Review of Health Care Services in the California Youth Authority (CYA)

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Introduction

Relative to class action litigation, Stevens v. Harper, which included medical issues, the California Youth Authority (CYA) in collaboration with the State of California Attorney General's Office retained the authors of this document, Dr. Michael Puisis and Ms. Madie LaMarre, Nurse Practitioner, as medical experts to evaluate medical care provided to wards in the CYA.

Scope

We were asked by Deputy Attorney General Stephen Acquisto to address the following eight questions:

1. Does the CYA have an appropriate number of medical and dental professionals?
2. Is the CYA's medical and dental staff appropriately trained and supervised?
3. Are the CYA's medical and dental records appropriate?
4. Does the CYA adequately screen incoming wards for medical and dental concerns?
5. Do wards have appropriate access to timely medical and dental care of an appropriate quality?
6. Does the CYA respond appropriately to medical and dental emergencies?
7. Does the CYA have appropriate quality control procedures, and have those procedures been appropriately implemented?
8. Are wards receiving medical and dental care that is commensurate with community standards?

Methods

To evaluate these questions, we met with staff from CYA Headquarters, reviewed multiple documents as listed in appendix A, and conducted site visits at seven of eleven CYA facilities. Each site visit generally consisted of the following activities:

- Tours of the medical unit, Outpatient Housing Unit (OHU), selected dormitories and lockdown areas
- Interviews with medical, nursing, dental, correctional staff, and wards
- Review of tracking logs and patient medical records
- Observation of selected health services such as medical reception, sick call, and medication administration
- Review of documents, including policies and procedures, and treatment manuals
- Review of staffing patterns and professional licensure

To establish a benchmark against which to measure care in the CYA, we used national or consensus standards including:

- "National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities," Second Edition, 1999. See Appendix A. The NCCHC Guideline can also be obtained free from http://www.ncchc.org/links/clinicalguides.html.
- "Guide to Clinical Preventive Services," 2nd Edition. Report of the United States Preventive Health Services Task Force (USPHSTF)
- "Guidelines for Adolescent Preventive Services (GAPS)," American Medical Association
- National Commission on Correctional Health Care Chronic Illness Guidelines. These can be located at http://www.ncchc.org/resources/clinicalguides.html.
- American Diabetes Association Standards of Care for persons with diabetes. These can be located at http://care.diabetesjournals.org/content/vol26/suppl_1/.
- The National Heart Lung and Blood Institutes guidelines for care of persons with hypertension, asthma and high blood cholesterol. These can be located at http://www.nhlbi.nih.gov/guidelines/index.htm.

Executive Summary

We would like to thank the CYA for the opportunity to review the health care system in the CYA. As we toured the sites and developed our report, all staff of the CYA and the Attorney General's Office has been courteous, helpful and cooperative. We encountered many excellent staff during our tours, which appeared dedicated to delivering a high level of medical services to the wards in the CYA. It is our hope that this report will assist them in development of an improved program of medical care. This summary provides an overview of our report and gives general recommendations that are a synopsis of more specific recommendations in the report.

A primary finding of our review is that medical care provided to wards in the CYA is not commensurate with community standards of care. However, the deficiencies are mostly organizational and procedural and not primarily financial and therefore are mostly correctable within the existing budget.

Additionally, adolescents are generally a healthy population. Their health care needs are mainly preventive in nature. Therefore, given the low prevalence of wards with chronic illness within the CYA, it will be easier to manage those wards that do have chronic illness. However, the preventive health needs of the wards in the CYA are not being addressed. There is a virtual absence of a preventive health counseling and health promotion program. This should be addressed.

It is our opinion that the most important task for the CYA, relating to medical care is to develop administrative and medical leadership. This cannot be done without a commitment by the CYA Director to support appropriate medical care for wards. This commitment will ensure the cooperation of the security staff in its interactions with medical staff as they perform their jobs. Without medical autonomy, appropriate medical care cannot be delivered.

The CYA lacks administrative and medical leadership and supervision. In part, the lack of supervision results from the diffuse administrative structure of medical services. It is our opinion; therefore, that medical services should be brought under centralized supervision with a single Medical Director. It is also our opinion that the CYA should institute centralized administrative leadership by appointing a Statewide Administrator. This position would be responsible for the administrative functions of the medical services.

