both agencies have taken immediate first steps to remedy the issues noted in this report by planning for and implementing system improvements.

Introduction

Audit Scope and Objectives

The scope of this audit is limited to the CMS section of the HCA/Medical and Institutional Health Services Division. Specifically excluded from audit are the other portions of Medical and Institutional Health Services, such as: Correctional Mental Health Services, Juvenile Health Services, and the Conditional Release Program. Correctional Dental Services was also not included in this analysis, but is included in some summary information.

The objectives of the audit are to:

1. Examine and document potential risks and operational deficiencies in the CMS program.

2. Identify improved business processes and operating efficiencies that will assist CMS in achieving its stated goals and objectives.

Audit Methodology

The audit included a detailed analysis of multiple data sets; review and observation of various systems and workflow processes used by CMS that impact organizational effectiveness; interviews with current/retired CMS staff; review of regional and national correctional medical reports and industry standards; examination of contractor operations; and a review of State regulations and inspections of jail inmate health operations.

Background Information

According to Titles 15 and 24 of the California Code of Regulations, OCSD is the responsible party for ensuring that adequate health care is provided to the inmates in its facilities. OCSD has chosen, with the 1975 concurrence of the

Board, to have its inmate health care administered by HCA/CMS. Having two separate agencies (HCA and OCSD), with two different missions, involved in the provision of health care to County inmates is a unique challenge that will be addressed later in this report.

CMS utilizes both County and contract resources. Internally, CMS has County staff in the following professional areas: Nursing, Physician, Pharmacy, and Administration. Contracted services include: hospital and clinic facilities through Western Medical Center – Anaheim (WMC-A); a multi-specialty physician group (Correctional Managed Care) that provides medical treatment such as surgical services and specialty consultations and minor procedures at WMC-A; fiscal intermediary services to track and manage expenses for emergency care situations in which inmates are sent to a hospital other than WMC-A; part-time contract physicians, nurses, and pharmacists that cover weekends, holidays, vacations and sick relief in all jail facilities; and outpatient dialysis services from Davita via a pass through agreement with WMC-A.

The FY 2008/09 budget for CMS is $36,869,377. In the past, HCA utilized both County General Funds and State Realignment funds to finance the CMS operation. However, several years ago, HCA made the decision to only utilize County General Funds in order to clarify the full program cost and to potentially trigger OCSD to contribute financial resources to cover the CMS budget, in total or in part. This decision highlights a discussion which continues today over who should bear fiscal responsibility for the CMS program.

What Works Well at CMS

The audit team identified the following areas where CMS is providing quality services:

- Basic inmate health care
- Initial health screening during inmate booking
- Medication supply and distribution
- An overall commitment to inmate care on the part of line staff

Recent CMS Accomplishments

- In response to the 2007 Grand Jury Report, CMS enhanced emergency medical response capabilities through increased training, drills, and new equipment.
- In 2008, the Board of Supervisors approved an HCA request to establish the Institutional Health Quality Assurance Panel to systematically assess, evaluate, and make recommendations regarding adult correctional healthcare in Orange County Jail facilities.
- In late 2008, CMS was successful in filling the long-vacant Director of Nursing position.
- HCA recabling of jails to provide CMS staff with access to internet and email service.
- Appointment of new Institutional Health Division Manager.
- In response to discussions with the audit team, HCA has formed a Task Force, which is currently addressing the recommendations included in this report.

Key Audit Findings

The audit team comprehensively examined all aspects of the CMS operation in both County jail facilities and those services provided externally by contractors. This examination yielded a considerable number of issues (some 48 findings), the more significant of which are summarized below.

CMS Organizational Culture

Nearly all staff interviewed during this audit identified several problems within the CMS organization that impede program efficiency and effectiveness. A consistent theme expressed to the audit team by CMS line and management staff was "nothing can be done; nothing will change." This attitude has limited the opportunities for initiative, innovation and lasting change within the

organization. This assessment is substantiated by the many audit findings that follow. Addressing these cultural issues is vital to ensuring that the more concrete recommendations that follow are accomplished.

Organizational Structure

The administrative program support function has become increasingly and inappropriately enmeshed in medical line operations due to a management vacuum created by a long-term vacancy in the Director of Nursing position (which was recently filled). This environment has been a source of considerable frustration among staff and, in part, led to the cultural issues described in the previous section. The Nursing operation, which is the backbone of the daily medical care service delivery in the jails, should have under its structural authority as many of the tools and resources as necessary to perform their daily line responsibilities.

Management

Two primary findings illustrate the core of CMS management issues:

1. Though inmate health care is a priority, it is a secondary priority for OCSD, and a non-core service for HCA. This status stems from OCSD's primary mission in the jails of ensuring the safety of the inmates and staff inside the jail facilities. In regard to HCA, correctional medical services were a County obligation that was assigned to the County Health Department (the pre-cursor to HCA) back in 1975. As a result, the provision of inmate health care predictably receives less attention than other parts of both OCSD and HCA.

2. CMS staff has generally not been held accountable for poor or non-performance, which is demonstrated by the following:

a. Some operational problems have continued for years without meaningful attention.

b. Employees with known, significant performance issues have been allowed to pass probation.

c. HCA authorized a consultant review during the course of this performance audit that addressed several staffing and scheduling issues already under review by the audit team.

d. It is common knowledge among CMS management that much of the statistical data collected and aggregated is unreliable.

e. The administration of CMS contracts has been inadequate and subsequently has not allowed CMS to properly manage contractor performance or fully prepare for effective contract negotiations with vendors.

f. There are a handful of conflicts of interest within CMS that have been left to linger for several years.

g. There are examples of recalcitrance among some CMS line staff. This was both conveyed to us by CMS management and observed during the audit team interviews.

Nursing

CMS nursing staff levels have been the subject of considerable scrutiny over the past several years. The nurses' employee association, the Orange County Employee's Association (OCEA), began raising concerns over staffing levels in FY 2003/04 after HCA cut a variety of CMS positions in order to address State budget shortfalls at that time. These staffing concerns and other issues culminated in an October 2007 "vote of no confidence" in the program's management, and several subsequent newspaper articles that amplified nursing staff's criticism of CMS leadership.

This audit reviewed both nursing staff levels and work schedules with the following findings:

- There is an excessive number of Supervising Nurse positions.
- There is an insufficient number of Senior Nurse positions to meet jail facility coverage needs.
- The current Licensed Vocational Nurse (LVN) work schedules are inefficient, resulting in staffing overlaps and a mix of nursing schedules, which makes it difficult to provide adequate supervision.
- The bi-weekly master nursing schedule and its development are the source of considerable frustration among nursing staff.
- There are four medication passes that occur every day at every jail facility. This number of daily medication passes consumes significant staff resources and may not all be necessary.

Physicians and Nurse Practitioners

CMS employs both in-house County as well as contract physicians to cover the five jail facilities. In addition, contract doctors are used to provide medical services at the WMC-A clinic and hospital. Significant findings in this area include:

- The contract hospital (WMC-A) and physicians (CMC) do not perform meaningful hospital or physician Utilization Reviews of services provided according to contract requirements. As a result, neither contract requirements nor best practices are followed, nor is the County formally assured that inmates are receiving quality care or that physician/hospital expenses are reasonable for the services provided.
- Medications prescribed by contract physicians at the hospital/clinic are not always properly reviewed by a CMS physician before the prescription is processed.

Pharmacy-Related Issues

The following are the more significant pharmacy-related findings:

- Controlled substance (i.e., potentially addictive substances/medications that are usually prescribed for mental health treatment or to substance abusers for withdrawal purposes) documentation and disposal procedures are not always followed.

- There is no validation that undistributed medications are properly returned to Jail Pharmacies to be destroyed.

- There is no inventory of routine, non-controlled medications maintained outside of the Pharmacy.

Administrative Issues

There are a myriad of administrative issues within CMS that must be addressed. Some of the more significant findings, by functional area, include:

Funding

- OCSD currently does not contribute any financial resources to offset the cost of medical services provided by HCA, other than transportation of inmates to hospital/clinic facilities.

Contract Administration

- CMS contract administration and program monitoring roles are not clearly defined, resulting in ineffective contract oversight.

- CMC contract physicians do not input discharge planning orders into the CMS electronic medical record system when an inmate leaves WMC-A.

- Profit and Loss Statements submitted by both CMC and WMC-A are not in compliance with the contract terms. In addition, the expense amounts in profit and loss statements could not be fully verified by the audit team.

- CMC's profit margin from the CMS contract far exceeds industry standards.

- The physician and hospital custody database maintained by CMC is incomplete, inaccurate, and largely unutilized by CMS for contract monitoring and program management purposes.

- CMS management is unable to definitively explain why there is a sustained increased in the daily census of inpatient inmates at WMC-A, that began in late 2007.

Hospital/Clinic Scheduling of Inmates for Medical Care

The audit team reviewed the outpatient clinic scheduling process and found that improvements are required to ensure that all inpatient hospital and outpatient clinic visits are properly authorized by the CMS Medical Director or Assistant Medical Director and all inmates receive timely specialty care in line with community practice.

Information Technology

IT issues pertain to CMS' electronic inmate medical record system (CHART). CHART was implemented in 1992 to document and manage inmate health records and to ensure that the record is available to health professionals in a timely manner. Significant issues include:

- The CHART system is underutilized resulting in significant system-wide inefficiencies.

- The CHART system is written in an outdated programming language and its future system maintenance and support is limited.

- CMS does not coordinate with HCA/IT or follow change management best practices when modifying the CHART system application.

Risk Management

Over the last five fiscal years, approximately $1.2 million has been spent settling or defending CMS lawsuits. Specifically, from July 1, 2003 to June 30, 2008, there were a total of 55 inmate lawsuit claims filed against CMS for a variety of reasons, all pertaining to the medical care received while in custody. Of these 55 claims, 18 resulted in either settlements and/or the incursion of outside legal expenses in defending the suit (six of the 18 were settled for a total of $513,500, and 17 of the 18 required the expenditure of funds for outside legal counsel, totaling $748,870); and 37 resulted in no legal or settlement costs to the County.

Human Resource Issues

Over the past decade, the recruitment of quality applicants for physician, pharmacy, and nursing positions has been a nation-wide challenge, especially in a correctional environment. In addition, the time required to perform security background checks by OCSD has further complicated recruiting efforts.

CMS Statistical Data

Statistical summary information of medical services delivered to inmates is not accurately prepared by health care staff. This information is required by Title 15 and provides the facility/system administrator (i.e., OCSD) with a basis of accountability, and ideally should be used by CMS to enhance performance and monitor productivity. The primary reason for inaccurate information is the manual processes used to track and summarize data.

Sheriff-HCA Coordination

The provision of quality inmate health care requires a cooperative effort between both OCSD and CMS management and line staff. This relationship was unproductive between prior management staffs in terms of addressing challenges and implementing innovations that would result in more efficient and effective inmate health care services. Examples include:

- The transportation of inmates from jail facilities to the clinic/hospital is expensive, taxes limited deputy resources, has security-related concerns, and often results in inmates missing their scheduled hospital or clinic appointments.

- During the booking process, inmates at the Intake & Release Center medical screening area are not afforded assurance of privacy while providing personal medical information, as suggested by best practices.

- There are physical improvements that need to be made within each of the five jail facilities to improve the quality of care provided to inmates.

- OCSD could charge modest fees to inmates for some medical services provided as is common to other law enforcement agencies. Specific examples include: 1) charging a fee for inmate requests for routine medical examination, and (2) for common over-the-counter medications. Currently, neither is done.

Summary of Key Recommendations

- Remove all organizational and personnel barriers to change within the CMS organization. Set in place a leadership team that is willing and able to promote an environment of performance and optimism that will ensure that the findings in this audit are implemented in a timely manner. A formal audit action plan should be established that is supported by the resources necessary to bring about lasting improvement, and CMS management's progress should be actively monitored by HCA Executive Management.

- Due to the risks inherent in a correctional medical operation (i.e., financial, ethical, legal, public/political sensitivity), CMS should be elevated to a first tier priority for both OCSD and HCA.

- HCA should create a Task Force of high-performance HCA employees to comprehensively address the deficiencies identified in this audit.

- Throughout CMS, performance standards should be established, communicated, and enforced. When basic performance expectations are not met, employee training, counseling, and then discipline should occur.

- Appropriately address all conflict of interest situations within CMS.

- Reduce the number of Supervising Nurses to two, with one responsible for nursing activities at the Theo Lacy and James Musick jail facilities, and one responsible for the Central Jail Complex. Each supervisor should be on site Monday through Friday to assist Senior Nurses with the day-to-day operations and facilitate problem solving.

- Transition all LVN positions to either an eight-hour or a twelve-hour shift in order to eliminate the unnecessary staff overlap that currently exists with the hybrid "4-10" and "9-80" schedule.

- CMS Physician and Pharmacy staff should perform a formal evaluation of the 1:00 p.m. medication pass to assess the feasibility of discontinuing the pass in the future, or limiting the pass to include only those medications that must be given between the 9:00 a.m. and 7:00 p.m. passes.

- CMS and OCSD should create a committee to work toward the development of a partnership with a local medical school to establish a physician residency program within the jails.

- CMS should ensure that adequate utilization review procedures exist and are followed with regard to the effective and efficient provision of contract physician and hospital services.

- CMS should immediately enforce the regulations and procedures related to controlled substances.

- CMS should evaluate the current Pharmacy work schedule with the goal of closer coordination between medication packaging timelines and medication distribution schedules in order to reduce the amount of wasted medications.

- OCSD should begin to contribute financial resources to cover at least some of the fiscal burden of providing inmate medical services. Immediate contribution opportunities exist with some much needed capital and infrastructure improvements such as, (1) refurbishing medical observation units at the jails, (2) an electronic medical record system, and (3) building out clinic space at the jails.

- HCA/Contract Administration and CMS should delineate the responsibilities for contract administration and contract program monitoring. Once this occurs, CMS should ensure that contract monitoring is performed as required.

- HCA should require by contract that CMC and WMC-A obtain independent audits of their annual Profit and Loss Statements to ensure that the statements accurately represent their profit.

- HCA should (1) request that CMC reduce their rates for the remainder of the current contract term (June 2009), and (2) ensure that future negotiated physician contracts provide appropriate profit margins in accordance with industry standards and are in line with other government entities contracting for correctional medical services.

- HCA needs to renegotiate with CMC to eliminate the $100,000 charge for inputting data that is already necessary for CMC to conduct its own internal billing and claims processing. This information should be provided to the County at minimal or no cost as part of normal contract monitoring.

- CMS management needs to specifically determine whether the increase in the inmate inpatient population is a permanent shift, or one that can be

mitigated through operational changes on the part of both CMS and OCSD.

- CMS should complete its efforts to fully interface outpatient/inpatient approval/scheduling process in the CHART system to include electronically created, sequentially numbered Treatment Authorization Requests with the online priority/approval function, outpatient scheduling, and reporting queries that provide CMS management information to monitor the process.

- CMS should work with OCSD to find solutions that will ensure that inmates are transported to scheduled clinic/hospital appointments.

- CMS should move forward immediately to purchase a new fully automated medical records information system. In the interim, CMS should more fully utilize the CHART system and establish a cross-over timeline for moving hard copy components to the electronic medical record in CHART until a new medical record system is available. In the near term, CMS should delete 2-3 medical records positions, and in the long run aim to eliminate 10-15 positions.

- CMS should work with HCA/IT to implement ongoing adequate IT change management procedures in accordance with best practices.

- In the short term, CMS should establish procedures to ensure that statistical summary information is accurately compiled by staff.

- OCSD and HCA should begin an in-depth analysis of the feasibility of implementing outpatient clinic(s) in its jail facility(ies).

- Work with OCSD to ensure that a deputy is present at all times during inmate sick call at the James Musick jail facility.

- OCSD and CMS should work together to determine the feasibility of charging inmates for sick call and/or the selling of over-the-counter medications through the Sheriff Commissary.

Estimated Cost Savings/Revenue Enhancements

The audit team calculated an estimate of cost savings and revenue enhancements from the implementation of all audit recommendations. Conservative assumptions and reasonable estimates were utilized. While some savings are readily measureable, others will not be known until they are implemented. Moreover, much of the estimated value added will not be achieved immediately, but rather over time as HCA and OCSD phase in the recommended operational changes. In addition, although the mitigation of risk, specifically liability risk, is difficult to value, it is clear that the recommendations provided in this report will significantly enhance risk protection for the County. Our minimum estimate of measureable annual value added (cost savings, revenue enhancements, increased productivity and staff time), contingent upon both HCA and OCSD operational changes, is approximately **$2,740,860 for a one year period, or $13.7 million if measured over a five year period.** In addition, our estimate of other potential, but less certain, savings is **$790,102 for a one year period**. The details of these estimates are provided in the Estimated Cost Savings/Revenue Enhancements section of the full report.

PERFORMANCE AUDIT

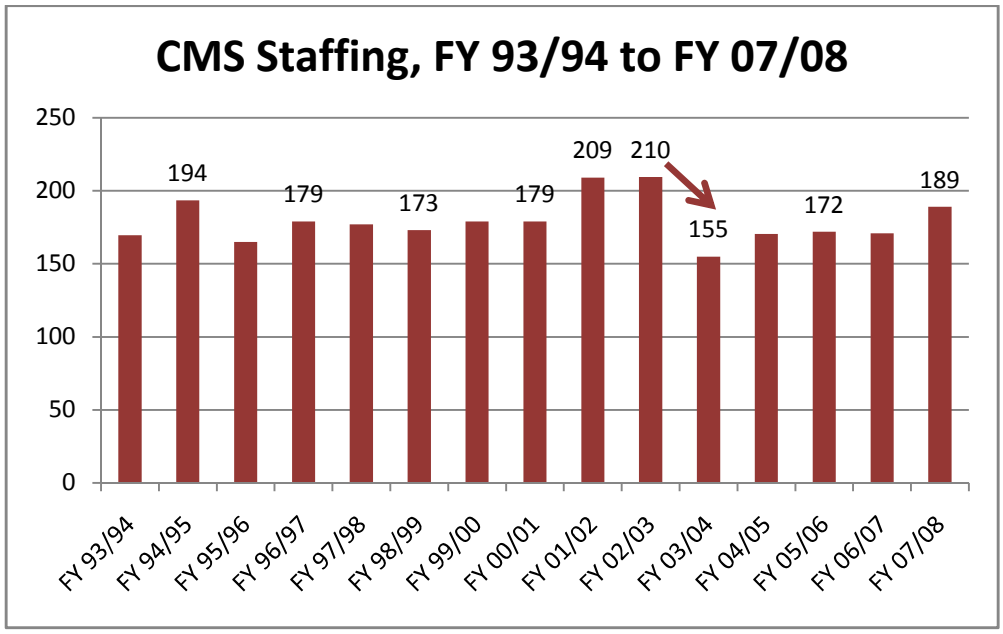
OF

HCA/CORRECTIONAL MEDICAL SERVICES

Introduction

Over the past several years, a number of events have significantly impacted the Health Care Agency's (HCA) Correctional Medical Services (CMS) operation. These events include:

- The 2002 State Budget deficit which reduced funding to CMS and resulted in significant staffing cuts, impacting program operational capabilities



- High profile custodial health events which have resulted in increased scrutiny of inmate medical care

- Retirement of key CMS managers and its impact on program operations

- Employee association efforts to publicize CMS deficiencies and a 2007 "no-confidence" vote taken by CMS line nursing staff against CMS management

- 2007 Grand Jury Report : "Man Down, Will He Get Up?" detailing circumstances surrounding an inmate death and subsequent findings related to nurse staffing and morale issues

These events, as well as the inherent risk from providing health care within a custodial environment, resulted in the CMS operation being ranked the 5th highest audit priority in the Office of the Performance Audit Director's (Office) Risk Assessment process. This process was used by the Board of Supervisors (Board) and the Office as a basis to determine which County operational areas have the highest risk potential and therefore should be examined.

The Office began the CMS audit in May 2008. It was, however, placed on hold by the Board in June 2008 when they directed the Office to commence an overtime audit of the Orange County Sheriff-Coroner Department (OCSD). The overtime audit was subsequently completed in late October 2008, and the CMS audit resumed.

Audit Scope and Objectives

The scope of this audit is limited to the CMS section of the Medical and Institutional Health Services Division of the HCA. Specifically excluded from this audit are other portions of Medical and Institutional Health Services, such as: Correctional Mental Health Services, Juvenile Health Services, and the Conditional Release Program. Correctional Dental Services was also not included in this analysis, but is included in some summary information.

The objectives of the CMS audit are to:

1. Examine and document potential risks and operational deficiencies in the CMS program

2. Identify improved business processes and operating efficiencies that will assist CMS in achieving its stated goals and objectives

Audit Methodology

The audit included a detailed analysis of multiple data sets; review and observation of various systems and workflow processes used by CMS that impact organizational effectiveness; review of regional and national correctional medical reports and industry standards; examination of contractor operations; and a review of State regulations and inspections of jail inmate health operations.

Information Reviewed

Information gathered included:

- Business Plans from 2001-2008
- Annual Budgets FY 2000/01 to FY 2008/09
- Budget detail worksheets prepared by HCA
- California Code of Regulations Titles 15 and 24
- CMS historical documents
- National Commission on Correctional Health Care Standards
- The Institute for Medical Quality (IMQ) Accreditation Standards
- Orange County Grand Jury Annual Jail Reports
- Pertinent inmates' medical records and hospital survey information
- Hospital and Physician contracts and expense and billing information
- CMS operating statistics
- Benchmarking data from other California counties
- Nursing position class specifications
- OCSD/Transportation statistics regarding inmate transportation
- State Inspection Reports of inmate medical care
- HCA and CMS Organizational structures
- Pharmacy records
- CHART electronic medical records system
- HCA/HR Investigation records of CMS
- Consultant staffing reports on CMS
- Conflict of Interest information
- Newspaper articles related to CMS
- Nursing and Physician work schedules

- Fair Labor Standards Act information related to nursing schedules
- Treatment Authorization Forms (TARS) approving inmate medical care off-site
- Hospital and Physician Utilization Review meeting minutes
- Claims/Lawsuits filed against CMS
- County Counsel analysis of providing clinic services in jail facilities
- Crout and Sida Jail Staffing Assessment for OCSD
- Nursing training requirements

Interviews

Interviews/discussions/correspondence with:

- HCA Executive Management
- Sheriff Jail Command staff
- CMS Administrative Management
- CMS Physicians
- CMS Pharmacy staff
- CMS Nurses
- Contract Physician Group
- Contract Hospital Management
- County Counsel
- HCA/Budget staff
- HCA/Human Resource staff
- HCA/Contract Administration staff
- HCA/Information Technology staff
- Benchmark Counties
- Consultants retained by CMS
- Retired CMS staff
- Orange County Employee's Association
- OCSD/Transportation staff
- OCSD/Administration staff
- Institute for Medical Quality staff

Data Review and Analysis

Substantial efforts were made to review, analyze and validate all data received. At several points during the engagement, audit staff met with HCA and Sheriff staff to ask questions, verify information, and to discuss findings. In addition,

audit staff examined data sets and conducted internal checks of all quantitative information to evaluate the accuracy and integrity of the data provided.

Report Preparation and Review

A confidential preliminary draft report was presented to HCA and to OCSD for a review of factual accuracy on January 15, 2009. Comments received and concurred with by the Office are included in this Final Draft Report, which has been distributed to HCA, OCSD, the County Executive Office, and the Board of Supervisors. Upon receipt of formal written responses to this Final Draft Report by HCA and OCSD (if desired), a Final Report will be agendized on the Board calendar with any responses included as attachments.

Background Information

Responsible Party for County Inmate Health Care

According to Titles 15 and 24 of the California Code of Regulations (CCR), OCSD is the responsible party for ensuring that adequate medical care is provided to the inmates in its facilities. These regulations are minimum standards for local detention facilities and, as such, provide general guidelines for compliance. Specific methods utilized to comply with these regulations are left to the discretion of each Law Enforcement Agency.

OCSD has chosen to have its health care responsibility administered by the County of Orange Health Care Agency/CMS. This arrangement was recommended by the County Administrative Office and subsequently approved in-concept by the Board of Supervisors on June 17, 1975 (see Exhibit 1):

> "…this Board hereby approves, in concept, the transfer of Correctional Medicine functions presently performed by the Sheriff-Coroner and Probation Departments, including involved personnel, services and supplies and fixed assets, to the Physician County Correctional Services

budget, under the direction of the County Health Officer, effective July 1, 1975…"

During its analysis, the County Administrative Office considered the following alternatives for organizational placement of Correctional Medical (See Exhibit 2):

- Retain the (then) present Physician County Correctional Services (PCCS) organizational structure
- Contract with a private firm for correctional medical services
- Consolidate all correctional medical activities under the Sheriff-Coroner or the Probation Department
- Have PCCS report directly to the Board of Supervisors or the County Administrative Officer
- Consolidate all correctional medical activities under the County Health Officer (chosen alternative)

This arrangement was formally adopted by Board Resolution on July 29, 1975 after a Memorandum of Understanding was developed and signed by OCSD, the County Health Department, and the Probation Department.

County Jail Facilities and Inmate Population

There are five 24/7 jail facilities operated by OCSD where medical care is provided to inmates: the Central Jail Complex (Men's Jail, Women's Jail, Intake & Release Center) in Santa Ana, the Theo Lacy Jail in the city of Orange, and the Musick Jail in the city of Irvine.

The total inmate population in the Orange County jail system averaged 6,148 inmates in 2008. The health of the inmate population across the country over the past several years has substantially declined. Borrowing from the recent Orange County Jail Assessment Report (Crout & Sida): "Jails everywhere are struggling with the reality that today's inmate is in poorer health, more drug addicted, more

mentally ill and more prone to violence than were inmates of a decade or more ago." In addition, correctional healthcare brings special challenges, such as patient access and treatment, patient health education, medical facilities, and the use of equipment. Also, the frequent movement of inmates through the correctional system creates difficulties in identifying and treating illness, controlling communicable disease, and managing medical risk.

Two Departments, Two Missions

As noted earlier, inmate health care in Orange County is impacted by two different County agencies (OCSD, HCA), with two different missions.

The primary mission of OCSD related to inmates is maintaining a safe and secure environment for the inmates and the jail staff. The responsibility for inmate health care has been delegated to HCA/CMS. Financially, other than the transportation of inmates from the jail to required clinic and hospital visits, OCSD bears no fiscal responsibility for inmate health care. As a result, health care is a secondary priority for OCSD.

The primary mission of HCA/CMS is to ensure the provision of adequate health care for the inmates. The accomplishment of this mission is quite complex with a number of internal and external players involved.

This distinction in mission between OCSD and HCA is important, resulting in unique challenges that will be addressed later in this report.

Accreditation

CMS is working toward reestablishing its accreditation with the Institute for Medical Quality (IMQ) Standards. IMQ standards delineate what constitutes quality inmate health care services. IMQ provides an accreditation service to verify an institution's compliance with established industry standards and state regulations. The U. S. Court of Appeals, Ninth Circuit has recognized IMQ accreditation standards as meeting the constitutional level of health services for inmates. The courts found that standards developed and evaluated by IMQ were appropriate for use as a defendable standard of healthcare. CMS has

established an Accreditation Committee with the goal of accreditation in 2009. IMQ currently has approximately 23 counties in its program that have or are trying to get accreditation. Almost none of the ten largest California counties (with the exception of Santa Clara and one facility in San Diego) participate in IMQ.

CMS Overview

Services Provided Directly by CMS

CMS provides medical services both in-house (in jail facilities) and externally by contracts with multiple health care providers outside of the jail facilities. Internally, CMS has County staff in the following professional areas: Nursing, Physician, Pharmacy, and Administration. A brief summary of services provided by County staff to inmates inside the jail facilities includes:

- Initial physical examination once entering the jail system (Triage)
- Daily sick call for inmates requesting to be seen by medical staff
- Pharmacy and distribution of daily medications
- Basic dental services
- X-ray
- Observation units
- Isolated disability care (”sheltered living”)
- Medical records
- Diabetic care and other chronic illnesses
- Coordination of clinic/hospital outpatient/inpatient specialty care
- 24/7 emergency medical response

Services Provided by Contract

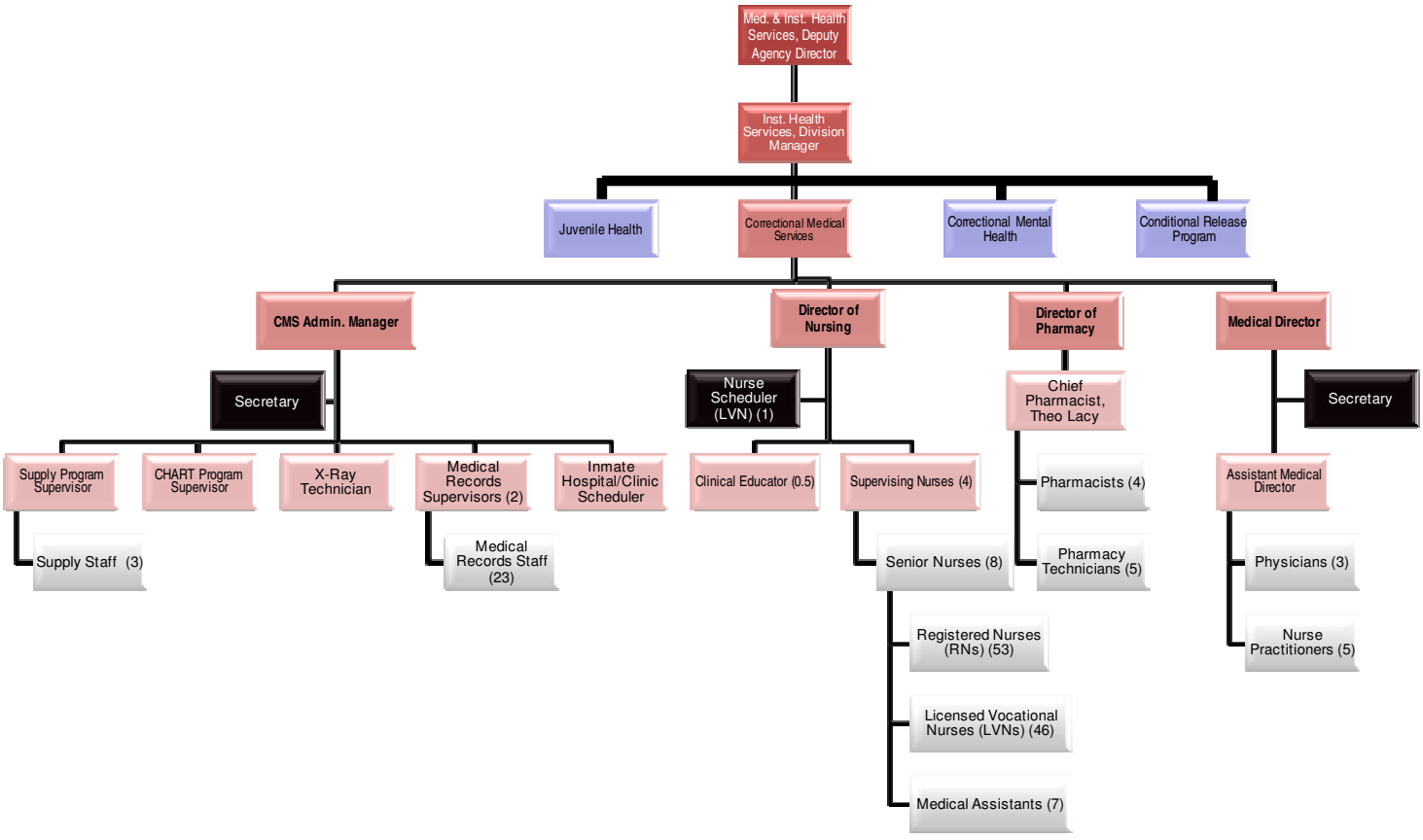
CMS also contracts for a number of services:

- Inpatient hospital and outpatient clinic services from Western Medical Center – Anaheim (WMC–A)
- Fiscal intermediary services to track and manage expenses for emergency situations in which inmates are sent to a hospital other than WMC-A

- A multi-specialty physician group, Correctional Managed Care (CMC), that provides medical treatment at WMC–A to inpatient and outpatient inmates. These services include surgical services and specialty consultations and minor treatment services (e.g., Orthopedic, Ear/Nose/Throat, Optometry, Dermatology, OB/GYN)
- Part-time contract physicians, pharmacists, nurse practitioners, and registered nurses that cover weekends, holidays, vacation and sick relief in all jail facilities. County physicians provide this care Monday through Friday during regular business hours.
- Outpatient dialysis services from Davita, via a pass through agreement with WMC-A

CMS Organization Chart

Provided below is the organization chart for CMS:



A brief description of individual CMS units and County medical staff includes:

- Physician Services – provides overall medical policy and direction for the provision of medical services to inmates; provides diagnostic, minor medical, and emergency care to inmates in jail facilities utilizing Physicians and Nurse Practitioners (NPs)

- Nursing Services – provides all jail facility nursing services to inmates utilizing Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Medical Assistants

- Pharmacy Services – provides pharmaceutical drug services within the jail facilities

- Program (Administrative) Services – provides a variety of administrative support services for CMS including budget, purchasing, contract administration and clerical services. In addition, includes ancillary support services such as Radiology, CHART electronic and manual medical records, the operation of jail medical supply rooms, and coordination of hospital/clinic scheduling of inmates.

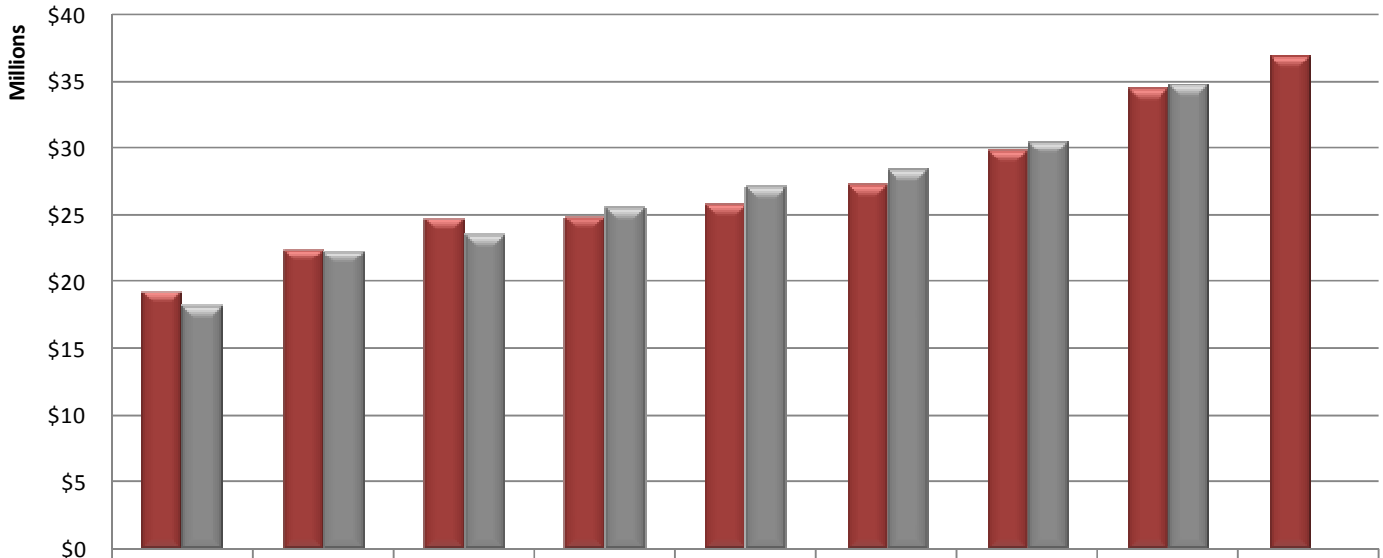
CMS Revenue/Expense Summary

The CMS Program is funded exclusively by the County General Fund as part of the Health Care Agency Budget. At one point, HCA utilized both State Realignment funding and County General Purpose Revenues to finance the CMS Program. However, several years ago HCA made the determination that the program should be funded only with General Fund money and not with any State Realignment dollars. HCA indicated that this decision was made in order to clarify the full cost of the CMS program for the Board of Supervisors and potentially trigger OCSD contribution of financial resources to cover the CMS budget, in total or in part. This decision highlights the discussion between HCA and OCSD over who should bear the financial responsibility for the CMS Program.

Total Actual Expenditures for the CMS Program have grown from just over $18 million in FY 2000/01 to nearly $34.7 million in FY 2007/08, an increase of 91% in seven years. As the chart below demonstrates, CMS has consistently spent above its budget since FY 2003/04, in amounts ranging from only $271,368 in FY 2007/08

to $1,295,017 in FY 2005/06. The CMS Total Expense Budget for FY 2008/09 is $36,869,377, which is a $2,179,515 (or 6.3%) increase from the Total Actual Expenditures in FY 2007/08.

Budget vs. Actual Expenditures - HCA/Correctional Medical Services, FY 2000/01 through FY 2008/09



	FY 2000/01*	FY 2001/02*	FY 2002/03	FY 2003/04	FY 2004/05	FY 2005/06	FY 2006/07	FY 2007/08	FY 2008/09
Budget	$19,237,480	$22,433,774	$24,730,446	$24,805,545	$25,855,080	$27,101,239	$29,759,520	$34,418,494	$36,869,377
Actuals	$18,142,151	$22,216,084	$23,538,387	$25,459,510	$26,979,848	$28,396,256	$30,444,032	$34,689,862	

*Note: FY 2000/01 and FY 2001/02 Budgeted Amounts were obtained from HCA/Internal Budget system that was utilized at that time, which adjusted information after it was downloaded from BRASS. All other data were obtained from CEO-Budget.

Within FY 2007/08 Total Actual Expenditures, the Total Salaries and Employee Benefits (S & EB) accounted for $18,040,344 or 52%. Within Total S & EB, Overtime and Extra Help costs accounted for $2,224,556 or 12.3%. Retirement costs accounted for $2,636,739 or 24% of Regular Salaries. Aside from Total S & EB, the other large expenditure line item is Professional/Specialized Services, which accounted for $14,205,139 million or 41% of Total Expenditures. The primary components of the Professional/Specialized Services category for CMS include (1) the County's contract with WMC-A for inpatient and outpatient care for inmates ($4.76 million), (2) the County's contract with CMC to provide physician services for both acute needs inpatients and as specialty clinic outpatients ($2.75 million), and (3) payments to non-contracted hospitals who

provide acute inpatient care to inmates ($3.32 million). In addition, the Professional/Specialized Services line item includes $2.72 million of administrative overhead allocation from HCA. The $16.5 million increase in Total Actual Expenditures from FY 2000/01 to FY 2007/08 came primarily in three categories: Professional/Specialized Services ($8.5 million), Retirement ($2.5 million), and Regular Salaries ($2.5 million).

What Works Well at CMS

The audit team identified the following areas where CMS is providing quality services:

- Basic inmate health care – CMS staff generally provides inmate access to basic quality health care services in a timely manner.
- Inmate Booking Triage – All inmates enter the jail system through the Central Jail Complex (Intake & Release Center) and immediately receive a basic health assessment before being housed in a jail facility.
- Medicine supply and distribution – Inmates generally receive prescribed medications in a timely manner.
- Commitment to Inmate Care -- Medical staff have a strong commitment to keeping inmates healthy.

Recent Accomplishments

- In response to the 2007 Grand Jury Report, CMS enhanced emergency medical response capabilities through increased training, drills, and new equipment.
- In 2008, the Board of Supervisors approved an HCA request to establish the Institutional Health Quality Assurance Panel to systematically assess, evaluate, and make recommendations regarding adult correctional healthcare in Orange County Jail facilities.
- In late 2008, CMS was successful in filling the long-vacant Director of Nursing position.

- HCA re-cabling of jails to provide CMS staff with access to internet and email services.

- Appointment of new Institutional Health Division Manager.

- In response to discussions with the audit team, HCA has formed a Task Force which is currently addressing the recommendations included in this report.

Findings & Recommendations

The audit team comprehensively examined all aspects of the County system that provides health care services to jailed inmates. The following findings and recommendations highlight areas are for improving the CMS operation.

CMS Organizational Culture

Finding 1: Negative employee morale impedes meaningful progress.

Nearly all staff interviewed during this audit identified several problems within the CMS organization that impede program efficiency and effectiveness. A consistent theme expressed to the audit team by CMS line and management staff was "nothing can be done; nothing will change." This attitude has limited the opportunities for initiative, innovation and lasting change within the organization. This assessment is substantiated by the many audit findings that follow. Addressing these cultural issues is vital to ensuring that the more concrete recommendations that follow are accomplished.

A summary of the specific issue areas that were identified are listed below, each of which will be discussed later in this report:

- Organizational Structure
- Management
- Nursing
- Physician
- Pharmacy
- Administration
- OCSD-CMS Coordination

Recommendation 1: Remove all organizational and personnel barriers to change within the CMS organization. Set in place a leadership team that is willing and

able to promote an environment of performance and optimism that will ensure that the findings in this audit are implemented in a timely manner. A formal audit action plan should be established that is supported by the resources necessary to bring about lasting improvements, and CMS management's progress should be actively monitored by HCA Executive Management.

Organizational Structure Issues

Finding 2: The current CMS Administrative Services structure impedes operational efficiency and effectiveness.

Each jail facility is the primary service delivery point for inmate health care. At each facility, there are both line and support staff. Line staff includes direct service providers such as doctors, nurses, and pharmacists. Support staff currently includes medical record personnel, supply room clerks, an X-Ray technician, and administrative program staff which provide budgetary, purchasing, information technology, and clerical support. Support staff is supervised by a Program Manager who is physically located at the Central Jail Complex. The program support function has become increasingly and inappropriately enmeshed in medical line operations due to a management vacuum created by a long-term vacancy in the Director of Nursing position. This environment has been a source of considerable frustration among staff and, in part, led to the cultural issues described in the previous section. However, with the recent hiring of a Director of Nursing, there is an opportunity for the program support function to refocus on strictly administrative issues, which are discussed in further detail in the Administrative Issues section of this report.