A statewide Administrator and Medical Director partnered with a state Director of Nursing could form the leadership team to manage the health care program for the CYA. This team's first priority should be the establishment of standardized policies, procedures, and a chronic illness program. Establishment of a budget should create fiscal accountability specific to health care. Productivity of staff should be evaluated. Appropriate inventory control should be established, especially for pharmacy. In the case of pharmacy, contracting out this service should be considered.

Ongoing supervision of clinical staff must be initiated by institution of a Continuous Quality Improvement program along with peer review of physicians and routine audits of the process of care. Critical peer review is essential to ensure that the clinical program is commensurate with community standards and is delivered in a decent and humane manner. Development of the clinical staff by training is an important adjunct to this process and should be initiated.

We have not reviewed every facility, but have reviewed a significant sample of facilities and feel confident that our report is representative of care as provided in the CYA. Our report is sufficiently detailed and provides specific recommendations that can be useful as programmatic goals. We are hopeful that this report serves to improve health care for the wards in the CYA, and will become the basis for instituting necessary changes in the existing program.

1. Does the CYA have an appropriate number of medical and dental professionals?

Conclusion:

As a whole, the CYA has appropriate numbers of health care professionals to provide adequate health care to wards. However, in some instances staff is unevenly distributed. It may be necessary to reallocate staff between facilities to create the right mix of staff.

Despite adequate numbers of health care professionals, there are institutional policies and/or practices that decrease staff efficiency and productivity, and affect ward access to health care.

Findings and Discussion:

According to National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities (Standard Y-26), the numbers and types of health care professionals required at a facility depend upon the following:

- Size of the facility
- Type of services delivered – medical, nursing, pharmacy, dental, or mental health
- Scope of services delivered – outpatient, inpatient, or specialty care
- The needs of the juvenile population
- The organization structure (hours of service, scheduling)

The CYA employs full-time physicians and dentists; and full to part-time pharmacists, x-ray, and laboratory technicians. The adequacy of staffing for each position is described in the following information.

Physician Staffing

Of the seven facilities visited, each had a Chief Medical Officer (CMO), and in most cases, a staff physician. However, staffing patterns vary without a clear rationale. At the Northern California Youth Correctional Center (NCYCC), the CMO is administratively responsible for 4 facilities, with 3 staff physician allocated to the 4 facilities. Three physicians and a nurse practitioner are employed at Herman G. Stark Youth Correctional Facility. One physician is allocated to Preston YCF. The aggregate ratio of physicians to wards at the seven facilities surveyed is 1 to 262. This is more than adequate staffing for a population of this size and medical acuity. The CYA should address the allocation of physician resources. CMOs should provide some direct patient care. This is not done at all facilities, and thereby reduces the availability of physicians.

Aside from the numbers of CYA physicians, a more important issue is the mismatch between health needs of the wards and training of the CYA physicians. We reviewed 15 credential files of non-psychiatrists practicing in the CYA. Only six were Board Certified in a field acceptable for primary care in the CYA (Pediatrics, Medicine, or Family Practice). The skill level of other physicians relative to the needs of the wards is questionable. Based on chart reviews, those physicians with only internships or with training in surgical specialties lacked knowledge in appropriate treatment of medical conditions (asthma, diabetes, hypertension, thyroid disease, etc.).

Despite adequate numbers of physicians, there are practices that result in low productivity and reduced access to wards. For example, although we found no policy describing this practice, full-time physicians work 32-hours/week versus a 40 hour/week, because they are credited 8 hours for providing on-call services after hours. In addition, one physician reported that he can be present at the facility (Northern Youth Correctional Reception Center) for one hour per day, but is paid for 8 hours.

At the NCYCC, the CMO has a full-time private medical practice in addition to full time employment with the CYA. This raises the question of how much of the physicians' time is actually devoted to the CYA. Staff reported that if a physician at the NCYCC returns to the facility after normal business hours or holidays, the physician is granted 4 hours compensatory time off (CTO) even if the physician is on-site for only one hour. Staff also reported that one physician was off approximately 3 months per year as a result of accrued leave time (annual and sick leave and CTO). Therefore, although adequate numbers of physicians are employed, it appears that the CYA does not receive the full benefit of these positions.

Nursing Staffing

With the exception of the Northern California Youth Correctional Center (NCYCC) that provides 16 hour, 7-day per week nursing coverage, staffing patterns of CYA facilities provide 24 hour, 7-day per week coverage. A Supervising Nurse (SN) is employed at each facility. In addition registered nurses (RNs), licensed vocational nurses (LVNs) and medical technician assistants (MTAs) are also employed.