Similarly, the Nursing operation, which is the backbone of the daily medical care service delivery in the jails, should have under its structural authority as many of the tools and resources as necessary to perform their daily line responsibilities.

Recommendations:

2.1 : Relocate the CMS Program Manager from the Central Jail Complex to HCA/Headquarters and assign the following overall administrative responsibilities for the CMS function: Human Resources Coordination, Budget, Contract Administration, Purchasing, and Medical Recordkeeping/IT. This position should continue to report to the Institutional Medical Health Division Manager, but have no line authority over jail medical staff.

2.2 : Realign the X-Ray Technician and Inmate Hospital/Clinic Scheduler under the CMS Medical Director.

2.3 : Realign the supply room function under the Nursing authority structure at each jail facility.

A recommended organizational chart can be found in Exhibit 3.

Management

Finding 3: Inmate health care is a priority, but a secondary priority for OCSD and a non-core service for HCA.

As previously stated, the mission of OCSD in the jails is to ensure the safety of inmates and those who work inside the jail facility. Health care responsibilities have been delegated to HCA/CMS. In addition, OCSD, except for the transportation of inmates to the hospital, does not contribute any financial resources toward the health care services provided to the inmates. As such, inmate health care delivery is a secondary priority both operationally and financially.

Although inmate health care has been delegated to HCA by the Board with OCSD concurrence, HCA management has described CMS as a "non-core service." This view stems from the circumstances surrounding the Board's decision in 1975 to have correctional medicine report to the County Public Health Department (the pre-cursor to HCA). At that time, the Physician County Correctional Services (PCCS) group, which provided health care in County correctional facilities, reported organizationally to the County Medical Center. When the County transferred ownership of the medical center to UCI, it was necessary to find an organizational placement for PCCS. Thus, the provision of correctional medical services has been a County obligation that was handed to HCA.

As a secondary and non-core service, the provision of inmate health care predictably receives less attention than other parts of both OCSD and HCA. As a result, making the time to address the issues within CMS, working through two different departmental chains of command, and gaining approval for the allocation of sufficient resources to make improvements has been an on-going problem.

Recommendation 3: Due to the risks inherent in a correctional medical operation (i.e., financial, ethical, legal, public/political sensitivity), CMS should be elevated to a first tier priority for both OCSD and HCA.

Finding 4: There is a lack of accountability with CMS management and line staff.

Despite the fact that CMS both knows it has deficiencies, and is aware that little progress has been made in addressing those deficiencies, employees have generally not been held accountable for poor or non-performance. This is confirmed by the following significant findings:

- Some problems have continued for years without meaningful attention including: outpatient scheduling of inmates and the assurance of their actual transportation to the hospital; inadequate utilization of the CHART electronic medical record system; ongoing issues with lost hard copy inmate medical records; orderliness and functionality of medical supply storerooms; accepting responsibility for the administration of contracts including the meaningful conduct of patient and medical facility Utilization Reviews; and following documentation and disposal policies and procedures regarding controlled substances.

  Despite the fact that these and other issues have been unresolved for several years, it was not until September 2008 that CMS put together a formal action plan that prioritized issues and tracked implementation progress. In addition, HCA Executive Management was consistently surprised at the depth of the problems within CMS and the lack of progress toward addressing their on-going issues. Lastly, this recently-created action plan is inappropriately monitored by a staff member in HCA/Strategic Projects Administration, not by CMS management.

- Employees with known, significant performance issues have been allowed to pass probation. In one instance, an employee passed because management/supervision was unwilling to confront the issues; in another instance an employee passed because of a failure to complete an evaluation before the end of the performance period thereby allowing the employee to pass by default.

- HCA authorized a consultant review during the course of this performance audit to address several staffing and scheduling issues previously covered by a prior consultant report and already under review by the audit team. In addition, one of the primary tasks of this second consultant review was to determine the staffing requirements needed to obtain IMQ Accreditation, despite the fact that several of the prior consultant's more pressing operational recommendations had not been resolved.

- It is common knowledge among CMS management that much of the statistical data collected and aggregated is unreliable. Despite this knowledge, this data was and is still used within CMS to provide

information to Executive Management, and on occasion was/is forwarded to the California Department of Corrections per state regulations.

- The administration of CMS contracts has been inadequate and subsequently has not allowed CMS to properly manage contractor performance or fully prepare for effective contract negotiations with vendors.

- There are a handful of conflicts of interest within CMS that have been left to linger for several years. These conflicts include the employment of relatives within the CMS program, and the utilization of at least one employee in multiple capacities as both a contractor and a County employee. The continuation of these situations has not only created unacceptable conflicts of interest, but has generated much animosity among staff both within CMS and OCSD, and exposed the County to potential and unnecessary liability.

- There are examples of recalcitrance among some CMS line staff. This was both conveyed to us by CMS management and observed during the audit team interviews. Simply put, some employees do not perform their required duties and very little, if anything, is done to address it by supervision/management.

Recommendations:

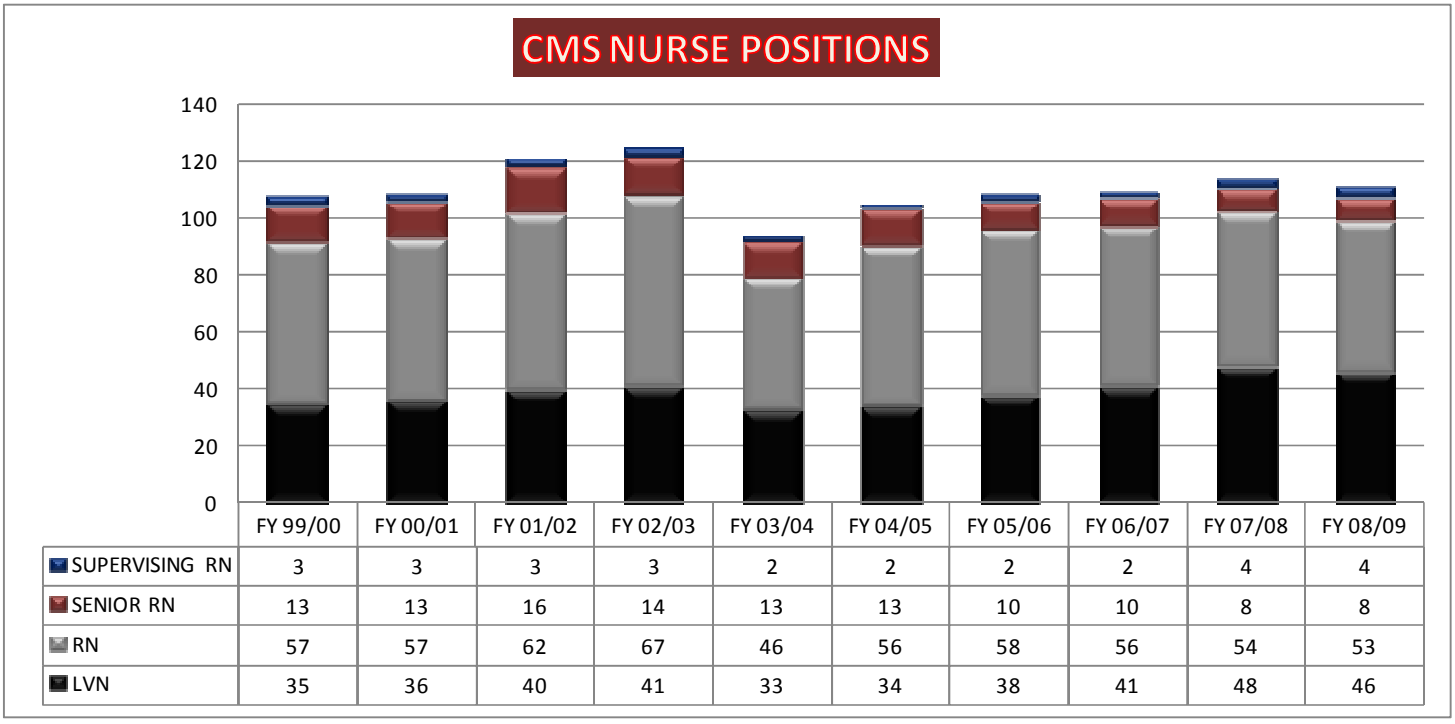
4.1: HCA should create a Task Force of high-performance HCA employees to comprehensively address the management/accountability deficiencies identified in this audit.

4.2: Throughout CMS, performance standards should be established, communicated, and enforced. When basic performance expectations and standards are not met, employee training, counseling, and then discipline should occur.

4.3: Appropriately address all conflicts of interest within CMS.

Nursing

CMS Nursing staff levels have been the subject of considerable scrutiny over the past several years. The nurses' employee association, the Orange County Employee's Association (OCEA), began raising concerns over nursing staff levels in FY 2002-03 after HCA cut a variety of CMS positions in order to address State budget shortfalls (the total number of nursing positions fell from 125 in FY 2002/03 to 94 in FY 2003/04). It should be noted that these staffing cuts came only two years after a significant staffing increase in the CMS program (the total number of nursing positions increased from 109 in FY 2000/01 to 121 in FY 2001/02).



	FY 99/00	FY 00/01	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09
SUPERVISING RN	3	3	3	3	2	2	2	2	4	4
SENIOR RN	13	13	16	14	13	13	10	10	8	8
RN	57	57	62	67	46	56	58	56	54	53
LVN	35	36	40	41	33	34	38	41	48	46

CMS nurses' concerns with staffing levels and other issues culminated in a October 2007 "vote of no-confidence" in the program's management, and several subsequent newspaper articles that amplified nursing staff's criticism of CMS leadership. In addition, in both 2006 and 2007, Grand Jury Reports on CMS indicated understaffing and a lack of training for nursing personnel after in-custody deaths prompted increased scrutiny of the program.

In response to this scrutiny, HCA hired an external consultant to conduct a nurse staffing review. The review was conducted from late 2007 through April 2008, with a final report issued to HCA management. Then, in fall 2008, HCA hired a second consultant to again review nursing staffing levels and identify the necessary resources to regain accreditation by IMQ which was lost in 2002.

The audit team's review of the CMS Nursing function resulted in the following findings:

Nurse Staffing Levels/Schedules

Finding 5: The current allocation of four Supervising Comprehensive Care Nurse positions is excessive.

Prior to the staffing reductions in FY 2003/04, CMS had three budgeted Supervising Nurse positions. Starting in FY 2003/04 to FY 2006/07, CMS reduced its Supervising Nurse positions to two. Then, in FY 2007/08, CMS increased the number of Supervising Nurse positions to four. Interviews with CMS management and staff, as well as detailed job descriptions provided by HCA management confirm that Supervising Nurses are utilized in a variety of disparate ways:

- One Supervising Nurse is primarily responsible for working with HCA/Human Resources to augment recruiting efforts for staff nurses, and to provide training once employees are hired.

- A second Supervising Nurse position, which is currently vacant, was responsible for collecting and verifying some operational statistics, as well as creating new and modifying existing policies and procedures in order to achieve IMQ accreditation. This second Supervisor was also responsible for the James Musick Facility, but was rarely on site.

- The third and fourth Supervising Nurses are utilized consistent with the responsibilities of their classification, and are responsible for the nursing operations at the Theo Lacy Facility and the Central Jail Complex, respectively.

Clearly, only two of the positions are used to meet the supervisory nursing needs of the organization.

Recommendations:

5.1: Reduce the number of Supervising Nurses to two, with one responsible for nursing activities at the Theo Lacy and James Musick Facilities, and one responsible for the Central Jail Complex. Each Supervisor should be on site Monday through Friday to assist Senior Nurses with the day-to-day operations and facilitate problem solving.

5.2: Both the vacant Supervising Nurse position and the Supervising Nurse position currently responsible for recruiting should be reclassified to a Senior Nurse level and reassigned to either (1) WMC – A as the CMS hospital liaison or (2) the Theo Lacy Jail Facility to improve Senior Nurse coverage.

Finding 6: The current allocation of eight budgeted Senior Nurse positions is insufficient to meet coverage needs.

The Senior Nurses are responsible for providing supervision to all nursing staff and ensuring the achievement of day-to-day operational tasks and goals at four of the five jail facilities. Currently, no Senior Nurse is assigned to the James Musick Facility due to its small size. Five Senior Nurses work the day shifts (6:30AM to 7:00PM) at the four facilities and four Senior Nurses work the night shifts (6:30PM to 7:00AM). One of these nine positions is a RN which was temporarily classified as Senior Nurse.

Based on our review of CMS nursing schedules and interviews with a variety of staff, there are frequent instances where only one Senior Nurse is on duty to cover all four jail facilities. In the majority of instances, Theo Lacy is the facility without a Senior Nurse. These occurrences are especially problematic as they

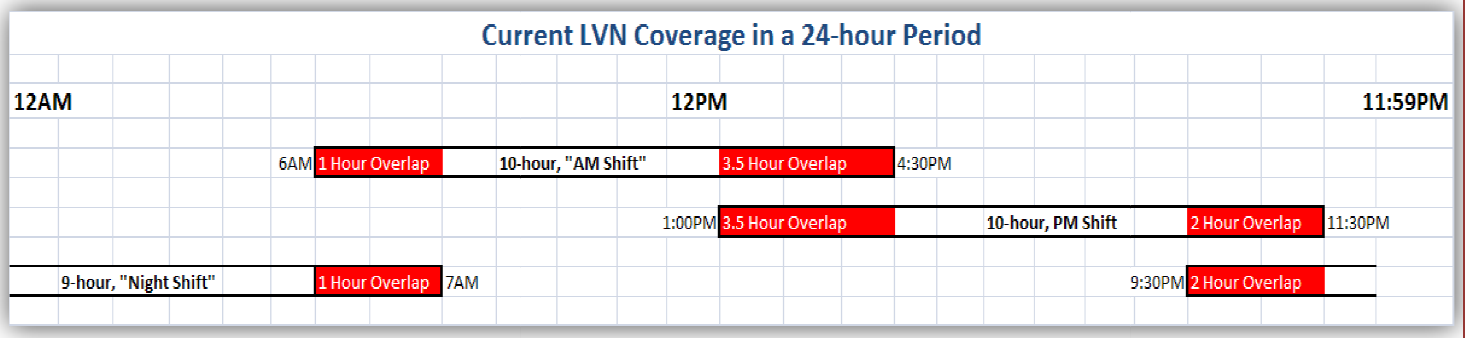
also often occur at times when no Supervising Nurse is on site. This results in no supervisor on site to (a) advise line staff during times of emergency, (b) handle supervisory problems that arise, and (c) ensure that all operational tasks are completed satisfactorily.

Recommendation 6: Increase the number of Senior Nurse positions to ten in order to fill in coverage gaps to ensure day-to-day supervision, especially at the Theo Lacy Facility. The one temporarily promoted position should be made permanent, and the second position should come from the reclassification of one of the Supervising Nurse positions.

Finding 7: **The current LVN schedules are inefficient and lead to supervision difficulty because they are inconsistent with the schedules of other nursing personnel.**

There are three different LVN shifts during a 24-hour period. Both the Day Shift (6:00AM to 4:30PM) and the PM Shift (1:00PM to 11:30PM) are 10-hour shifts, but the Night Shift (9:30PM to 7:00AM) is a 9-hour shift. It is important to note that these LVN shifts differ from the RNs and the Senior Nurses who work 12-hour shifts from either 6:30AM to 7:00PM (Day Shift) or 6:30PM to 7:00AM (Night Shift). These different schedules weaken the ability of the Senior Nurses to plan and manage their respective staffs because of the multiple shift changes that occur. Similarly, staff cohesion and cooperation during a given twelve-hour period is limited because of these staggered shifts. Lastly, because the LVN Day Shift begins thirty minutes before the Senior Nurse Day Shift, Senior Nurses raised concerns about monitoring punctuality among LVN staff.

In terms of efficiency, the audit team identified a significant amount of idle or "down" time on each shift created by the overlap of staff (i.e., from 1:00PM to 4:30PM, from 9:30PM to 11:30PM, and from 6:00AM to 7:00AM). The total hours of LVN staff overlap under the current schedule for any given position is 6.5 hours in a 24-hour period, which equates to 2,372.5 hours in a year in which there is excessive staff coverage (See graphic below). Staff also indicated that from midnight to 4:00AM, there is simply not very much going on at any of the facilities, with the exception of the IRC, where inmates are booked into the jail system on 24/7 basis.



CMS is currently budgeted 49 FTE LVN positions, with three being utilized for non-nursing assignments. Thus, the 46 remaining positions are used to cover the different LVN shifts detailed in the chart below:

Location	Day Shift	PM Shift	Night Shift
IRC	2	2	1
Lacy	2	2	1
Lacy – Mod O	1	1	1
Men's	2	2	1
Women's	1	1	1
Total LVNs	8	8	5

Six months ago, the LVNs and OCEA created a proposal to transition to the "3-12" schedule that is used for Registered Nurses in order to address these inefficiencies and create a more consistent working environment. HCA is currently evaluating this proposal.

Recommendation 7: Transition all LVN positions to either eight-hour shifts or twelve-hour shifts in order to eliminate the unnecessary staff overlap that currently exists with either the "4-10" and "9-80" schedule. Implementing this change would be more efficient, allowing six LVN positions to either be deleted or reassigned to assist with IMQ accreditation-related tasks (e.g. 14-day health inventories). The decision between eight and twelve-hour shifts needs to be made only after a thorough review of shift activities and Fair Labor Standards Act (FLSA) requirements is completed and any procedural adjustments are made (e.g. reduction in the number of medication passes).

Finding 8: The bi-weekly master nursing schedule has been the source of considerable frustration among nursing staff.

Historically, the schedule has been compiled by a full-time Nurse Scheduler, but due to a leave of absence, a Supervising Nurse is covering this very time-consuming task. This temporary change has addressed a concern among staff that the Nurse Scheduler, historically filled by an LVN, did not have the authority to review leave and other requests for other LVNs and especially for the higher-classified RNs. This problem was exacerbated by the fact that the Director of Nursing (DON) position had been vacant for the last several years, and the Nurse Scheduler reported directly to the Program Manager, who does not have nursing management experience or a clinical background.

Though the temporary assignment of a Supervising Nurse to complete the schedule has addressed some of the aforementioned problems, it has created another: the use of high-level nurse management resources (i.e., a Supervising Nurse) to complete a task that substantively and procedurally could be done by an employee in a lesser paid administrative support role.

Recommendation 8: Utilize an administrative support employee who reports to the Director of Nursing (DON) to develop the schedule for review by the DON. This person should also work collaboratively with the Supervising Nurses assigned to specific facilities to address any problems that arise. This solution will not only make more effective use of the Supervising Nurse resources, but will empower the Scheduler to make any schedule-related decisions in consultation with, and with the authority of, the DON and Supervisors.

Daily Medication Passes

Finding 9: The current number of daily medication passes consumes significant staff resources and may not all be necessary.

CMS performs four medication passes per day requiring intensive LVN resources. One of the four medication passes, performed at 5:00 a.m., is required for providing medications to a relatively small number of inmates, many of whom are attending court (for the period July 1 through November 30, 2008, an average of 36 packaged medications were processed by the Pharmacy per day for the Central Jail Complex). The largest passes occur at 9:00 a.m. and 7:00 p.m. and include an average of 1,092 and 1,904 (for the period July 1 through November 30, 2008) packaged medications for the Central Jail Complex. One substantially smaller pass with an average of 141 packaged medications occurs at 1:00 p.m. The CMS Director of Pharmacy informed us that a review of the medications administered at the 1:00 p.m. medication pass was performed

several months ago informally at the direction of the Institutional Health Services Division Manager. At that time, it was determined that the 1:00PM med pass was necessary due to the current detoxification protocols established and medication prescribed for dental needs. The audit team compared the number of medication passes to other Counties in a benchmark study and found that it is not uncommon to have two main medication passes, with additional medication passed only when absolutely necessary or self-carried by inmates.

Recommendation 9: CMS Physician and Pharmacy staff should perform a formal evaluation of the 1:00PM med pass for the purpose of determining the feasibility of discontinuing the pass in the future, or limiting the pass to include only those medications that must be given between the 9:00AM and 7:00PM passes.

County Physicians and Nurse Practitioners

Background Information

CMS employs the following Physician and Nurse Practitioner staffing complements:

- Full Time County Physicians
  There are currently five full time County Physician positions in CMS:

  - (1) Medical Director
    Per Title 15 of the CCR, this is a mandated position, which is chosen by both HCA and OCSD, which has the responsibility to:

    - Provide overall medical policy direction for the CMS operation
    - In consultation with HCA Executive Management, to determine the level of medical care provided within the jail system
    - Be the final arbiter in all medical decisions regarding inmates
    - Ensure that contractors providing medical care to inmates both within and outside the jail do so in an acceptable manner

- In cooperation with OCSD, identify, approve, plan, and implement improvements in the provision of inmate health care

- (1) Assistant Medical Director

  This position is responsible for the day-to-day provision of doctor and nurse practitioner services within the County's five jail facilities. In addition, both the Medical Director and Assistant Medical Director are the final approval required for sending inmates for outside clinic or hospital care.

- (3) Physicians

  Three County Physician positions (only two are filled) are allocated to CMS and cover the five jail facilities from Monday through Friday during regular business hours. Regular duties include: examination of patients who have been referred for examination by nursing staff; evaluation of chronic disease patients (e.g., cardiac, asthma, seizure); rounds for patients temporarily confined to infirmaries for observation (e.g., oxygen delivered, sleep apnea, alcohol and drug detoxification, surgical recuperation); care of complex cases, including hepatitis and HIV.

- Part-time Extra Help Physicians

  Due to the 24/7 nature of jail operations, part-time Extra Help Physicians are employed on a contract basis to provide medical care to inmates during nights, weekends, holidays, and for sick/vacation relief of County full time physicians. There are currently 11 Extra Help Physicians working a variety of hours, a cumulative average of about 21 hours per week.

- (5) Nurse Practitioners

  CMS has five Nurse Practitioner positions that provide important skilled medical care that can be done at lower expense. Typical duties include: inmate physicals during Triage, case management of identified illnesses, sick call for inmates referred by nurses, and treatment of routine illnesses.

All Nurse Practitioners report to the Assistant Medical Director. Four of the five positions are currently filled.

Residency Programs

Finding 10: Coordination efforts between OCSD and CMS have been unsuccessful in establishing a physician residency and training partnership with local medical programs.

The establishment of a Physician Residency program could be a win-win solution for both the County and new doctors in residence. From the Resident perspective, it would allow new doctors invaluable experience in a correctional setting caring for patients whose illnesses are less prevalent than those found in the public at-large: tuberculosis, HIV, and hepatitis-C. For the County, it could retain the services of less expensive physician services and assist in long-term recruiting efforts. CMS physician staff did attempt to establish a partnership with a local optometry program, but the effort was ultimately dropped due to background check issues and delays.

Recommendation 10: CMS and OCSD should develop a partnership with a local medical school residency program.

Utilization Review

Finding 11: WMC-A does not perform meaningful hospital or physician Utilization Reviews of services provided according to contract requirements.

The purpose of the utilization review program is to provide a consistent, quality-controlled method of assuring cost-effective utilization of health resources. This is performed by three review methods: 1) a Prospective Review provides for pre-authorizing urgent procedures/tests/treatment to ensure it meets established criteria (i.e. is medically necessary & appropriate), 2) a Concurrent Review is a program for reviewing the cases of currently hospitalized patients in order to determine that the level of care is appropriate and the treatment plan is the most efficient and cost-effective, and 3) a Retrospective Review is for reviewing historical hospital inpatient and clinic outpatient utilization statistics for the purposes of education, pattern identification, and quality assurance.

Specific requirements to perform these reviews are documented in WMC-A's Utilization Management (UM) Procedures dated November 18, 2008. The audit team reviewed the utilization plan, inquired with contract staff regarding procedures performed, and reviewed utilization meeting agenda minutes. Our examination found that these utilization reviews are not performed as stated in UM Procedures. Instead, these reviews have become cursory and less than meaningful. As a result, neither contract requirements nor best practices are followed, nor is the County formally assured that inmates are receiving quality care or that physician/hospital expenses are reasonable for the services provided.

Contractors informed us that the UM procedures, established many years ago, are outdated and they plan to work with CMS at the beginning of 2009 to review, update, revise, and follow the procedures by the end of the first quarter.

Recommendation 11: CMS/Physicians should ensure that adequate utilization review procedures are performed. Any changes to utilization procedures should be discussed with CMS Management before implemented.

Medication Orders

Finding 12: Telephone orders for medication are not approved electronically in the CHART electronic medical record system.

All telephone medication orders must evidence documented approval within 72 hours. When a physician is not physically present (on-call), the RN will obtain a telephone order and enter the medication as a verbal order into the CHART system and as a telephone order on the Medical Orders form. CHART (Correctional Health Assessment, Recording, and Tracking) is an electronic medical record information system used by CMS. The medical orders form is faxed to the Pharmacy. Pharmacy ensures the medication order is accurately recorded in the CHART system. Physicians are required to record authorization of the medication manually on the hard copy Medical Orders form. Subsequent documented approval of the telephone order is not required electronically. The ability to electronically approve telephone orders is a feature that is currently available in the CHART system and is utilized by HCA Mental Health Psychiatrists. CMS informed the audit team that they plan to roll-out this feature in the near future. More specific CHART system findings and recommendations will be discussed later in the Administrative Issues/Information Technology Section of this report.

Recommendation 12: CMS should complete its efforts to roll-out the electronic approval of verbal medication orders in the CHART system.

Finding 13: Medications prescribed by contract Physicians at the hospital/clinic are not always properly reviewed by a CMS physician before the prescription is processed.

After an inmate is seen at the hospital, the hospital physician may prescribe a recommended medication. The County Medical Director has pre-authorized the transcription of hospital orders onto the CMS medical order sheets under his name although the prescription portion was not actually reviewed. The RN enters the order into the CHART system as prescribed by the County Medical Director although this did not actually occur.

Recommendation 13: All medication orders should be properly reviewed and approved, at least verbally, and ideally electronically, by a County Physician before it is entered into the CHART system.

Pharmacy-Related Issues

There are several important findings in this area that have been discussed with HCA Executive Management so immediate changes could be implemented.

Controlled Substances

Finding 14: Controlled substance documentation and disposal procedures are not always followed.

There are approximately twelve controlled substances utilized by CMS. Controlled substances are defined as substances that may be addictive and are medications that are usually prescribed for mental health treatment or to substance abusers for alcohol or benzodiazepine withdrawal or detoxification. CMS Pharmacy policy requires a perpetual inventory of controlled substances distributed to nurses and maintained at nursing stations. A sequentially numbered "Controlled Substances Administration Record" is used by nursing staff to document an audit trail of each dose. Further accountability is established by requiring dual authorization for all medications received and disposed of as well as to verify substances on hand at the end of each shift. A Senior Nurse is required to review each record to ensure the form is properly completed. After each shift, the LVN must update the CHART system to record whether the inmate received the medication or the reason if it was not administered (e.g. refused, at court, released). The audit team identified the following control weaknesses in regard to controlled substances:

- The "Controlled Substances Administration Record" is not always adequately updated. The audit team reviewed all Controlled Substances Administration Records completed and returned to the pharmacy for three sample months. We found that it is common practice for medications that are not administered to be returned to inventory without proper notation on the controlled substance record to clarify that the inmate did not receive the medication.

- Dual verification is not always performed as required. During fieldwork, the audit team observed a LVN document dual verification of a shift count even though it did not occur. The LVN informed us that it is her understanding that physically verifying controlled substance information is not required, and that accountability is established with the nurse that performed the count.

- Controlled substances are not always properly destroyed per federal regulation. Several LVNs stated that in some cases controlled substances are flushed down the toilet although tamper resistant boxes are available for disposal. Title 15 requires that controlled substances be disposed of in accordance with Drug Enforcement Administration (DEA) procedures. The DEA requires the transfer of controlled substances to a distributer that is registered with the DEA to destroy drugs. CMS has a contract with a vendor for these purposes.

- There is no established verification schedule to confirm the accuracy of controlled substance records. To ensure controlled substances are properly accounted for, a periodic review of a sample of doses administered according to the Controlled Substances Administration Record should be compared to the inmate's medication record in the CHART system or hard copy record to ensure the inmate was prescribed the medication and there is documentation that the drug was administered. This is especially important because CMS does not have a consistent process for documenting medications administered. Examples include "Stat" doses which are medications determined urgent and are provided in a rush so they are allowed to be documented on medical order forms or nurse progress notes; inmates may have two medical records (medical and mental health records are not combined); or as noted earlier, substances returned to inventory do not always identify the inmate that did not receive the medication. For a one sample month (June

2008) period, the audit team examined 45 inmate doses documented on Controlled Substances Administration Records. For the sample selected, we compared the controlled substance dose, inmate name, booking #, and date administered documented on the Controlled Substances Administration Record, to the substance administered according to the CHART system or hard copy record. Our review found seven instances (a 16% error rate) where records did not properly account for controlled substances due to the following reasons:

- Three doses administered according to the Controlled Substances Administration Record did not agree with the dose prescribed in the CHART system.

- Two doses were recorded in the CHART system as not administered because the inmate was released, although the Controlled Substances Administration Record indicated that the dose was administered to the inmates. We discussed this with CMS and later found that the controlled substances were returned to inventory but there was no notation to identify the inmate that did not receive the medication. Due to the incomplete record keeping, CMS had to review the medication record for all inmates that received the same controlled substance for the medication pass in order to provide sufficient evidence to the audit team that the substances were properly accounted for.

- Two doses were recorded in the CHART system as administered. For one, the Controlled Substances Administration Record identified that the dose was destroyed because the inmate did not receive it. For the other, the record did not indicate the controlled substance was removed from inventory.

- Pharmacists perform monthly spot-checks, as part of a monthly Medication Area Inspection report, to confirm that the drug counts according to the Controlled Substances Administration Record correspond to the actual count of medication on hand. However, there is no specific written policy on the part of CMS/Pharmacy that requires pharmacy staff to complete these counts. As such, there is confusion at

Theo Lacy as to why such inspections are necessary, though they are completed.

These controlled substance findings are important given the jail environment where many of the inmates are either chemically or alcohol addicted. In addition, controlled substance documentation weaknesses increase the possibility that these substances could be misused or stolen, and may result in increased risk to the County.

Recommendations:

14.1: CMS should immediately enforce the regulations and procedures related to controlled substances.

14.2: CMS Pharmacy should provide additional training to nursing staff on the proper procedures to account for and dispose of controlled substances.

14.3: The Pharmacy Director should ensure that a specific formal policy and procedure exists and is enforced to address required spot checks of controlled substance inventories at all dispensary facilities.

14.4: Additional monitoring procedures should be performed by the Senior Nurse responsible for ensuring the substance administration record is properly completed to include a periodic review of the CHART system medication/hard copy distribution record to the Controlled Substances Administration Record. Any differences should be immediately addressed.

Undistributed Medications

Finding 15: There is no validation that undistributed medications are properly returned to Jail Pharmacies to be destroyed.

Many formulary medications (approved stock list of available medications provided by CMS) cannot be distributed because the inmate is at court, transferred to another facility, released from custody, refused the medication, or was discharged. These medications, packaged primarily by the Pharmacy, do not include controlled substances. LVNs maintain the undistributed medications in an unsecured *Return to Pharmacy Box* in the nursing dispensary until the following day when they pick-up medications for the next medication pass and return undistributed medications from prior shifts to the Pharmacy to be destroyed. The Pharmacist does not verify that all medications that were not distributed, according to the CHART system, were returned. The Pharmacy Director informed us that due to the number of undistributed medications and limited system reports available in the CHART system, verification would be impossible with the current staffing levels.

Recommendation 15: A process to ensure that undistributed medications are properly returned to the Pharmacy should be evaluated by CMS Management. That process should include the overnight storage of medications in a secure location with access only by Pharmacy personnel and the medication nurse.

Medication Packaging

Finding 16: The CMS Pharmacies package medication too far in advance resulting in a significant number of medications that must be destroyed.

Pharmacy staff informed the audit team that medications must be processed the previous day for the next day's 5:00AM, 9:00AM, and 1:00PM medication distributions. The 7:00PM medication is packaged at 8:30AM the same day. This is required because the pharmacy closes by 5:00PM and does not open until 7:00AM Theo Lacy processes medication two days in advance for the Monday

medication pass because Pharmacy Technicians, responsible for packaging medications are not on duty Sunday. Due to the magnitude of inmate movement, medication should be packaged closer to the time the medication is distributed. In light of the fact that CMS spends nearly $1 million per year on medications, the audit team estimated that addressing this practice would result in meaningful cost savings.

Recommendation 16: CMS should evaluate the current Pharmacy work schedule with the goal to improve medication packaging timelines that are closer to medication distribution schedules.

Finding 17: Some new medication orders are not included in the inmate's medication package when they are filled by the Pharmacy.

Since formulary medications are often packaged the day before they are distributed, some recent medication orders (new bookings or new medication orders) entered into the CHART system are not included in the inmate's medication package from the pharmacy. As a result, the LVN's package these new formulary medications from nursing station stock. LVNs add supplemental medication orders processed after the medications have already been packaged by opening the pre-packaged medication packet in order to add the formulary medication from nurse station inventory. The audit team's review of manually prepared medication packaging statistics maintained by CMS found that this practice has resulted in the LVN's packaging an average of 2,900 medications per month at the Theo Lacy facility alone. CMS has planned to implement an update query in CHART for some time where new medication orders received after the medications are packaged may be processed through CMS's automated medication packaging system, CIPS (Correctional Institution Pharmacy System) that is interfaced with the CHART system; however this effort has not been

completed. This would dramatically reduce the number of medications hand-packaged by the LVNs.

Recommendation 17: CMS should quickly complete its efforts to create the required update query in the CHART system in order to reduce the number of medications packaged by the LVNs.

Self-Carry Medication Documentation

Finding 18: Random spot checks of Musick jail facility self-carry medications are not always provided weekly to the Pharmacy according to policy.

Pharmacy procedures require a weekly documented spot check of at least ten inmates to monitor inmate compliance with prescribed medication instructions. The audit team's review of the Musick jail facilities "Self Administered Medication Compliance Monitor" records found that for the period January 1, 2008 through October 31, 2008, approximately 28, or 64% of the 44 required weekly documented spot checks were not provided to the Pharmacy. Documented spot checks provide evidence that monitoring of the self-carry medication program occurred as required.

Recommendation 18: The CMS Pharmacy should monitor self-carry medication random spot check records to ensure documentation is provided in compliance with established procedures.

Perpetual Inventory of Non-Controlled Substances

Finding 19: There is no perpetual inventory of formulary medications maintained outside of the Pharmacy.

Some formulary medications are maintained in the Nursing Station to provide to inmates that transfer or otherwise miss the regular distribution cycle processed through CIPS. A manual tracking system was implemented at the women's jail to track each non-controlled medication provided to an inmate. However, this process was never rolled out to other medical locations because the process is labor intensive. CMS informed us that dispensing systems are available to properly track medications but were never purchased due to budget constraints over the last three fiscal years.

Recommendation 19: CMS should evaluate available dispensing systems that may be purchased within current budget constraints.

Administrative Issues

There are a number of significant administrative issues within CMS that require attention. By functional area, they include:

Funding

Finding 20: OCSD currently does not contribute any financial resources to offset the cost of correctional medical services provided by HCA.

As noted in the background section of this report, the cost of providing health care to Orange County Jail inmates has nearly doubled in the last eight fiscal years. HCA continues to fund the entire program out of its General Fund allocation. A sample of other California counties indicates that this arrangement is not uniformly utilized. The audit team noted at least two Southern California counties (San Diego & San Bernardino) where inmate medical services fall under the auspices, both organizationally and financially, of the County Sheriff's Department. In addition to OCSD General Fund revenues, other counties also utilize State Mental Health Realignment Funds and Proposition 172 funds to offset some of the cost of providing inmate medical care where possible. Other counties also help fund some correctional medical costs through the Inmate Welfare Program.

Recommendation 20: OCSD should begin to contribute financial resources to cover at least some of the fiscal burden of providing inmate medical services. Immediate contribution opportunities exist with some much needed capital and infrastructure investments, such as: (1) refurbishing medical observation units at the jails, (2) an electronic medical record system, and (3) building out clinic space at the jails. In addition, the cost of over-the-counter (OTC) medications sold through the commissary, when such a program is implemented, should be funded with Inmate Welfare/Commissary dollars in OCSD.

Contract Administration

CMS has a fixed price contract with CMC to provide physician services at WMC-A, and a separate contract with WMC-A for use of the hospital facility.

Responsibility for Contract Administration

Finding 21: CMS contract administration and program monitoring roles are not clearly defined, resulting in ineffective contract oversight.

HCA/Contract Administration should be responsible for contract solicitation, negotiations, procurement, and for technical contract language interpretation once developed. CMS should be responsible for day-to-day monitoring of contractor performance and ensuring that required medical expense information is provided according to contract terms. During the course of this audit, the audit team found that contract administration duties were not delineated in this fashion, were uncoordinated when they were performed, and in some cases, were not performed at all. For instance, as discussed in subsequent findings related to WMC-A and CMC profit and loss statements, this information is often inaccurate, unverifiable, and not prepared according to the contract. None of these issues had been previously identified or addressed by HCA.

Recommendation 21: HCA/Contract Administration and CMS should delineate the responsibilities for contract administration and contract program monitoring. Once this occurs, CMS should ensure contract monitoring is performed as required.

Update of Inmate Medical Records in CHART System

Finding 22: CMC contract physicians do not input discharge planning orders into the CHART system when an inmate leaves WMC-A.

Inmate patient discharge summary information includes ordered medications and follow-up appointments. Part IV, Section C of CMC's contract states that all physicians or designees shall write legibly in custody patient charts and input discharge planning recommendations in the CHART system. CMC informed us that the former CMS Hospital Liaison RN used to input this information directly into the CHART system for them. This discontinued after CMS changed their computer system as it was no longer compatible with the hospital system.

The inmate discharge summary is provided to Sheriff Transportation deputies when an inmate returns to the jail facility (Intake & Release Center). CMS medical record clerks are then responsible for sorting these documents and distributing them to the appropriate jail facility where the inmate is housed. On many occasions, the discharge summary does not arrive at the appropriate jail facility for several days.

Recommendation 22: CMS should ensure that County and contractor computer systems are compatible to allow for electronic access to the medical records. After this occurs, CMS should require that CMC contract physicians input discharge planning information into the CHART system in order to achieve a fully electronic medical record as required by the contract.

CMC Profit and Loss Statements

CMC is required by contract to provide an Expenditure and Revenue report of the actual cost of custody physician services for the preceding period or portion thereof, no later than sixty days following each period to HCA for informational purposes only. The report is to be prepared in accordance with the procedure that is provided by HCA and in accordance with generally accepted accounting procedures. CMC has prepared a Profit and Loss Statement annually as the method to comply with the contract terms. Our audit of Profit and Loss Statements resulted in the following findings:

Finding 23.1: Profit and Loss Statements are not prepared according to the contract period as required.

The CMC contract clearly identifies each contract period as July 1 through June 30 for the period of five years commencing July 1, 2004. However, since 2004, CMC has provided the statements on a calendar year basis. Per the audit team's

request, CMC provided revised statements according to the required fiscal year basis.

Finding 23.2: CMC over-reported expenses included on Profit and Loss Statements.

Audit team fieldwork included reviewing CMC documentation to support the amounts reported to HCA on the Profit and Loss Statements. The audit team was unable, however, to reconcile CMC's records to amounts reported. As a result of our analysis, CMC agreed that their statements were incorrect and subsequently revised their Profit and Loss Statements for the periods July 2005 through June 2007. Per review of the revised completed fiscal year statements, it appears that expenditures were originally over-reported by approximately $306,099 and $126,329, respectively. CMC stated that differences were the result of physician claims received several months after the end of the service month. This explanation, however, is not reasonable because if claims were missing then preliminary expense totals should be lower not higher. It should be noted that since this is a fixed-fee contract, the over-reporting of expenses has no current financial impact to CMS, but is important information for future contract negotiations.

Finding 23.3: CMC's Revised Profit and Loss Expenditures do not agree with supporting documentation.

CMC allocates "corporate expenses" (indirect overhead expenses) to each contract they are awarded. According to CMC, the allocation is based on the contract award amount as a percentage of all CMC contracts. A spreadsheet is prepared monthly to allocate these overhead expenses to the CMS contract in order to include it on the Profit and Loss Statements. The audit team's review of this practice resulted in the following findings:

1. Since November 2006, CMC has allocated approximately 84% of its corporate expenses to the CMS contract. Based on the audit team's calculation of CMC's contract awards, CMC should have only allocated 74% of its corporate expenses to the CMS contract. For FY 2005/06 and FY 2006/07, these incorrect allocation percentages resulted in an inaccurate overhead allocation to the CMS contract of approximately $9,000 and $45,000, respectively.

2. CMC corporate expenses are recorded onto monthly spreadsheets based on amounts recorded into a Quickbooks accounting system in order to allocate them across CMC's contracts awarded. For a one fiscal year sample period (July 1, 2006 through June 30, 2007) the audit team recalculated monthly corporate expenses included on the monthly spreadsheets and compared them to expense amounts recorded in CMC's Quickbooks accounting system and found that the expenses do not agree. As such, we were unable to confirm the accuracy of corporate expenses allocated to the CMS contract.

Recommendation 23: HCA should require by contract that CMC obtain an independent audit of the Profit and Loss Statement annually to ensure that the statements accurately present CMC's profit.

CMC's Profit Margin

Finding 24: CMC's profit margin from the CMS contract far exceeds industry standards.