The number of nursing staff required at each facility depends, in part, on the mechanisms of service delivery. For example, if sick call or medication administration services are centralized in the main medical unit, fewer nurses are required. If services are decentralized, requiring the nurses to go to the housing units, then more staff is required because these services must be delivered within narrow time frames.

CYA policies and practices regarding delivery of these services are not standardized from facility to facility. At the Northern YCRCC and EL Paso de Roblas YCF, wards come to the main medical clinic to receive medications. At Ventura YCF, and Herman G. Stark YCF, the nurses go to the housing units. At N.A. Chaderjian YCF, the majority of medications (except psychotropics and narcotics) are delivered by the Correctional Youth Counselors (YCCs).

Primary care (sick call) is delivered by nursing staff in the housing units except at Herman G. Stark where the physicians and nurse practitioner conduct sick call, and at El Paso de Roblas YCF where sick call is conducted in the main medical clinic.

Given the varying practices of health care delivery at each facility, it is difficult to accurately estimate the number of nurses required statewide. However, it is our belief that staffing at N.A. Chaderjian is insufficient based upon the need to have Youth Correctional Counselors administer medications. In addition, at Ventura YCF, only one nurse is staffed on weekends in the main medical unit. This means the nurse must leave the main medical unit if there is an emergency in the facility. This poses a dilemma if a ward is also housed in the OHU for medical reasons.

Pharmacy Staffing

With the exception of Preston Youth Correctional Youth Facility (PYCF), each facility provides in-house pharmacy services. The seven sites reviewed employ six pharmacists and three pharmacy technicians. This is a pharmacy staff to ward ratio of 1 to 386. This is more than adequate staff.

It was noted that some practices of the pharmacists are inefficient and labor intensive. At NYRCC, Preston YCF, and Herman G. Stark YCF, the pharmacists dispense each prescription on a daily, twice weekly, or weekly basis, when the prescription could be dispensed once for up to a 30-day period. This practice is inefficient and results in pharmacists not addressing other important duties, such as establishing Standard Ward Inventory (SWI) controls and checking expiration dates for medications that are stored outside the pharmacy.

Another example of inefficient practices is found at Herman G. Stark YCF. Staff reported that when the nurses pick up the medication to take to the housing units, the pharmacists and nurses jointly count the medication in each dispensed package. The nurse signs that she has received the specified quantity of medication. This practice was instituted because of discrepancies in what the pharmacist dispensed and what nurses stated they received. This is labor intensive for both the pharmacists and nurses.

Dental Staffing

According to the California Department of the Youth Authority Dental Standards of Care (February 1999), dental services for the wards in the CYA are provided by 17 dentists, 3 chief dentists, and 19 dental assistants. In October 2002 there were 5730 wards in the CYA. This is a dentist to ward ratio of 1 to 286 that is more than sufficient staff to care for the dental needs at the 11 CYA facilities.

Since these are clearly sufficient numbers, it would be more appropriate to perform an ongoing evaluation of productivity of the existing dentists. One particular problematic site, in terms of access, was Chad. At the Chad facility, the dentist sees an average of

three wards a day because wards are not transported to the dental office due to security issues. In addition, the dentist at that facility had a narrow interpretation of the scope of work required (see Dental Standards of Care). Therefore, at Chad, the dentist performs no preventive work. Instead, he primarily conducts emergency evaluations in response to ward pain. This is not in keeping with the existing dental standards.

Medical Record, Laboratory and Radiology Technician Staffing

Each of the facilities reviewed employed a health record technician. This staffing appears to be adequate.

The Northern YCRCC is the only facility with a licensed clinical laboratory. A .75 FTE laboratory technician is employed at the facility. Only syphilis (RPR) screening and urinalysis testing is performed in-house. There is a statewide contract with Unilab, which performs all other lab testing. This is more than adequate laboratory staffing.

Radiology services are provided on-site at each facility, ranging from a 0.1 to a 1.0 FTE. The volume of x-ray films is relatively low and required most often for ruling out fractures. At Herman G. Stark YCF, a full-time radiology technician is employed. A review of the radiology log for the months of September-December 2002, showed that on average, 3 wards a day required x-rays. At the Northern YCRCC, a .50 radiology technician is employed. An average of 3-4 wards a day required x-rays. This is more than adequate radiology technician staffing.