The audit team compared CMC's profit margin before taxes to the profit margin reported by the Risk Management Association (RMA) for offices of physicians. RMA compiles financial data primarily from audit reports and tax returns. RMA benchmark data reports average profit before taxes of 9.9% for groups with balance sheet assets of two to ten million dollars (CMC is in this category). The audit team confirmed, however, that CMC receives a 36% profit before taxes

from its contract with CMS. This finding should be placed in context by noting that it has been difficult over the years to find a contractor to provide specialty physician services to inmates. CMC was the only physician's firm to bid during the last solicitation.

Recommendation 24: HCA should (1) request that CMC reduce their rates for the remainder of the current contract term (June 2009), and (2) ensure that future negotiated physician contracts provide appropriate profit margins in accordance with industry standards and are in line with other government entities contracting for correctional medical services.

WMC-A Profit and Loss Statements

Finding 25.1: WMC-A is unable to provide sufficient documentation to explain the expenses reported in the Profit and Loss Statements provided to the County.

On an annual basis, WMC-A is required to provide a profit and loss statement for the previous fiscal year. WMC-A staff indicated that FY 2004/05 was used as a baseline to determine the subsequent years' expenditures, and as such, the audit team sought documentation to support that fiscal year. However, while WMC-A was able to provide a total "Usual and Customary Charges" for that fiscal year, they were not able to sufficiently explain how the information is used to determine the costs reported to the County on the annual profit and loss statement. The audit team worked with WMC-A staff for over a month to secure this documentation, but WMC-A was never able to fully explain or support the cost allocation methodology used in creating the profit and loss statements. WMC-A staff indicated that the cost allocation methodology utilized in the FY 2004/05 timeframe would again be used in the creation of the FY 2007/08 profit

and loss statement. While this information is not used for annual billing (this is a fixed fee contract), the information is vital for subsequent contract negotiations in order to determine appropriate profit margins. Thus, with the WMC-A contract due to expire in June of this year, HCA has no verifiable information on the actual expenses incurred by WMC-A as a result of providing custody hospital services.

Finding 25.2: Profit and Loss Statements are not provided or prepared according to the terms of the contract.

The WMC-A contract requires that a report detailing the "actual cost of Custody Hospital Services" shall be submitted to the County no later than sixty (60) days following the end of the fiscal year (June 30th) and according to generally accepted accounting principles. However, the audit team determined that for FY 2005/06 and FY 2006/07, the reports were provided between six and nine months after the end of the fiscal year. As of the writing of this report, the revenue and expenditure report for the FY 2007/08 time period has still not been submitted to the County (now seven months after the end of the fiscal year). In addition, the audit team determined that for FY 2005/06 and FY 2006/07, the expenses reported by WMC-A were not prepared using generally accepted accounting principles. Instead, an arbitrary inflation factor was applied to the FY 2004/05 Total Expense per Adjusted Patient Day, which, as noted in the previous finding, was itself an estimated number. Lastly, the arbitrary inflation factor was not applied in a uniform fashion in the data reported to the County, and as such the profit and loss statements are not consistently prepared for the two fiscal years, FY 2005/06 and FY 2006/07.

Recommendation 25: HCA needs to hold WMC-A accountable to the terms of the contract regarding the preparation of annual profit and loss statements. In addition, HCA needs to work directly with WMC-A to clarify and verify the actual costs of the Custody Hospital Services that WMC-A provides in order for

both sides to be fully prepared for the upcoming request for proposal (RFP) and potential contract negotiations. Lastly, HCA should require that WMC-A obtain an independent audit of their annually-provided profit and loss statements to ensure that the County has complete and accurate information.

WMC-A Hospital and CMC Physician Expense Databases

Finding 26: The physician and hospital custody database maintained by CMC is incomplete, inaccurate and largely unutilized by CMS for contract monitoring and program management purposes.

HCA compensates CMC approximately $100,000 per year to input information into a County database that tracks services rendered by physicians to inmates as part of the contract between CMC and the County. This database was created by HCA/IT and loaded on a computer at CMC's office, then CMC staff were trained on how to import the data from their existing internal billing system to the County's database. All the pertinent data tracked in this database is already input by CMC clerical staff into their own claims and billing system in order to pay their physicians for services rendered. Thus, HCA unnecessarily compensates CMC for a process that they already perform in the course of running their business. WMC-A also compensates CMC $60,000 in order to manually input the hospital's claim forms into the County's custody database.

All of the physician and hospital data is aggregated by CMC and sent on a CD to HCA/Contract Administration on a monthly basis, where the data is imported into the historical database maintained by HCA. The purpose of maintaining this database is to provide HCA, and specifically CMS, with a tool for (1) monitoring physician and hospital services rendered per the contract, (2) identifying trends in care, and (3) negotiating subsequent contracts with accurate utilization data. Because the contracts with both the physician's group (CMC) and the hospital (WMC-A) are fixed fee contracts, the utilization database does

not impact current charges or billing, however, as indicated above, its contents can be useful in a variety of ways.

The audit team interviewed County/contract staff and reviewed the custody database; the following issues were identified:

- The FY 2007/08 data set was incomplete. The audit team requested the Custody database information for the complete FY 2007/08, however the data received from HCA/Contract Administration was missing several months of data, which is not in compliance with contract terms. This data was later appended to include the missing months after HCA/Contract Administration notified CMC of the audit team's finding.

- The database contains multiple entries for the same services rendered to the same inmate on the same day. CMC staff indicated that at one point during FY 2006/07, there had been some problems with the importation of data and that a member of HCA/IT had come to fix the problem. However, the audit team determined that duplicate entries continued to show up in the FY 2007/08 data. The audit team identified approximately $105,000 of duplicate physician charges and $34,000 of duplicate hospital charges in FY 2006/07, and $36,000 of duplicate physician charges and $200,000 of duplicate hospital charges in FY 2007/08.

- The database is often missing charge data for physicians that subcontract with CMC on a fixed-fee basis. In short, if the physician is compensated by CMC on a fixed fee basis, his or her billing information is not always incorporated in the custody database because no payment claim form is submitted to CMC for processing. Instead, CMC requests, but does not require, that these fixed-fee physicians provide a claim form as if they were billing, with the understanding that the form will only be used for informational purposes. As a result, physicians often choose not to provide this information in a timely manner, if at all.

- CMS management does not monitor or utilize the custody database for any sort of operational or strategic purposes.

- Prior to this audit, the data in the custody database maintained by CMC had never been audited for accuracy by an independent party or by the County.

Recommendations:

26.1: CMS and HCA/Contract Administration need to articulate the goal for maintaining the custody database and who is responsible within HCA to ensure that goal is achieved. Both parties need to work together to determine how this data, and any additional data that can be captured, will be utilized to improve CMS from a programmatic and operational standpoint.

26.2: HCA needs to renegotiate with CMC to eliminate the $100,000 charge for inputting data that is already necessary for CMC to conduct its own internal billing and claims processing. This information should be provided to the County for minimal or no charge as part of normal contract monitoring. CMC should be able to provide a data file to the County on a monthly basis with all relevant information.

26.3: HCA/Contract Administration should work directly with WMC-A to import their charge data directly into a database that is maintained in-house by HCA/Contract Administration or by CMS program management.

26.4: HCA/Contract Administration or CMS program management needs to conduct some degree of periodic auditing of this data to ensure accuracy and completeness. Based on the audit team's experience, this objective can be achieved with minimal time and resources on the part of HCA.

Increase in Inmate Clinic/Hospital Visits

Finding 27: **CMS management is unable to definitively explain the reason that there is a sustained increase in the daily census of inpatient inmates at WMC-A, that began in late 2007.**

HCA, WMC-A, and OCSD Transportation statistics confirm that the average daily census at the WMC-A custody unit often exceeded the unit's capacity during 2008, forcing inpatient inmates to be housed in other non-secure parts of the hospital. In these situations, at least one Deputy Sheriff from Theo Lacy must sit with each inmate on a one-on-one basis, twenty-four hours per day. Such a situation leads to significant amounts of overtime for OCSD, and strains the existing contractual arrangement with WMC-A as this sustained impact on the hospital was not envisioned during negotiations.

There were two theories provided by CMS staff for the increased inpatient inmate population: (1) the recent implementation of the "R3" classification (i.e. an inmate charged as a sex offender), which requires that such inmates be segregated from general population inmates, including at the hospital, and (2) the reluctance of CMS staff, nurses and managers, to accept patients returning from the hospital who may need some degree of "skilled nursing" attention in an observation unit. Such a patient would typically be allowed to return home and receive in-home care from a family member or friend if they were not in jail. CMS staff's reluctance typically stems from either a discomfort with providing a somewhat higher degree of personal care or from a belief that the observation units available are not clean, safe or modern enough to accommodate this "skilled level" of nurse care. Despite these hypotheses, no one from CMS was able to definitively identify the causes of the significant increase in inpatient population, which has had significant impacts on both OCSD and WMC-A. HCA/Contract Administration staff informed the audit team that they are in discussions with WMC-A to build out a section of the hospital directly adjacent to the custody unit where eleven more inmate beds can be placed to handle this increased capacity.

Recommendation 27: CMS management needs to specifically determine whether this increase in the inpatient hospital inmate population is a permanent shift, or one that can be mitigated through operational changes on the part of both CMS and OCSD. If in fact some of the inmate inpatients at WMC-A can be moved back to the jail by making some improvements to the observation units at the jail, and boosting training and initiative on the part of nursing staff, then

HCA and the County may be able to lower the inpatient hospital inmate population to a level that can be accommodated in the existing unit, thereby avoiding an expensive build-out of additional custody space. If, however, HCA and OCSD determine that there are no internal measures to address the increased inpatient population, then both HCA and OCSD should commit financial resources for the build-out of the custodial facility at WMC-A, should the current contract be extended past June 2009. Not only does the responsibility for care ultimately fall to the Sheriff's Department, but OCSD also stands to achieve significant cost savings if they do not have to commit overtime resources to one-on-one guarding of each inmate patient that is out in the general population of the hospital.

Hospital/Clinic Scheduling of Inmates for Medical Care

Finding 28: The inpatient/outpatient scheduling process requires improvement.

A CMS Scheduling Clerk is responsible for coordinating these outpatient/inpatient services with WMC-A. The Clerk reports organizationally to the CMS Program Manager (Administration). The audit team reviewed this scheduling process and found that process improvements are required to ensure that all inpatient hospital and outpatient clinic visits are properly authorized by the CMS physician and all inmates receive timely specialty care in line with community practice. Failure to provide required specialty care, depending on the circumstances, may result in a significant liability to the County. Examples of scheduling problems include:

- The CMS process for tracking inmate Treatment Authorization Request (TAR) forms is ineffective. As a result, CMS is unable to determine whether inmates that require outpatient/inpatient specialty care received those services in a timely manner. A pre-numbered TAR form is required

to be completed by a CMS physician before an inmate may receive specialty care at the hospital or clinic. The CMS Assistant Medical Officer is primarily authorizing the TAR and assigning a priority number. The priority number (Priority 1 is High Priority and 3 is Low Priority) identifies the urgency of the appointment. Priority numbers came about as the result of the large number of inmates requiring outpatient/inpatient services. An Appointment Log was originally created in Excel to track TAR requests. However, despite this logging process, there is no verification of whether the inmate was actually seen or if the appointment should be canceled because it is no longer necessary due to inmate release or other circumstances. The audit team reviewed the log and found that it was no longer being used due to the volume of activity, and because the log was not properly updated to track who was or was not seen by a physician. We also found that TAR forms are not properly filed within the hard copy medical record chart.

- The WMC-A TAR logs are also not always updated. The TAR forms are provided to a clerk at the hospital for the actual formal scheduling of inmates for appointments. The hospital clerk receives the TAR and date stamps the photo copy and enters the TAR onto an Excel spreadsheet. The spreadsheet is updated once the inmate is actually seen at the hospital. The audit team, however, observed that the spreadsheet is not always updated per this procedure. A sample of TAR requests included on the spreadsheet showed no notation was made that the inmate was seen. The audit team requested and the clerk was able to provide evidence that the inmate was actually seen at the hospital, although the log was not updated. Since the log is not properly updated, WMC-A was unable to generate a list of all outstanding TAR requests, creating confusion and increasing the difficulty of auditing this process.

- The appointment scheduling and monitoring process is ineffective. One problem, as noted above, is that CMS and the hospital clerk maintain two separate TAR logs, which are not properly updated. In other cases, TAR forms are not prepared by CMS when inmates require follow-up appointments recommended by CMC Physicians. In these cases, the hospital clerk uses a variety of methods to schedule inmates: maintaining the hard copy medical record as a tickler file if a TAR was not provided for a follow-up appointment, reviewing current and prior month TAR Excel logs, and adding inmates to the appointment schedule upon urgent

requests by CMS. In addition, the current scheduling process is inefficient as it relies on the hospital clerk's working knowledge of the schedule, and CMS has no mechanism to monitor the status of scheduling requests. These scheduling problems have escalated in the previous year due to changes in inmate classification categories (e.g., "R3" sexual offenders) requiring segregation, the significant increase in the number of inmates requiring specialty services, and the number of required rescheduled appointments due to the increased backlog. As a result of these issues, at the time of our audit, approximately 30-40% of inmates scheduled daily for clinic/hospital visits do not make their appointments. In other instances, inmates were rescheduled multiple times over several months or were never seen. Such situations have the potential to result in significant liability to the County.

- The CHART system has a scheduling feature; however, it is not utilized. CMS informed us that they plan to implement the CHART scheduling function and to prepare an electronic TAR request form with electronic prioritizing and approval. This will require customization of the CHART system and coordination with WMC-A.

- The CMS Scheduling Clerk does not report organizationally to a CMS physician, but rather to the CMS Program Manager (Administration). Inmate continuity of care is the primary responsibility of the CMS Medical Director and physicians. The scheduling clerk job responsibilities require ongoing coordination with the CMS physicians on a regular basis and have increased significantly since the CMS hospital liaison position was eliminated.

Recommendations:

28.1: CMS should complete its efforts to fully interface the outpatient/inpatient approval/scheduling process in the CHART system to include electronically created sequentially numbered TARs with online priority/approval function, outpatient scheduling, and reporting queries that provide CMS Management information to monitor the process.

28.2: CMS should change its organizational structure to have the CMS Scheduling Clerk report to the Assistant Medical Director with technical support from program administrative services.

28.3: CMS should work with OCSD to find solutions that will ensure that inmates are transported to scheduled clinic/hospital appointments.

Information Technology

CHART Electronic Medical Record System

Finding 29: The CHART electronic medical record information system is not fully utilized resulting in significant system-wide inefficiencies.

CHART was implemented in 1992 with the assistance of Insight Enterprises. Management of health records and ensuring the record is available to health professionals enhances continuity of care, facilitates early and correct diagnosis based on review of prior symptoms and findings, and permits coordination of treatment by multiple clinicians. IMQ Health Care Accreditation Standards require that health records maintained be legible, individual, completed, and stored in a "secure area readily accessible to health care providers, but inaccessible to custody staff or inmates." Inaccurate or missing records can create significant risks for CMS as important medical information must be available when needed for current treatment options and administration of further medical services. Use of electronic medical records provides increased operating efficiency, as well as better medical service for inmates.

The current CHART system capabilities are not being fully utilized resulting in CMS maintaining both a partial electronic medical record and a hard copy medical chart. The decision to continue to partially utilize CHART has resulted in CMS unnecessarily having 23 clerical staff (Office Assistants and Office Technicians) that manually prepare schedules, locate/pull hard copy charts, and send medical record documentation to other jail facilities. Based on the

interviews with medical records staff, a review of the "Duties Overview" prepared by medical records staff, and process observation, the audit team determined that these manual processes comprise the bulk of tasks completed by medical records staff on a daily basis.

The audit team reviewed the CHART system capabilities and found that a majority of the tasks performed by clerical staff can be eliminated with the scheduling component of the CHART system, and fully utilizing the system to document inmate medical visits for such things as: problem lists, diagnosis and treatments, RN progress notes, and hospital discharge summaries as well as vital signs, diabetic readings and lab results. All staff interviewed stated that hard copy charts go missing on many occasions and in some cases cannot be located at all. A fully electronic medical record would significantly improve the services provided and allow for full automation and timely accessibility of statistics required by Title 15. To implement the fully electronic medical record would require minimal integration of paper forms with the existing system, such as inmate medical message slips and inmate consent and refusal forms. CMS informed us that they plan to replace the CHART system with the purchase of a new electronic medical record system. However, even if CMS were to start today, a new system would not be functional for at least two years. In the short term, CMS has not expressed a commitment to fully utilize the CHART system until a new medical record system is available. A commitment to more fully utilize the CHART system may potentially save CMS between $500,000 and $750,000 each fiscal year as an estimated 10-15 clerical positions attending to hard copy charts could be deleted once the significant manual process burden is eliminated.

Recommendation 29: CMS should move forward immediately to purchase a new fully automated medical records information system. In the interim, CMS should more fully utilize the CHART system and establish a cross-over timeline for moving hard copy components to the electronic medical record in CHART until a new medical record system is available. A formal on-going training program is required regardless of which electronic medical record system is in place. An analysis of hard copy medical records currently used should be performed to determine if any system customization is required to achieve this

goal. In the near term, CMS should delete 2-3 medical records positions, and in the long run aim to eliminate 10-15 positions.

Finding 30: The CHART system is written in an outdated programming language and its future system maintenance and support is limited.

CHART was developed from the COSTAR system and is written in the ANSI Standard MUMPS (Massachusetts General Hospital Utility Multi-Programming System) programming language created in the late 1960s for use in the healthcare industry. COSTAR was customized to meet the special requirements of CMS. HCA/IT informed the audit team that the programming language is outdated and as a result system support is difficult to find. Recent efforts to recruit a MUMPS System Analyst were unsuccessful because there are very few qualified applicants and the one selected was unable to pass the Sheriff's background clearance.

Insight Enterprises currently supports the CHART system through an annual support agreement costing approximately $47,000 per year. However, Insight Enterprises has stated that system maintenance and support will only be provided for the next few years.

HCA has planned for some time to develop a request for proposal (RFP) in order to purchase a new system to replace CHART. The first stage, in progress, is the hiring of an IT consultant to assist in specifying the business requirements of a new system to be included in the RFP. The consultant services are scheduled to be completed by November 2009, however, HCA has stated that the current budget situation may delay the project.

Recommendation 30: HCA should continue its efforts to purchase a new system to replace CHART, especially in light of the short term support available in the

near future, the cost savings to be realized from a reduction in the manual recording keeping process, and to mitigate potential high-risk operating deficiencies created by maintaining a semi-manual medical record keeping system.

Finding 31: CMS does not coordinate with HCA/IT or follow change management best practices when modifying the CHART system application.

The audit team reviewed CMS's process for prioritizing and approving CHART system changes, documentation maintenance, deploying changes, and testing change programs. Our review found that CMS neither effectively utilizes the services of HCA/IT nor does it have adequate controls over the modification of the CHART system in place to ensure program modifications are properly authorized, tested and approved. System control weaknesses identified are noted below:

1. CMS does not have a formal process for prioritizing and authorizing system change requests. A list of planned system changes/rollout of existing system functions is maintained electronically in a Word document by the CMS CHART system Supervisor. The list has approximately 21 priority system changes including rollout of existing CHART system functions that are not currently utilized. Two items on the list, patient scheduling and electronic approval of treatment request authorizations (identified as number 1 and 4 on the priority list) are planned for implementation in early 2009. However, there is no documented approval of these planned system changes by the Institutional Health Services Division Manager. And, more importantly, the majority of CMS staff who would be using the system had no idea that system changes were being contemplated.

2. A formal process for CHART end-users to convey system change requests to management, such as a standard change request form, is not used. User requests should include, at a minimum, the requestor's name, date of the request, priority of the request, and thorough description of the change and expected benefits of the change. User requests should include review

and authorization by management. CMS management indicated that they are developing a CHART Project Request Form based on HCA/IT's Request Form in order to prioritize and approve requests and maintain a list of the approved CHART projects. CMS plans to implement the Request Form in early 2009. During fieldwork, the audit team observed inefficient processes that could be remedied if end-users had a process to request changes to the CHART system.

3. Documentation of detailed test plans for each system modification is not prepared. System testing is performed only by the CHART system Supervisor and Insight Enterprises (vendor/programmer). To be effective, tests should be conducted in advance of any proposed roll-out and in an environment that simulates the conditions that are likely to be encountered when the modification is implemented. Individuals from all affected business areas should be represented in testing from developing test cases to reviewing and approving test results. Test plans should be developed for all levels of testing that define responsibilities of each party (e.g. end-users, programmers, system analysts, quality assurance) and approved and signed off by appropriate management. Interviews with CMS end-users found that staff is not usually aware of the planned system changes although the changes will significantly affect the workflow of physician and nursing functions, outpatient scheduling, and medical record's staff responsibilities.

4. The Insight Enterprises vendor/programmer is responsible for migrating CHART changes into production. This is inconsistent with IT best practices, as programmers should not have write, modify or delete access to production data.

5. HCA/IT is not involved in the CHART change management process. HCA/IT utilizes a formal change management process when implementing changes to other HCA applications, however, these practices are not utilized to support changes to CMS's CHART system. Having all agency IT applications reviewed by HCA/IT ensures agency-wide consistency and compatibility, and brings greater resources to bear. Some of the risks to CMS of not having HCA/IT involved in this process include unauthorized modifications negatively affecting the CHART system, or new systems not properly implemented, thus preventing CMS from having medical information available to staff in a timely manner.