Recommendations:

1. At the CYA Headquarters level, Security and Health Care authorities should standardize policies and procedures regarding mechanisms of health care delivery at the facilities. With the exception of lockdown units, centralization of services is recommended to reduce staffing requirements.

2. Following the standardization of policies and procedures, CYA Headquarters should conduct a comparative review of health position assignments by site and re-allocate positions based on medical and security needs such as medical mission, size, etc.

3. With regard to physician hiring practices, the Chief of Health Services Division should preferentially hire physicians with Board Certification in Pediatrics, Medicine or Family Practice. To most appropriately use current staff, consider consolidating wards with chronic illness at facilities with physicians Board Certified in a primary care field so that care is appropriately provided.

4. The Chief of Health Care Services Division (HCSD) should review physician scheduling practices, work expectations, and productivity. Physicians should be

compensated for hours worked. Taking call and some direct patient care should be part of routine expectation of the CMO.

5. Given the low medical acuity of the wards, and small facility size, nurse staffing should be re-evaluated. If patients with diabetes and significant chronic disease are classified to only certain facilities, nurse staffing could be reduced to 16 hours per day versus 24 hours per day at some facilities without such patients. To evaluate this further, a study should be undertaken for 3 to 6 months evaluating the number of urgent events that occur on the night shift and to an alternate classification system to redirect wards with chronic illness to specific facilities.

6. At a minimum, pharmacy labor practices should be reviewed to increase efficiency.

7. Strong consideration should be given to outsourcing pharmacy.

8. Routine radiology services may be able to be outsourced provided that there is a mechanism for emergent and urgent radiology services.

9. It is not cost effective to have a licensed laboratory and .75 laboratory FTE at Northern YCRCC for the purpose of conducting in-house syphilis and urinalysis testing. It is recommended that the laboratory is closed and all laboratory testing be performed by the reference laboratory.

10. CYA Headquarters should perform a productivity analysis of each dentist, based on patients seen on a daily basis. Performance standards for dentists should be developed, implemented, and monitored to meet community standards. As referenced above, policies and procedures should be developed and enforced to improve ward access to dental care.

2. Is the CYA's medical and dental staff appropriately trained and supervised?

Conclusion:

The CYA's medical and dental staff is not appropriately trained because there are no adequate orientation and training programs, policies and procedures, nor clinical guidelines to guide staff. In addition, the credentialing process for physicians is inadequate and does not ensure that competent physicians will be hired. Once hired, clinical supervision of physicians is virtually non-existent.

The absence of these components in the health care program is due to an absence of clinical and administrative leadership at the statewide level.

Findings and Discussion:

The provision of an adequately trained and supervised staff requires:

- Appropriate guidance and oversight of a Statewide Responsible Health Authority
- Development and implementation of standardized policies, procedures, and clinical guidelines
- Orientation and training to the respective policies and guidelines
- Periodic monitoring and oversight to ensure policy compliance

Each of these areas is discussed below.

Statewide Responsible Health Authority

The CYA does not have a single medical authority actively responsible for delivery of health care to wards. The CYA Chief of Health Care Services, Dr. Jerrold Wheaton, has implied supervisory role over physicians, but this relationship is ambiguous, not clarified in writing, and not evident in practice.

We reviewed a proposed table of organization for the Health Services Central Office that creates centralized supervision of health care staff. However, this proposal has not been enacted. Currently, there is no Table of Organization that delineates reporting relationships, and responsibility for health care delivery is diffuse, misunderstood, and ambiguous.

In his Duty Statement, Dr. Wheaton has the responsibility to plan, operate, evaluate, and monitor the cost and quality of health care services to wards of the CYA. There is no

accompanying supervisory authority with this responsibility. Therefore, the practical effect is that Dr. Wheaton serves only in an advisory capacity to the CYA. He indicated to us that he has no authority to supervise physicians. He is authorized to write policy, but he has no de facto authority to enact or establish changes in practice because he doesn't supervise anyone in the field. The result is confusion and an absence of medical leadership. Physicians simultaneously recognize Dr. Wheaton as the Chief of Health Care Services, but in interviews there was no agreement amongst physicians as to what was Dr. Wheaton's role.