The HCA/IT Support/Software Development manager informed us that they would like to include the CHART system in the HCA/IT change management process and to seek approval for CHART changes from the HCA Change Advisory Board (CAB) prior to moving them into production. HCA/IT will work with CMS and the Insight vendor to prepare the Request for Change and present it to the CAB. This will ensure that best practices are followed.

Recommendation 31: CMS should work with HCA/IT to implement ongoing adequate change management procedures in accordance with best practices.

Finding 32: Sheriff AJS (Adult Justice System) inmate demographic information is not uploaded often enough into the CHART system.

OCSD utilizes the AJS system to perform a variety of inmate record keeping functions. The CMS CHART application interfaces with the Sheriff's AJS for inmate demographic information only. A batch routine is received by the CHART system every four hours, which updates information such as where the inmate is physically located (e.g., what jail facility, in court, etc.). New bookings are interfaced real time in CHART. Having real time inmate demographic information is important since the information included in the CHART system is transferred to the Pharmacy CIPS (Correctional Pharmacy Software) system for medication packaging. Due to the regular movement of inmates between jail facilities and courts, or being released from custody, the four-hour batch update of the CHART system from AJS is not sufficient and results in a large amount of medications being destroyed as inmates are not present at their last known location to receive their packaged medication. Additionally, this information will be required to effectively utilize the CHART scheduling features as planned by CMS for inmate sick call and outpatient clinics. Discussion with OCSD found

that the batch routine can occur as often as CMS needs, and just requires coordination between the two IT groups.

Recommendation 32: CMS Management should work with HCA/IT and OCSD/IT to receive more frequent updates of AJS information in the CHART system.

Risk Management

Finding 33: A total of $1.2 million has been spent either settling or defending CMS lawsuits over the last five fiscal years.

The audit team reviewed inmate claims/lawsuits specifically related to medical care over a five year period from July 1, 2003 through June 30, 2008. During that period, there were a total of 55 inmate lawsuit claims filed against CMS for a variety of reasons, all pertaining to the medical care received while in custody. Of these 55 claims, 18 resulted in either settlements and/or the incursion of outside legal expenses in defending the suit (six of the 18 were settled for a total of $513,500, and 17 of the 18 required the expenditure of funds for outside legal counsel, totaling $748,870); and 37 resulted in no legal or settlement costs to the County. Thus a total of approximately $1.2 million has been spent either settling or defending CMS lawsuits over the last five fiscal years.

Though the elimination of litigation risk is not possible, this data emphasizes the importance of tightening processes and procedures within CMS in order to provide the County with as much risk protection as possible. For clarification, the claims mentioned above do not include those filed by inmates against OCSD that also have components pertaining to the medical care received while in custody. CEO/Risk Management is not equipped to electronically search claims at that level of detail.

Recommendation 33: With the implementation of recommendations included in this report, CMS should realize greater risk avoidance and liability protection.

Human Resource Issues

Finding 34: Recruiting medical professionals has been challenging for CMS.

Over the past decade, the recruitment of quality applicants for physician, pharmacy, and nursing positions has been a nation-wide challenge, especially in a correctional environment. In addition, the time required to perform security background checks by OCSD has further complicated recruiting efforts. This issue has been discussed with both HCA and OCSD.

Recommendation 34: CMS should address this background issue with OCSD at their periodic meetings to determine if OCSD could customize its background check to expedite the hiring process. If this cannot be done, and if finances permit, CMS should consider partially funding an OCSD background position whose first priority would be to perform CMS-related background checks.

Purchasing/Supplies

Inventory Tracking System

Finding 35: CMS has not implemented a medical supply inventory tracking system.

Previous Grand Jury and consultant reports found that the medical supply storage rooms at the Central Jail Complex were disorganized and poorly

controlled. This audit confirms that these conditions still exist. CMS supply room staff does not have an accurate count of supplies on hand and supply replenishment is performed by visually checking the shelves. HCA/IT performed an analysis of four different inventory tracking systems and provided CMS an inventory system recommendation in a report dated August 2008. The recommendation, to utilize an existing supply vendor, would not require any additional scanning software or training costs to CMS. The proposal provides for minimal hardware fees. CMS is working with HCA/IT to finalize the agreement and to determine an implementation date.

Recommendation 35: CMS should complete the inventory tracking project as soon as possible.

Storeroom Staff Reporting Structure

Finding 36: CMS Storeroom/Supply staff report organizationally to the CMS Program Manager.

Supply rooms house all the items and equipment which directly support CMS nursing functions and require on-going communication with nursing staff. Having this function staffed and supervised by non-line and non-medical staff adds an unnecessary layer of coordination and approval, causing delays in acquiring supplies and in the motivation to make changes in a timely manner.

Recommendation 36: CMS should assign the supply room function to report organizationally to the Director of Nursing. Any ancillary purchasing support needed can be provided by the CMS/Administration function recommended earlier in this report.

CMS Statistical Data

Finding 37: Statistical summaries of medical services delivered by CMS to inmates are not accurate and are compiled by the inappropriate organizational unit.

Statistical summary information of medical services delivered to inmates are not accurately prepared by health care staff and are entered into an Excel spreadsheet by the Storeroom Supervisor. This information is required by Title 15 and provides the facility/system administrator (i.e., OCSD) with a basis of accountability, and ideally should be used by CMS to enhance performance and monitor productivity. The primary reasons for inaccurate information are that staff manually track processes performed from memory, and/or errors occur in transcribing statistics manually to the required hard copy form. This information is provided to the Storeroom Supervisor who has no basis for verifying the statistics being collected; is in handwritten, hard copy forms on a daily basis; and is manually entered into an Excel spreadsheet on the storeroom computer.

Recommendation 37: In the short term, CMS should establish procedures to ensure that statistical summary data is accurately compiled by staff and assign the responsibility to compile statistics to CMS Administration. Once CMS has implemented a fully electronic medical record, statistical data should be generated from the CHART system automatically.

Sheriff—HCA Coordination

In order for quality inmate health care to be provided, it requires a cooperative effort between both OCSD and CMS management and line staff. This

relationship was non-productive between prior management staffs in terms of addressing challenges and implementing innovations that would result in the more efficient and effective provision of inmate health care services. Examples include:

Outpatient Clinics

Finding 38: The transportation of inmates from jail facilities to the clinic/hospital is expensive, taxes limited deputy resources, has security-related concerns, and often does not result in all scheduled inmates getting to hospital or clinic appointments.

OCSD is responsible for the physical transport and guarding of inmates outside the jail facilities for medical care, and its corresponding cost in the following circumstances:

- For short-term (a few hours) outpatient care at the clinic
- For long-term inpatient care in the hospital (overnight or longer)
- For emergency transport of inmates with life-threatening conditions

To provide an indication of the quantity of inmates being transported outside jail facilities for medical care, the following statistics were provided by OCSD and the Santa Ana Fire Department/Paramedics.

Reason for Transport	2008 Total	2008 Daily Average	2007 Total	2007 Daily Average
Scheduled Hospital visits (only weekdays)	2,436	9.4	1,761	6.8
Emergency transport: OCSD	468	1.3	686	1.9
Emergency transport: Paramedic	N/A	N/A	129	0.4

As previously mentioned, outpatient clinic and some inpatient hospital visits are pre-scheduled, and inmates often miss outpatient clinics and occasionally miss scheduled inpatient visits. Reasons include a lack of available deputies to transport, the time of transport conflicting with other Sheriff responsibilities (inmate Court transport), and the security classification of individual inmates. Depending upon the nature of the illness/injury of the inmate, and the time it takes to reschedule the inmate, this situation increases County exposure to litigation risk.

OCSD/Transportation allocates three full time Deputy II positions Monday through Friday for the daily transport of inmates to the clinic/hospital. On a yearly basis, the straight line salary and benefit projection of three Deputy II officers in the Transportation Bureau is $414,765. This figure does not include the various transport costs (vehicle, maintenance, gas, insurance, etc), the additional cost of emergency transportation visits outside of the Monday through Friday day time runs to the hospital, or any necessary overtime costs. Any reduction in the need to transport inmates could result in General Fund savings for OCSD or the ability to use staff resources for other purposes.

In addition, each transport of an inmate outside the jail system increases security risks to the community, to the deputies, and to medical staff. To the extent that this transport can be curtailed would lessen this risk.

To address this issue, clinic(s) could be established within the jail system, saving the County money, reducing security risks, and eliminating the persistent problem and potential litigation risk of the non-transport of inmates to medical care. To clarify, this recommendation is only related to daily outpatient clinic visits where inmates see medical specialists and on the same day are returned to the jail system. It does not pertain to inmates who require inpatient hospital care.

This idea has been discussed periodically over the years between HCA and OCSD with no progress being made. Common reasons given for not moving forward with this innovation include: finding sufficient space within the jail system for the clinic, ensuring that contract physician specialists would work inside the jail system, and the ability of the jail system to meet any required state

standards for the establishment of a clinic. As evidenced by other sheriff departments statewide who do provide clinics within their jail system, each of the above concerns may be mitigated. For example:

Identifying Sufficient Space

Space has been a constant concern of OCSD jail operations, particularly in the Central Jail Complex. However, both Theo Lacy and the Musick jail facilities have adequate space that could be used or developed for use for clinics as the space required for a clinic is minimal (one room). Theo Lacy has space adjacent to Mod O that was set aside over a year ago for in-house dialysis services. However, to date this space has not been utilized for dialysis or other purposes. In addition, most modules at Theo Lacy have a medical office set aside for sick-call and other treatments. Though staff utilizes this space at certain times of the day for these purposes, the space is also often vacant. Since inmates are already transported daily between jail facilities, inmates scheduled for medical clinic visits could easily be incorporated into these runs.

Availability of Physician Specialists Willing to Work Inside the Jail

An expressed issue over the years has been the ability to find qualified multi-specialty groups/individuals who are willing to provide medical care to inmates. The last solicitation only yielded one vendor, the current contractor (CMC), who is now in the last year of a five year contract that will expire in June 2009. The current contract allows the County to require that the physician group provide these services inside jail facilities. Given that the contract is currently in its last year, and the current economic climate is distressed, this year's solicitation for physician services may attract additional proposers, and again should require that any physician group chosen should agree to provide clinic services within jail facilities if necessary.

As stated earlier, other Sheriff agencies provide clinic services within their jail facilities. Clinic services are akin to basic office visits made by the public to specialty doctors for diagnoses and minor treatment and prescription medication. In addition, the Theo Lacy facility has the necessary equipment to conduct in-house dialysis, a service which is currently provided by a separate contract outside the jail facility.

CCR Title 14 and 25 Guidelines provide a decision-tree analysis of what a law enforcement agency with a jail facility must take into consideration when determining whether or not to establish an on-site clinic. Given that there are considerable benefits to be gained from establishing a jail clinic (e.g., transportation cost savings, staffing cost savings, elimination of off-site clinic security issues, elimination of inmate scheduling issues, mitigation against litigation risk from non-transport of inmates for medical care), an in-depth analysis of this issue should be undertaken.

Recommendation 38: OCSD and HCA should begin an in-depth analysis of how to implement outpatient clinic(s) in its jail facility(ies).

Finding 39: The clinic schedule often conflicts with OCSD/Transportation's court runs.

The current early-morning timing of several outpatient clinics conflicts with the morning court runs for OCSD/Transportation. Clinics typically begin between 7:30-8:30 a.m., the same time court runs are being made. However, later in the morning when the morning court runs are complete, more deputies are available to help with clinic transportation needs.

Recommendation 39: CMS should work with CMC contract physicians to reschedule clinic times to accommodate OCSD/Transportation and maximize transportation resources.

Jail Physical Plant

IRC Triage

Finding 40: The IRC medical screening area is not adequately designed to ensure privacy of medical information.

This issue was discussed in previous consultant reports provided to CMS and OCSD. Each arrestee is required to answer a series of questions from CMS health staff relating to their health history prior to beginning the OCSD booking process. Questions are answered through a speaking device since the area is secured by glass, which magnifies the arrestee's responses and may be heard by anyone within the IRC triage area. This situation is not in compliance with best practices regarding the confidentiality of personal health information and can discourage inmates from sharing important medical information.

Recommendation 40: CMS should work with OCSD to make the necessary adjustments to comply with best practices.

Men's Jail Observation Unit

Finding 41: Facility improvements are needed in the Men's Jail Observation Unit to provide a higher quality of care for inmates who need skilled nursing care.

The Men's Jail has approximately 20 beds in an enclosed area for the purpose of providing infirmary care to inmates with an illness or diagnosis that requires 24-hour monitoring or assistance with skilled nursing intervention, or their conditions prevent them from returning to the normal population. Improvements to the physical condition of the Observation Unit are needed, including improvements in bed conditions and cleanliness of the facility. These improvements will not only enhance the quality of care to convalescing inmates but also make the Unit better equipped to receive inmates from the hospital sooner, thus saving costs.

Recommendation 41: OCSD should upgrade the condition of the Men's Jail Observation Unit.

Women's Jail

Finding 42: The physical layout of the area in the Women's Jail designated as the Observation Unit does not allow for adequate line-of-sight viewing of the inmates.

This confinement area is square-shaped with individual cells around its perimeter which have locked doors with small observation windows at eye level. The nursing station is in the middle of the square. In this set-up, nursing staff

are unable to observe the inmate's condition and must physically walk to each cell at regular intervals.

Recommendation 42: OCSD should investigate placing cameras in each cell that could be viewed at the nursing station.

Theo Lacy Jail

Finding 43: Frequent maintenance problems with the lone elevator to Mod-O and the Theo Lacy Pharmacy are a cause for concern with CMS staff.

CMS staff indicated, and OCSD confirmed, that there is only one elevator that can be utilized to get to both Mod-O and the Theo Lacy Pharmacy. According to staff, this elevator is frequently broken, causing a variety of problems as the only other ingress/egress is the stairway. Such problems included the movement of sick inmates in Mod-O to other parts of the facility or to outside medical facilities, or the movement of large pharmacy packages being shipped to outside County facilities, primarily juvenile detention centers. Pharmacy staff also indicated that although their current location, which is inside of Mod-O, is convenient for the medications distributed in Mod-O, these medications represent only 20% or less of the total medications they package and distribute to medical staff. Approximately 30% of all medications are given to the Theo Lacy Dispensary and then passed out by LVNs, and roughly 50% are packaged and sent out to juvenile facilities. The somewhat remote location of the current pharmacy on the 2nd floor of the facility is less convenient and efficient for meeting the majority of their customer needs.

Recommendation 43: OCSD staff needs to ensure that the elevator to Mod-O and the Theo Lacy Pharmacy is functioning at all times. In addition, CMS and

OCSD should consider relocating the Theo Lacy Pharmacy to a more central location, such as at the current Theo Lacy Dispensary. Such a move would give pharmacy staff easier access to vehicles picking up and dropping off medications, and would also give doctors, LVNs and RNs easier access to pharmacy staff for the last-minute procurement and packaging of medications.

Musick Jail

Finding 44: There is not a sustained security presence in the medical area.

As has been documented in the recent Crout & Sida Jail Assessment Study, the James Musick jail facility in Irvine is reaching the end of its useful life in its present condition. This includes the medical facility, a double-wide trailer which is deteriorating and is exposed to some outside environmental conditions.

In addition, the audit team identified a safety concern that needs to be addressed within the medical trailer. There were instances where no deputy was present inside the locked medical trailer to provide security to medical staff administering inmate care. In addition, when a deputy is present, he/she is usually watching the inmates in the sick call waiting area. This area, due to the facility layout, does not allow visual access into the inmate treatment area where medical staff is providing inmate care. There are "panic buttons" within the medical trailer which will quickly summon deputy assistance, but it is not sufficient to ensure staff safety.

Recommendation 44: Ensure that a deputy is present at all times during inmate sick call at the James Musick Facility.

Charging Inmates Modest Fees

Finding 45: OCSD currently does not charge modest fees to inmates for some medical services provided as is common with other law enforcement agencies.

Two specific examples of fees that could be charged include:

1. Fee for Service for Sick Call

   This practice institutes a minor fee (e.g. $3) charged to inmates for inmate-initiated sick call. Any time an inmate requests to see medical staff, they fill out a "pink slip" and place it in a secure depository which is viewed every day by the nursing staff. The inmate is then scheduled to be seen by medical staff within 24 hours. Interviews with both medical and OCSD staff confirm that not all inmates requesting sick call are indeed ill.

   Instituting a minor fee for sick call has been a practice that has been implemented with success in several other counties. The fee is affordable to the majority of inmates who carry a monetary balance inside the jail for the purchase of personal and other commissary items, and cuts down on the instances of marginal sick call requests. This proactively reduces workload in this area, freeing nurses up for other duties. In addition, it provides a nominal revenue source for OCSD for use in other inmate areas. Of course, to comply with State regulations, if an inmate does not have the ability to pay, the service will be provided at no cost.

2. Selling of Over-the-Counter (OTC) Medication via the Commissary

   A considerable amount of medical staff time is spent in dispensing of common OTC medications to inmates such as: Tylenol, Advil, foot and skin crèmes, powders, etc. in nurse sick call. If these OTC medications could be provided via the Commissary, CMS would reduce workload for medical staff and also, by charging a fee for service, OCSD would also collect a nominal fee. This practice is also being done at many other law

enforcement jurisdictions. In fact, CMS conducted a pilot project to have LVNs distribute OTC meds in order to reduce unnecessary RN sick call. However, the project was stopped when it was determined that LVNs are not legally allowed to pass out OTC medications.

Recommendation 45: OCSD and CMS should work together to determine the feasibility of charging inmates for sick call and/or the selling of OTC medications through the Sheriff Commissary.

Benchmarking Results

Benchmarking of medical services and practices provided to inmates was done with other California sheriff agencies of comparable size. The chart below details the results of this research:

Variable	Orange	Contra Costa	San Bernardino	Riverside	San Diego
Department	Health Care Agency	Health Services Department	Sheriff's Department	Riverside County Regional Medical Center	Sheriff's Department
Average Adult Population	6,200 Adults	1,534 Adult, 266 Juveniles	5,500-6,000	3,600 - Adult, 500 Juvenile	5,000 Adults
Who Funds?	General Fund	County Health Services Agency (General Fund), with some juvenile funding from Juvenile Services, and Inmate Welfare for OTC medications	General Fund & Inmate Welfare Fund	General Fund	General Fund, Realignment Revenue, some other minor sources
Total Annual Budget	Approx. $36 million	Approx. $17.3 million	$17 million	$17.5 million	$51 million
Total Staff	Approx. 190 (Not including Dental or Mental Health Staff)	52.8-Adult, 11-Juvenile, 63.8-Total (not including Dental or Mental Health Staff)	126 FTE (not including administrative staff), 30 per diem	98 (Not including mental or dental staff)	278 (includes Dental and Mental Health Staff)
# of RNs	54	21.2 + Approx $1 million in extra-help, per diem nurses- Adult, 8 - Juvenile, 29.2 - Total, (not including Dental or Mental Health Staff)	52 FTE, 20 per diem	N/A	157
# of LVNs	46	14.8 - Adult, 2 - Juvenile, 16.8 - Total (not includig Dental or Mental Health Staff)	38 FTE, 10 per diem	N/A	48
Nurse Schedule	RN - 3/12, LVN - 4/10, 9/80	5/8	RNs work all schedules, depending on preference (3/12, 4/10, 5/8), LVNs are on 3/12	Predominantly 3/12, but some on 5/8s and 4/10s	RNs - mix of 5/8, 4/10, 2/12 & 2/8, LVN - 5/8
MOU with Sheriff Department	Yes	With Probation, but not the Sheriff's Dept.	N/A	Yes	N/A
# of Med. Passes	4	Two main medication rounds, two minor for a very few medications. Keep as much as possible on twice daily or "keep on person."	4 passes, but to the extent possible prescribe medications that do not require more than 2 passes.	2	9 passes per day covering a 24-hour period that starts at 4am.
OTC through Commissary	Tylenol, Tums, Cough Drops, Multi-Vitamins	Yes - multivitamins, Vitamin C, Antifungal cream, hydrocortisone cream, ibuprofen, medicated foot poweder, nasal decongestant, cough drops, tylenol, artificial tears, benzyl peroxide acne lotion, chlorpheniramine, laratadine, prilosec OTC, stool softener, hemmorrhoid suppositories, antacid tablets, petroleum jelly, clotrimazone cream.	Yes and vending machines. Healthcare also allows for self carry medications.	Some basic items, such as creams and some pain relievers	None. OTC medications are passed as prescribed by attending physicians.
Clinics in Jails?	No	No	Yes (Obstetrics, Orthopedics, GastroIntesntinal, Oral Surgery, HIV, Dermatology, Optometry, Dialysis)	No	Yes, sick call, but most specialty clinics done at contract hospital (UCSD)
County hospital?	No	Yes	Yes	Yes	No
Charge Inmates for Medical Service	No	Yes, $3 Sick Call, $3 medications	Yes, $3	Yes, $3	No

Issue Prioritization

One of the primary reasons CMS has made little progress in addressing known deficiencies has been a lack of issue prioritization. Accordingly, the audit team has attempted to assist in this area by categorizing issues identified during this audit as either short or long-term priorities. It is important that any prioritization process utilized by CMS should be viewed and decisions made within the context of achieving program IMQ Accreditation.