The California Code of Regulations, Title 22 requires the CYA to establish Correctional Treatment Centers (CTC's), which are licensed health care facilities. Dr. Wheaton indicated to us that he spends all of his time initiating and organizing the Correctional Treatment Centers (CTCs). However, the amount of time Dr. Wheaton has dedicated to the CTC problem diverts management attention from the substantial issues involving day-to-day care of the wards. In addition, based on the medical acuity of wards at the facilities we visited, it is our opinion that very few wards will need Correctional Treatment Centers, as proposed, for medical care. Most moderately ill patients can be handled in well-run outpatient housing units. There has been no estimate of the projected need for CTC beds specifically for medical patients. These beds are most needed in the area of mental health. Nevertheless, Dr. Wheaton has interpreted the requirements of Title 22 in a global manner and has organized the entire health care operation as if it were a CTC. This is misguided, inefficient, ineffective, and expensive.

It is also our opinion that Dr. Wheaton's interpretation of Title 22 requirements, specifically regarding administration of the medical staff, is overreaching and unnecessary. Routine medical care at the CYA is fundamentally outpatient primary care medicine provided by an employee-unionized medical staff that should be organized much like a health maintenance organization.

CYA Bylaws

Effective leadership requires a recognized statewide health authority. However, Dr. Wheaton has authored Bylaws that attempt to organize the medical care system in a manner similar to a hospital composed of a large group of private practitioners who have unique and individual financial interests in the management and rules of the hospital. The plan of organization, therefore, does not match the needs of the CYA or the qualifications of the staff. The practical effect is an abdication of health care authority and accountability.

Bylaws are customarily the "operating manual" for a medical staff that is developed by, agreed to, and adhered to by an independent medical staff. However, the only physician contributor in writing the CYA Bylaws was Dr. Wheaton. The Bylaws are complicated and difficult to understand and the medical staff does not see the Bylaws as their "operating manual." Virtually all of the physicians we spoke to did not understand the Bylaws; some did not understand their responsibility or the responsibility of the officers of the medical staff as described in the Bylaws.

Nevertheless, all individual physicians are required to participate in committees and vote for officers even though they do not understand the responsibilities of the positions for which they are voting. In addition, some physicians do not have the administrative or clinical abilities required to provide the designated responsibilities. The expected result is indifference in participation by most physicians and ineffective supervision and management of the health care program. For example, the current Chairperson of the Infection Control Committee did not understand fundamental issues involved in Infection Control in a correctional facility, yet he is responsible for that function.

The Chief of Staff role as delineated in the Bylaws is concerned with "professional health services in a consultative leadership role." The Chief of Staff is, therefore, a clinical and professional leadership role. Yet this is an elected position subject to personality, willingness to serve, and availability. There is no guarantee of ability in an election.

Many of the physician staff is poorly trained in medical leadership and some are poorly credentialed to consult other physicians regarding medical care decisions. The most frequent training history of the existing medical staff is an internship only. Given this fact, how could someone with such limited training provide guidance on clinical issues to the medical staff. In fact, the most recent elected Chief of Staff had his election reversed because he did not attend the required number of meetings.

Under the CYA Bylaws, it is also possible for a staff physician whose only training is an internship to become Chief of Staff and have consultative responsibilities to his (her) CMO or to physicians who are Board Certified in a medical specialty. It is also entirely possible, given the current organizational structure, for an incompetent physician or a physician with poor judgment to become the clinical and professional leader of the medical staff. These are all undesirable but real scenarios.

Customarily, an Agency Medical Director provides the responsibility for supervisory leadership of a correctional health care program. In the CYA Bylaws, that role has been re-distributed to staff physicians and CMOs, some of whom are poorly trained to provide supervisory leadership and who are otherwise entirely engaged in provision of medical care at their respective facilities. This organizational structure is poorly designed and is unlikely to result in adequate clinical leadership or clinically sound programs. This situation also reflects poorly on the leadership abilities of the current Chief of the Health Care Services Division who designed and supports this system. There is very little appropriate clinical guidance or supervision provided to the medical staff, which very much operates without supervision, direction, or support.

Budget and Administration

There is no statewide budget for health care in the CYA. Superintendents of individual facilities are responsible for the medical care budget at their site. Because individual superintendents are not trained in health care administration, there is poor to little oversight of health care expenditures. This is especially obvious in the area of pharmacy, where lack of inventory control and basic pharmacy management skills results in excess

inventory and considerable waste of resources. We estimate very conservatively over $400,000 in excess inventory statewide.