Short Term Priorities (in no particular order)

- ❑ Establish an internal HCA Task Force to prioritize issues, develop strategies for achieving audit recommendations, and ensure implementation of those strategies (completed).
- ❑ Remove conflict of interest situations (in progress)
- ❑ Prepare for Hospital and Physician contract solicitations (in progress)
- ❑ Improve monthly meetings between CMS and OCSD (in progress)
- ❑ Make appropriate personnel and organizational changes (some in progress)
- ❑ Follow proper documentation and disposal procedures to account for Controlled Substances
- ❑ Improve contract administration practices
- ❑ Conduct appropriate and beneficial Utilization Reviews on Hospital and Physician contracts
- ❑ Identify CHART system modules that can be put into production now and ensure appropriate change management practices are utilized; reduce medical record positions as these changes are implemented.

- ❑ Provide clear mission, goals and strategies for CMS staff
- ❑ Ensure that all employees are evaluated accurately and in a timely manner
- ❑ Ensure that all statistical information collected and disseminated is accurate
- ❑ Develop useful management reporting tools for use by CMS management and supervision
- ❑ Fully utilize the resources available to CMS from HCA and OCSD
- ❑ Provide monthly updates on audit recommendation progress to HCA and OCSD Executive Management
- ❑ Develop an effective and efficient LVN work schedule that meets the goals of the organization (in progress)
- ❑ Ensure that all inmates scheduled for outpatient clinics are transported
- ❑ Approach CMC to reduce Physician contract rates for the remainder of the contract term

Long Term Priorities (in no particular order)

- ❑ OCSD and HCA review of medical services, inmate health goals and service deliver, and any subsequent revisions to MOU
- ❑ Study the feasibility of establishing clinics in the jail(s), including the provision of dialysis services
- ❑ Go out to bid for a new medical records IT system
- ❑ Pursue IMQ accreditation once the majority of audit recommendations are implemented

- ❑ Reduce the amount of medication runs in each jail facility
- ❑ Research the feasibility of, plan for, and implement a Doctor Residency program
- ❑ Research the feasibility of, plan for, and implement a fee for service and a OTC medication program
- ❑ Work with OCSD to make the necessary facility changes to accommodate medical care improvements
- ❑ Decrease the processing time and/or background requirement checks for medical staff
- ❑ After implementing audit recommendations, examine staffing and resource levels

Estimated Cost Savings/Revenue Enhancements

The audit team calculated an estimate of the cost savings and/or revenue enhancements from the implementation of the audit recommendations provided throughout this report. Conservative assumptions and reasonable estimates were utilized to provide a minimum level of cost savings or revenue enhancements. While some savings/revenues are readily measureable, others will not be known until they are implemented. Moreover, much of the estimated value added will not be achieved immediately, but rather over time as HCA and OCSD phase in the recommended operational changes. Our minimum estimate of measureable annual value added (cost savings, revenue enhancements, increased productivity and staff time), contingent upon both HCA and OCSD operational changes, is approximately **$2,740,860 for a one year period, or $13.7 million if measured over a five year period.** In addition, our estimate of other potential, but less certain, savings is **$790,102 for a one year period**.

- Estimated annual savings of **$750,000** from reducing the number of medical records staff by 15, made possible by more efficient use of electronic medical record systems (maximization of the existing CHART system in the near term, and procurement of a new system in the long term). These savings will be phased in during the near to mid-term as an increasing number of processes are automated with CHART.

- Savings of 1,095 hours or **$37,985** of LVN staff time per year resulting from reducing the number of medication runs in jail facilities from four to three times per day.

- **$432,918/year** of cost savings resulting from decreasing LVN staff by six, due to more efficient LVN scheduling.

- **$117,000/year** of revenue generated from charging a $3 co-pay for sick call visits. This estimate assumes that of the 130,000 RN sick calls that occur on an annual basis, that only 30% (39,000) are chargeable and collectable.

- **$14,580/year** of revenue generated from charging inmates for over-the-counter medications through the Sheriff/Commissary, which are currently given by RNs or doctors during sick call. This estimate assumes that of all the sick calls (RN, doctor, and nurse practitioner), approximately 30% or 48,600 currently result in distributions of such medication. This estimate also assumes that $1 on average is charged for such medications and only 30% of charges are collectible.

- Savings of 22,750 hours or **$1,242,377** of RN staff time resulting from decreased sick call demand because inmates are (1) charged a co-pay for inmate-initiated visits, and (2) more OTC medications can be purchased through the Sheriff-Commissary. Analysis from the prior CMS pilot projects and from other jurisdictions indicates that total RN sick call will, conservatively, be reduced by 35% resulting from these changes (annual decrease of 45,500 sick calls per year). This estimate assumes that each sick call requires approximately 30 minutes of RN time to complete all tasks associated with a sick call (e.g. triage, physical assessment, and charting).

- Savings of **$16,000/year** from reclassifying two existing Supervising Nurse positions to Senior Nurse positions.

- **$100,000/year** of cost savings due to eliminating the compensation to Correctional Managed Care (CMC) for unnecessary database management.

- **$30,000/year** of cost savings from working directly with WMC-Anaheim to obtain hospital charge data, rather than through CMC. This assumes that only 50% of the $60K that WMC-A pays to CMC is passed along to the County in the total contract amount.

Other Potential Savings

In addition to specific dollar savings, the audit team has identified the following other areas where savings are available but are more difficult to quantify until

implemented. As such, the savings estimates presented in this section are less certain than the ones identified in the previous section:

- Significantly improved risk avoidance and increased productivity for the County from improved processes and procedures, management and oversight. For instance, if the $1.2 million that has been spent settling or defending CMS lawsuits over the last five years (approx. $240,000/year) were reduced by 10% as a result of the changes suggested in this report, the savings to the County would be **$24,000/year**.

- Staff time savings resulting from the discontinuance of the "weekender" program at the jails and the associated repetitive triage of inmates that occurs with that program.

- Savings of **$72,000/year** from deletion of one LVN position from the Central Jail Complex night shift staff if it is determined that the night shift duties (especially the 5:00 a.m. medication pass) at the three Central Jail facilities (Men's Jail, Women's Jail, IRC) can be handled by two roaming LVNs, instead of the current three LVNs, with one at each facility.

- Savings from performing meaningful Hospital and Physician Utilization Reviews. Improvements in this area would not only potentially lead to savings in the hospital contract with WMC-A, but also could open up more beds at the custody unit at WMC-A, which would, in turn, decrease the amount of one-on-one coverage provided by Theo Lacy deputies to watch inmates for whom there is no space in the custody unit. For example, if such a change lead to a decrease of 4,380 Deputy I hours at the hospital (12 hours per day multiplied by 365 days per year), which is highly conservative in light of the amount of deputy resources that are currently used to watch inmates in the hospital, that would be a savings of **$254,697** per year.

- Fewer wasted pharmaceuticals resulting in less medication costs to CMS. For instance, in FY 2007-08, CMS spent $991,345 on pharmaceuticals. A conservative 10% reduction in such spending equates to **$99,135** in cost savings.

- Savings at the negotiating table with outside vendors resulting from improved contract administration and monitoring. For instance, reducing the profit margin for Correctional Managed Care to 25%, instead of the current 36%, would result in a cost savings of **$340,270**.

- Savings resulting from greater program efficiency and performance monitoring due to better gathering of data and statistics, both internally and with respect to external contracts.

- Reduction in the use of contract nursing staff to complete training sessions and exercises, with greater reliance on in-house staff that have similar training abilities and credentials and can train staff during shift down time.

- Lower cost physician services through the establishment of a partnership with a local medical school residency program.

- Less deputy resources required for transportation to clinics at WMC-A if more clinics are held within the jail facilities.

Concluding Remarks

Overall, while this audit indicates that inmate health care is generally adequate and available, the cumulative impact of the system and management-related deficiencies noted in this report is increased risk to the County.

Due to the high volume of substantial issues identified during this audit, HCA should form an internal Task Force to prioritize issues, develop specific work plans, with effective strategies and time schedules to address identified areas, and provide the group with the necessary authority for seeing the plans through to completion.

Since the commencement of this audit, HCA Executive Management has been actively engaged in discussing these many issues, understanding the depth of the problems, and has begun to make a number of changes to the CMS organization. In addition, the recent changes in OCSD Jail and CMS management increase the possibility that real reform of conditions, systems, processes, and the implementation of important innovations can be made and sustained.

In conclusion, the audit team wishes to thank the Board of Supervisors for their continued support in its performance auditing efforts, and to the Health Care Agency and the Orange County Sheriff-Coroner Department for providing us access to their operations.

Exhibit 1: CMS Board Resolution

RESOLUTION OF THE BOARD OF SUPERVISORS OF

ORANGE COUNTY, CALIFORNIA

June 17, 1975

On motion of Supervisor Clark, duly seconded and carried, the following Resolution was adopted:

WHEREAS, by letter dated June 9, 1975, the County Administrative Office submitted to this Board its recommendations regarding the proposed consolidation of Correctional Medicine functions;

NOW, THEREFORE, BE IT RESOLVED that this Board hereby approves, in concept, the transfer of Correctional Medicine functions presently performed by the Sheriff-Coroner and Probation Departments, including involved personnel, services and supplies and fixed assets, to the Physician County Correctional Services budget, under the direction of the County Health Officer, effective July 1, 1975.

BE IT FURTHER RESOLVED that this Board hereby approves, in concept, the proposed Memorandum of Understanding between the Health Department, Sheriff-Coroner, and the Probation Department and hereby directs the County Health Officer, with the cooperation of the Sheriff-Coroner and the Probation Officer, to review and modify, if necessary, the proposed Memorandum of Understanding.

BE IT FURTHER RESOLVED that the County Health Officer is hereby directed to report back to this Board within sixty days with a final version of the Memorandum of Understanding signed by the County Health Officer, the Sheriff-Coroner, and the Probation Officer.

AYES: SUPERVISORS RALPH B. CLARK, THOMAS F. RILEY, ROBERT W. BATTIN, LAURENCE J. SCHMIT, AND RALPH A. DIEDRICH

NOES: SUPERVISORS NONE

ABSENT: SUPERVISORS NONE

Resolution No. 75-853
Approved in Concept, Consolidation of Correctional Medicine Functions

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

I, W. E. ST JOHN, County Clerk and ex-officio Clerk of the Board of Supervisors of Orange County, California, hereby certify that the above and foregoing Resolution was duly and regularly adopted by the said Board at a regular meeting thereof held on the 17th day of June, 1975, and passed by a unanimous vote of said Board.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 17th day of June, 1975.

W. E. ST JOHN
County Clerk and ex-officio Clerk
of the Board of Supervisors of
Orange County, California

By June Alexander
Deputy

F1031-22

2.

RESOLUTION OF THE BOARD OF SUPERVISORS OF

ORANGE COUNTY, CALIFORNIA

July 29, 1975

On motion of Supervisor Clark, duly seconded and carried, the following Resolution was adopted:

BE IT RESOLVED as follows:

1. The Memorandum of Understanding between the Sheriff-Coroner, Probation, and Health Departments is hereby received and filed.

2. The Sheriff-Coroner and Probation Departments are hereby directed to transfer the fixed assets and personnel files of the Correctional Medicine staff to the Health Department.

3. The Health Offixer is hereby authorized to consult with and receive recommendations from the State Board of Pharmacy concerning pharmaceutical dispensing matters in correctional medicine facilities.

AYES: SUPERVISORS RALPH B. CLARK, THOMAS F. RILEY, LAURENCE J. SCHMIT AND RALPH A. DIEDRICH

NOES: SUPERVISORS NONE

ABSENT: SUPERVISORS ROBERT W. BATTIN

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

I, WILLIAM E. ST JOHN, County Clerk and ex-officio Clerk of the Board of Supervisors of Orange County, California, hereby certify that the above and foregoing Resolution was duly and regularly adopted by the said Board at a regular meeting thereof held on the 29th day of July, 1975, and passed by a unanimous vote of said Board members present.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 29th day of July, 1975.

WILLIAM E. ST JOHN
County Clerk and ex-officio Clerk
of the Board of Supervisors of
Orange County, California

By Jane Alexander
Deputy

Resolution No. 75-1056
Memo of Understanding
Trans. of Correctional
Medicine

Exhibit 2: CAO Analysis of CMS Options

COUNTY OF ORANGE

COUNTY ADMINISTRATIVE OFFICE

R. E. THOMAS
COUNTY ADMINISTRATIVE OFFICER

COUNTY ADMINISTRATION BUILDING
515 NORTH SYCAMORE STREET
SANTA ANA, CALIFORNIA 92701

TELEPHONE: 834-2345
AREA CODE 714

June 9, 1975

FILED
JUN 17 1975
W. E. ST JOHN, County Clerk
By.....Deputy

Honorable Board of Supervisors
County of Orange
Santa Ana, CA

SUBJECT: Proposed Consolidation of Correctional Medicine Functions

NARRATIVE: Proposes consolidation of all Correctional Medicine functions presently being performed by the Sheriff-Coroner and the Probation Departments into the Physician County Correctional Services budget under the direction of the County Health Officer.

Gentlemen:

Presently, the Physician County Correctional Services (PCCS) which provides physician services and directs nursing and related health services within adult and juvenile institutions and Albert Sitton Home, reports to the Medical Center for administrative support and limited professional supervision. As your Board is well aware, it is anticipated that the Medical Center will be transferred to University of California, Irvine control. After this transfer, PCCS will no longer be tied organizationally to Orange County Medical Center and therefore will essentially be without direct administrative support and supervision.

In addition to the PCCS budget, there are nursing and clerical personnel, services and supplies, and fixed assets in other budget units (i.e., Juvenile Hall, Los Pinos Forestry Camp, Youth Guidance Center, and Sheriff-Coroner) which make it difficult to direct, control and administer a comprehensive medical treatment program in the County's adult and juvenile institutions. In view of this situation, coupled with the imminent transfer of the Medical Center, it seemed appropriate to evaluate various alternatives to determine where best to place the Correctional Medicine function organizationally. Alternatives investigated included the following:

- Retain the present PCCS organizational structure;
- Contract with a private firm for correctional medicine services;
- Consolidate all correctional medicine activities under the Sheriff-Coroner or the Probation Department;
- Leave PCCS in an independent status reporting directly to the Board of Supervisors or the County Administrative Officer; and

C: EACH SUP.
AO & CO CO.

- Consolidate all correctional medicine activities under the County Health Officer.

The total County-wide costs associated with the Correctional Medicine function for FY 1974-75 are anticipated to be approximately $983,000. (A detailed breakdown of this figure is provided on Attachment I). This amount represents the total salary, wage and benefit figures for the thirty-three (33) employees involved in the proposed transfer (PCCS, Sheriff-Coroner, and Probation Department staff), extra help and overtime coverage, services and supplies, and maintenance work on fixed assets. (All fixed assets used by Correctional Medicine and supporting staff currently listed in the Sheriff and Probation Departments' budget have been identified and will be transferred, along with the responsibility for their maintenance).

This amount also includes real and anticipated hospital charges incurred by the Sheriff-Coroner and the Probation Departments at the Orange County Medical Center. In addition, there is presently clerical assistance provided by trusties in the medical unit of the Main Jail. While all direct costs for Correctional Medicine have been identified in the $983,000 mentioned above, there are indirect costs incurred by the Sheriff and the Probation Departments for transporting adult prisoners and minors under the jurisdiction of the Juvenile Court to and from the Medical Center, providing the necessary security for those who are hospitalized, etc.

EVALUATION OF ALTERNATIVES

Retain Present PCCS Organizational Arrangement

As indicated above, nursing staff, services and supplies, and fixed assets which support the PCCS function are scattered throughout four budget units, with no one department having responsibility for the entire Correctional Medicine function. This situation has led to operational inefficiencies and misunderstandings between the involved parties. One such problem, for example, has resulted from Correctional Nurses in the Sheriff-Coroner and Probation Departments receiving medical supervision from the physician in charge of PCCS on one hand and administrative direction from the Sheriff-Coroner and Probation Departments on the other.

In addition, the existing organizational arrangement between the Medical Center and PCCS has been less than satisfactory from the outset. The Medical Center has not been able to provide PCCS with the necessary level of professional supervision, guidance, and administrative support.

Under these circumstances, the alternative of retaining the present organizational arrangement between the Orange County Medical Center and the PCCS, as well as the decentralized approach to administering the Correctional Medicine function, does not appear to be a preferred alternative and is not recommended.

Contract with a Private Organization for Providing Correctional Medicine Services to the County

While this alternative appears feasible on the surface, a number of significant problem became apparent during our analysis. The most significant of these problems is that there are no known firms which provide this particular type of health service. However, even if such an organization existed, we would have to obtain necessary security clearances for staff assigned to work within the institutions. In our estimation, the impact of such a procedure would be to increase administrative requirements and thus escalate the cost of such a contract significantly. For these reasons, this also did not appear to be a preferred alternative and is not recommended.

Consolidate all Correctional Medicine Activities into one Operational Unit and Place it Either Under the Sheriff-Coroner or the Probation Department

Either of these departments should be able to provide the necessary administrative support to the Correctional Medicine unit. However, neither the Sheriff-Coroner nor the Probation Department would be in a position to evaluate the effectiveness of Correctional Medicine programs, assist the medical staff in program planning and development, and provide needed medical supervision and guidance to staff.

Consolidate all Correctional Medicine Activities into One Operational Unit with a Direct Line Reporting Relationship to the Board of Supervisors or the County Administrative Office

This alternative would consolidate all Correctional Medicine activities into one operational unit, but would provide no direct administrative link between this unit and a health or health related organization. Establishing such a direct line reporting relationship to the Board appears contrary to the County's present reorganization efforts, which has as a primary objective to limit the number of independent functions reporting to the Board.

Consolidate all Correctional Medicine Activities into one Operational Unit and Place it Under the County Health Officer

The most feasible and practicable alternative might be to establish Correctional Medicine as an element in a Health or Health and Services Agency if and when such an agency is formed. Lacking that possibility, we recommend placement of the Correctional Medicine function under the County Health Officer. This would provide the County's principal public health professional the opportunity to:

- Input into the program planning and development process;
- Provide constructive criticism regarding medical functions;
- Provide a home base and needed administrative support; and
- Provide professional supervision and guidance to staff.

An additional benefit in this consolidation would be centralized control of drug acquisition, storage, and distribution for both PCCS and the Health Department. Savings would result in the elimination of one vacant half time Pharmacist and the Health Department could assume the PCCS stores function with existing personnel allowing for a reduction of one Store Clerk through attrition.

Our recommendation would be to transfer this function to the Health Officer effective July 1, 1975 or as soon thereafter as practicable.

We have prepared a proposed Memorandum of Understanding (MOU) (attached) which identifies the major areas of responsibility for each of the concerned departments. Signing the MOU would ratify the working relationship between the principals involved. A summary of the agreement is provided below.

The Health Department would have the responsibility:

- to provide medical, dental and nursing services to adults and juveniles in correctional institutions and Albert Sitton Home;
- to disburse all medications and pharmaceutical items;
- to provide necessary control over the services and supplies and equipment accounts, and to handle procurement and other essential administrative functions;
- to maintain equipment or fixed assets in the event of a breakdown; and
- to coordinate the appointment of new or replacement staff for Correctional Medicine with the Sheriff-Coroner and the Probation Department. The selection and appointment of a new Physician County Correctional Services, will be the joint responsibility of the Sheriff-Coroner (Penal Code Section 4023) and the County Health Officer. Selection input will also be solicited from the County Probation Officer.

The Sheriff-Coroner would have the responsibility:

- to retain control over and set policies for maintaining security within the Main Jail, Jail premises, etc;
- to retain responsibility for providing all building maintenance needs associated with the medical area in the Main Jail;
- to provide prospective employees with a background clearance. The final appointment of a prospective employee to be assigned to the medical area in the Main Jail shall be subject to a favorable background clearance by the Sheriff-Coroner.
- to retain responsibility, along with the County Health Officer, for the selection of a new Physician County Correctional Services.

The Probation Department would have the responsibility:

- to retain control over and set policies for maintaining security within the juvenile institutions, institution premises, etc;
- to retain responsibility for providing all building maintenance needs associated with the medical areas in the various institutions and Albert Sitton Home;

- to provide prospective employees with a background clearance. The final appointment of a prospective employee to be assigned to one of the juvenile institutions shall be subject to a favorable background clearance by the Probation Department;

- to provide input to the Sheriff-Coroner and the County Health Officer on the selection of a new Physician County Correctional Services.

Another item which must be discussed centers around the area of hospital care during emergencies for the adults and juveniles within the County's correctional institutions and Albert Sitton Home. Presently, there are longstanding procedures regarding the provision of hospital services, including pre and post operative care, surgery, etc., for inmates. Should the Medical Center be transferred to University of California, Irvine control, the agreement between the County of Orange and UCI specifies that the County is entitled to purchase and the University shall sell to the County the required hospital services (this includes patient care services for custodial babies, adult prisoners, and minors under the jurisdiction of Juvenile Court). The details and procedures associated with providing these types of services and the billing process involved are presently being worked out by the Administrative Office.

Since all costs related to the Correctional Medicine function in the County are being congregated into one operational unit (i.e., PCCS) there will no longer be a need for cost applying expenditures to the Sheriff-Coroner or the Probation Departments.

RECOMMENDATIONS:

1. Approve, in concept, the transfer of Correctional Medicine functions presently performed by the Sheriff-Coroner and Probation Departments, including involved personnel, services and supplies, and fixed assets, to the Physician County Correctional Services budget under the direction of the County Health Officer effective July 1, 1975.

2. Approve, in concept, the proposed Memorandum of Understanding and direct the County Health Officer, with the cooperation of the Sheriff-Coroner and the Probation Officer to review and modify, if necessary, the proposed Memorandum of Understanding.

3. Direct the County Health Officer to report back to the Board within 60 days with a final version of the Memorandum of Understanding signed by the County Health Officer, the Sheriff-Coroner, and the Probation Officer.

Respectfully submitted,

R. E. Thomas
County Administrative Officer

VJI:nf
cc: J. R. Philp, Health Officer
Brad Gates, Sheriff-Coroner
Margaret C. Grier, Probation Officer
E. Wallace, Physician County Correctional Services

Attachment

PROPOSED MEMORANDUM OF UNDERSTANDING BETWEEN THE HEALTH DEPARTMENT, SHERIFF-CORONER, AND THE PROBATION DEPARTMENT OF THE COUNTY OF ORANGE, STATE OF CALIFORNIA

This Memorandum of Understanding between the Sheriff-Coroner, the Probation Department, and the Health Department of the County of Orange ratifies the working relationship between said departments in the area of Correctional Medicine, as described below, effective July 1, 1975.

WHEREAS, the Physician County Correctional Services, which provides physician and nursing services within adult and juvenile institutions and Albert Sitton Home, currently reports to the Medical Center for administrative support and professional supervision; and

WHEREAS, it is anticipated that the Orange County Medical Center will be transferred to University of California, Irvine control; and

WHEREAS, in addition to the Physician County Correctional Services budget, there are nursing, clerical, services and supplies, and fixed assets in other budget units, (i.e, in the Juvenile Hall budget, the Los Pinos Forestry Camp budget, the Youth Guidance Center budget, and in the Sheriff-Coroner budget), which make it difficult presently to direct, control, and administer a comprehensive medical treatment program in the County's adult and juvenile institutions; and

WHEREAS, it is imperative that the Correctional Medicine function, in order to provide a proper service level in the most efficient and effective manner possible, be consolidated into one operational unit and placed under the Health Department for administrative support, professional supervision, and budgetary control.

NOW THEREFORE, the Department of Health, the Sheriff-Coroner, and the Probation Departments agree to the following definitions and division of responsibilities:

I. HEALTH DEPARTMENT

A. Medical Services
Health Department shall:

1. insure that the level of medical services presently provided to adults and juveniles in correctional institutions and Albert Sitton Home will be maintained at or increased over present levels;

2. evaluate the medical needs of those within the County's correctional institutions and Albert Sitton Home and prescribe the type of medical treatment necessary;

3. provide (per Board Resolution No. 73-471, dated May 1, 1973) emergency and palliative dental care to adults and juveniles in custody and, when feasible, definitive dental care to juveniles whose detention would be prolonged (this program is now in the final stages of implementation and it is anticipated that it will begin operation by April or May 1975);

4. provide the adults and juveniles in custody and those residing in Albert Sitton Home with the needed medications and to have available the medical equipment necessary to render accurate medical evaluations;

5. coordinate proposed staffing changes tied to the initiation of new medical programs with the Sheriff-Coroner and Probation Department prior to implementation;

6. maintain all records and undertake disbursement responsibility for all medications and pharmaceutical items;

7. maintain proper medical records and histories on adults and juveniles within the institutions which receive medical treatment. (Medical files on juveniles will be transferred to Probation after a juvenile reaches the age of 18 for eventual destruction and confidentiality of minor's identity).

B. Administration and Personnel
Health Department shall:

1. notify the vendor or appropriate maintenance personnel in the event of an equipment or fixed asset breakdown and instruct them to perform the necessary maintenance work;

2. provide necessary control over the services and supplies and equipment accounts, and to handle procurement and other essential administrative functions;

3. coordinate the appointment of new or replacement staff for Correctional Medicine with the Sheriff-Coroner and the Probation Departments. The selection and appointment of a new Physician County Correctional Services will be the joint responsibility of the Sheriff-Coroner and the County Health Officer. (The Sheriff is included in the selection process because by statute - Penal Code Section 4023, it is his responsibility to appoint the Physician, County Correctional Services). Selection input will also be solicited from the County Probation Officer;

4. retain the flexibility of rotating staff between adult and juvenile institutions for administrative, developmental, or other reasons. Whenever such action is contemplated, the County Health Officer will coordinate with the Sheriff-Coroner or the Probation Officer so they are made aware and can provide input on the proposed rotation of the employee(s)

C. General
Health Department shall:

1. comply with all security procedures established within adult and juvenile institutions.

II. SHERIFF-CORONER

A. Security

The Sheriff-Coroner shall:

1. retain control over and set policies for maintaining security. This includes the provision of security within the Main Jail, jail premises, as well as the provision of safe and secure storage areas, i.e., shelved cupboards, closets, etc., for all medications and pharmaceutical items in the care of Correctional Medicine staff.

2. provide necessary security measures for those inmates confined in the medical area in order to insure the safety of Correctional Medicine staff.

B. Administration and Personnel
The Sheriff-Coroner shall:

1. insure that during certain instances where security, administrative, or other considerations must take precedence over medical procedures or considerations, the contemplated action must be brought to the attention of and discussed with the County Health Officer or his designee before such action is taken;

2. monitor and insure compliance with established procedures for referral of inmates to the medical unit for treatment;

3. maintain necessary communications with the Correctional Medicine staff in order to be aware of the general medical condition of inmates;

4. retain responsibility for providing all building maintenance needs associated with the medical area in the Main Jail;

5. provide prospective employees with a background clearance. The final appointment of a prospective employee to be assigned to the medical area in the Main Jail shall be subject to a favorable background clearance by the Sheriff-Coroner. However, a background clearance shall not be required when an employee is rotated from the Main Jail to work in one of the juvenile institutions;

6. retain responsibility, along with the County Health Officer, for the selection and appointment of a new Physician County Correctional Services. Selection input will also be solicited from the County Probation Officer.

III. PROBATION DEPARTMENT

A. Security
The Probation Department shall:

1. retain control over and set policies and procedures for maintaining security. This includes the provision of security within the juvenile institutions, institution premises, as well as the provision of safe and secure storage areas, i.e. shelved cupboards, closets, etc., for all medications and pharmaceutical items in the care of Correctional Medicine staff;

2. provide necessary security measures for those inmates confined in the medical area in order to insure the safety of Correctional Medicine staff.

B. Administration and Personnel
The Probation Department shall:

1. insure that during certain instances where security, administrative, or other considerations must take precedence over medical procedures or considerations, the contemplated action must be brought to the attention of and discussed with the County Health Officer or his designee before such action is taken;

2. monitor and insure compliance with established procedures for referral of juveniles to the medical unit for treatment;

3. maintain necessary communications with Correctional Medicine staff in order to be aware of the general medical condition of juveniles;

4. retain responsibility for providing all building maintenance needs associated with the medical areas in the various institutions and Albert Sitton Home;

5. provide prospective employees with a background clearance. The final appointment of a prospective employee to be assigned to one of the juvenile institutions shall be subject to a favorable background clearance by the Probation Department. However, a background clearance shall not be required when an employee is rotated from the Main Jail to work in one of the juvenile institutions;

6. provide input to the Sheriff-Coroner and the County Health Officer on the selection of a new Physician, County Correctional Services.

Over the years, a great deal of rapport and cooperation has developed between Correctional Medicine staff and personnel working in adult and juvenile institutions. As a result of the proposed transfer of Correctional Medicine and related functions to the Health Department, and since all aspects and details of organizational relationships cannot be included in an agreement, it is hoped and encouraged that these long standing relationships and areas of cooperation between the involved parties in the area of Correctional Medicine will be maintained and strengthened.

Signed this _____ day of _____, 19 ____.

By _____
Health Department

By _____
Probation Department

By _____
Sheriff-Coroner

ATTACHMENT I

CORRECTIONAL MEDICINE: DETAILED COST BREAKDOWN FOR 1974-75 FISCAL YEAR

° Physician, County Correctional Services

Personnel:

		Salary		
1	Dental Assistant	$ 9,396		
1	Dentist	29,100		
1	Pharmacist (20 hours)	10,506		
1	Physician	30,744		
1	Physician (10 hours)	7,686		
1	Physician, Co. Correctional Svs.	37,020		
1	Steno Clerk III	10,752		
1	Store Clerk	9,924		
1	Typist Clerk II (20 hours)	4,356		
			149,484	
	Extra Help	2,370		
	Retirement	7,086		
	Employee Group Insurance	2,665		
			12,121	

Services and Supplies:

Insurance	219	
Equipment Maintenance	200	
Medical & Dental Lab Supplies	19,000	
Office Expense	700	
Professional/Specialized Services	205	
Transportation/Travel-General	1,800	
Transportation/Travel-Meetings	300	
	22,424	
Sub-total Physician County Correctional Services:		$184,029

° Sheriff-Coroner

Personnel:

Main Jail

1	Senior Correctional Nurse	$ 16,956	
8	Correctional Nurse	121,440	
1	Clerk III	10,212	
1	Clerk II	8,712	
			157,320

	Salary		
Extra Help/Shift Differential	$ 6,328		
Overtime	6,412		
Retirement	7,457		
Employee Group Insurance	3,258		
		$23,455	
Services/Supplies:	5,329	5,329	
Service Contracts on fixed assets:	3,304	3,304	
Hospital Charges Incurred at OCMC:	353,733	353,733	
Sub-total Sheriff/Coroner:			$543,141

Probation: Juvenile Institutions

Personnel:

Juvenile Hall			
1 Senior Correctional Nurse	16,956		
7 Correctional Nurse	106,260		
1 Correctional Nurse (20 hours)	7,590		
1 Clerk II	8,712		
		139,518	
Los Pinos Forestry Camp			
1 Correctional Nurse (20 hours)	7,590	7,590	
Los Pinos Forestry Camp Expansion			
1 Correctional Nurse (20 hours)	7,590	7,590	
Youth Guidance Center			
1 Correctional Nurse	15,180	15,180	

Extra Help/Shift Differential	$22,064		
Overtime	800		
Retirement	8,052		
Employee Group Insurance	3,406		
		$34,022	
Services/Supplies:	1,950		
		1,950	
Hospital Charges Incurred at OCMC:	50,000		
		50,000	
Sub-total Probation:			$255,850
COUNTY-WIDE COST FOR CORRECTIONAL MEDICINE, FY 1974-75			$983,020

Breakdown by Expenditures for Adults and Juveniles

	Adults		Juveniles		Summary
Physician County Correctional Services:	$84,161	+	$99,868	=	$184,029
Sheriff-Coroner:	543,141			=	543,141
Probation:Juvenile Institutions:			255,850	=	255,850
TOTAL:	$627,302	+	$355,718	=	$983,020

Exhibit 3: Recommended CMS Organizational Chart

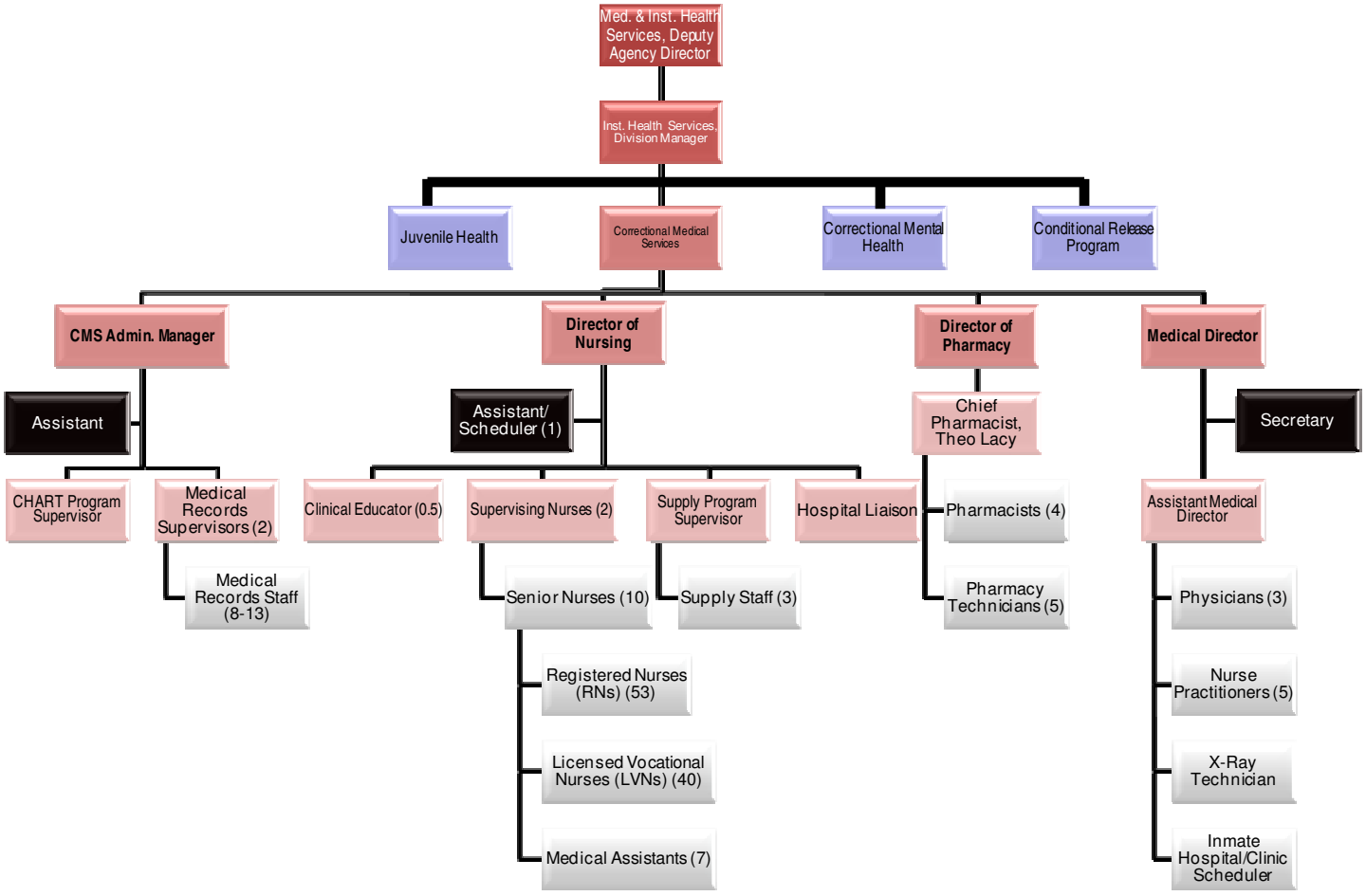


Exhibit 4: CMS Budget vs. Actual Expenditure Detail, FY 2000/01 to FY 2007/08

	FY 2000/01		FY 2001/02		FY 2002/03		FY 2003/04		FY 2004/05		FY 2005/06		FY 2006/07		FY 2007/08		Actual Spending FY 00/01 through FY 07/08	
Exp. Object	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Dollar Change	% Change
PROF/SPEC S	Detailed Data Not Available	$5,676,360	Detailed Data Not Available	$6,630,552	$7,229,803	$7,304,015	$9,612,248	$9,566,772	$9,343,187	$9,618,781	$10,406,335	$10,552,457	$10,544,919	$10,632,881	$13,681,988	$14,205,139	$8,528,779	150.25%
REG SALARIE		$8,504,839		$10,015,734	$11,014,055	$10,235,539	$8,489,578	$9,481,173	$9,580,073	$9,653,388	$9,477,739	$9,477,916	$10,003,695	$10,103,717	$10,795,891	$10,995,732	$2,490,893	29.29%
RETIREMENT		$91,534		$128,253	$640,011	$569,004	$758,669	$889,427	$1,165,362	$1,242,494	$1,431,495	$1,516,829	$2,069,409	$2,344,592	$2,453,248	$2,636,739	$2,545,205	2780.62%
EXTRA HELP		$82,839		$758,103	$1,045,371	$878,206	$1,181,339	$768,905	$934,179	$901,932	$934,179	$1,069,303	$1,267,308	$1,092,136	$1,155,112	$1,151,017	$1,068,178	1289.47%
OVERTIME		$379,442		$418,707	$357,139	$366,613	$369,639	$540,984	$369,639	$949,622	$369,639	$1,075,953	$556,460	$1,169,115	$573,154	$1,073,539	$694,098	182.93%
PHARMACEUT'		$754,644		$829,024	$775,460	$822,556	$986,779	$910,289	$1,059,796	$1,063,209	$1,059,796	$1,104,674	$1,299,987	$1,306,851	$1,399,987	$991,345	$236,702	31.37%
HEALTH INSU		$611,136		$729,608	$1,022,782	$833,198	$895,284	$928,908	$1,016,208	$911,326	$1,016,676	$898,249	$1,029,093	$893,762	$1,113,804	$937,909	$326,773	53.47%
OTHER PAY		$772,157		$736,016	$666,688	$716,215	$644,627	$672,375	$690,627	$642,189	$663,273	$647,440	$676,538	$625,586	$635,732	$665,507	-$106,650	-13.81%
MED SUPPLIE		$369,239		$478,373	$265,572	$360,684	$280,195	$333,192	$280,195	$423,578	$280,195	$376,053	$369,881	$373,491	$422,057	$369,359	$120	0.03%
RNTS/LEAS-E		$11,021		$17,514	$13,000	$12,103	$11,520	$33,408	$11,520	$15,126	$11,520	$55,478	$187,525	$25,068	$289,944	$215,821	$204,800	1858.33%
MEDICARE		$127,220		$158,234	$150,646	$166,955	$118,568	$164,928	$133,659	$169,668	$132,956	$172,268	$129,924	$182,140	$151,835	$194,970	$67,750	53.25%
WORK COM GE		$0		$235,618	$327,551	$327,552	$279,667	$276,700	$358,016	$353,391	$352,385	$348,527	$259,336	$259,159	$235,126	$173,172	$173,172	N/A
TEL/TG-I/F		$68,652		$83,803	$0	$104,233	$0	$89,308	$0	$86,806	$0	$62,465	$67,015	$66,784	$69,294	$137,453	$68,801	100.22%
MAINT -EQUI		$116,446		$93,699	$144,603	$107,225	$98,203	$85,030	$98,203	$189,671	$98,203	$128,499	$98,128	$156,349	$117,464	$133,218	$16,772	14.40%
INSURANCE		-$52,851		-$53,786	$44,485	$45,467	$65,463	$58,350	$81,267	$71,430	$91,753	$80,081	$114,542	$93,712	$132,294	$104,334	$157,185	-297.41%
OTHER INSUR		$50,190		$109,212	$124,644	$110,159	$88,920	$99,610	$101,088	$96,737	$102,336	$96,403	$104,368	$92,181	$113,052	$97,168	$46,978	93.60%
AN LV PAYOF		$0		$0	$0	$38,743	$0	$45,609	$0	$37,144	$94,900	$112,650	$96,798	$170,800	$99,702	$94,795	$94,795	N/A
AMBUL CONTR		$84,061		$79,259	$85,000	$109,177	$98,400	$116,352	$111,254	$93,213	$111,254	$100,807	$109,703	$82,910	$113,433	$77,065	-$6,996	-8.32%
MIN MED EQ-		$15,526		$18,752	$27,300	$1,396	$28,975	$0	$20,065	$9,502	$20,065	$15,751	$39,724	$86,186	$54,035	$67,801	$52,274	336.68%
SPEC DEPT E		$10,143		$28,199	$114,500	$33,939	$68,632	$25,003	$45,622	$26,037	$45,622	$34,384	$56,786	$32,540	$87,635	$51,198	$41,055	404.75%
OTHER		$469,559		$721,211	$681,836	$395,406	$728,839	$373,186	$455,120	$424,602	$400,918	$470,069	$678,381	$654,074	$723,707	$316,584	$296,672	63.18%
Grand Total	$19,237,480	$18,142,151	$22,433,774	$22,216,084	$24,730,446	$23,538,387	$24,805,545	$25,459,510	$25,855,080	$26,979,848	$27,101,239	$28,396,256	$29,759,520	$30,444,032	$34,418,494	$34,689,862	$16,547,712	91.21%

*Note: FY 2000/01 and FY 2001/02 Budgeted Amounts were obtained from HCA/Internal Budget system that was utilized at that time, which adjusted information after it was downloaded from BRASS. All other data were obtained from CEO-Budget.