Other administrative functions, such as scheduling, supervision of non-clinical staff, supply management, etc., are very much a local effort and in some cases are unsupervised. Distribution of medical resources is not planned on a statewide basis. Therefore, there is uneven distribution of resources and staffing through the system. One facility (Preston YCF) did not have physician coverage when the CMO was on vacation, yet Herman G. Stark YCF has three physicians and a mid-level practitioner even though there was only one examination room in which to see patients. Statewide coordination of resources by the Chief of Health Services Division would ensure better distribution of resources.

The CMOs are responsible for the administrative management of the health care program, but lack expertise and training in this area. As a result, management of the health care units is not business-like or thorough. There is no standardization of administrative, non-clinical processes in the medical units. There is not a single person in the CYA who could responsibly discuss the cost of care, expenditures for health care, or the administration of the statewide health care program in a manner that demonstrated operational efficiency, standardization, and accountability. Although CYA reports* indicate that in fiscal year 2002/2003, it cost $49,200 to house each ward, the CYA does not know how much it spends on health care overall, nor can it breakdown expenditures according to category (pharmaceuticals, hospitalizations, etc.). This lack of administrative oversight creates operational deficiencies and additional costs. CMOs should provide clinical administrative management, but appropriate administrative support for business functions could free up time for CMOs to provide some direct patient care. This type of arrangement would be a better use of resources.

*CYA Fact, Department of Juvenile Justice, October 2002.

Monitoring and Oversight

Adequate clinical supervision of medical, nursing, dental and pharmacy practice requires a process of periodic on-site review by professionals qualified by training and experience to conduct such reviews at a statewide level. In addition, the reviewer should be empowered to make changes should deficiencies be found. The Health Care Services Division does not have a formal program of clinical oversight that results in routine review of clinical and nursing practice.

In the CYA, the CMO reports to the Superintendent of the facility. By CYA policy, the CMO is responsible for the "public health" of the wards. The Superintendents are responsible for completing the performance evaluations of the CMOs. (NOTE: We did not review the performance evaluations of the CMOs.) A layperson, such as the Superintendent, is not qualified to review the clinical performance of physicians.

As a result, a qualified medical person does not evaluate the clinical performance of the CYA physicians in a formal or reportable way. We believe that this has a detrimental impact on health care and contributes to ongoing substandard clinical care in several facilities we visited. A physician must supervise practicing physicians.

The Peer Review function as described in the CYA Bylaws could be an opportunity to evaluate medical care. However, there is no mechanism for the Peer Review Committee to evaluate physician practice in an organized manner, and in practice the Peer Review Committee is not engaged in any meaningful evaluations of physician practice.

The Statewide Director of Nurses is a position that has no line authority over CYA nurses. She does not have clinical authority to guide nursing practice in the CYA. At each facility, the Supervising Nurse reports to the CMO. Therefore, if the CMO does not concur with the Director of Nurses, her recommendations are not enforced.

In addition, there is no oversight of pharmacy practice or expenditures in the CYA. During our reviews we found varying and sometimes questionable practices of medication storage, dispensing and administration.

Policies and Procedures

Written policies and procedures are essential to establish clinical standards and practices, and should be used to orient and train staff. Clinical practices and processes at facilities we visited were not guided by standardized policy or procedure.

Staff at most facilities indicated that they referred to *The Department of Youth Authority Medical and Dental Services Institutions and Camps Manual* as their policy and procedure manual. Staff could also produce, when requested, a facility-specific policy and procedure manual that contained a variable number of medical policies. These manuals varied from site to site. However when we asked staff members regarding their use of the policy and procedure manual, there was a general lack of recognition at virtually all sites. In some cases, staff did not know if there was a policy and procedure manual.

In summary, there was no standardized policy and procedure manual that guides clinical or medical administrative practice at all facilities.

Developing Policy and Procedure

There is no established mechanism to develop policy or procedure. It was reported to us that Dr. Wheaton drafts all new policies and procedures. The CMOs do not participate in development or review these documents. They view policy development as top-down and non-collaborative. In addition, the Director of Nurses, Deborah Pettigrew, does not have the authority to develop or provide meaningful input regarding policies related to nursing practice. She is provided the opportunity to comment on policies developed by Dr. Wheaton, but does not receive feedback regarding her input. Policies are not reviewed and updated annually.

In the absence of timely policy development and distribution, Dr. Wheaton issues policy-type positions in memos to the staff. This is generally not acceptable practice for routine issues. This ad hoc policy-by-memo practice increases confusion, does not provide staff with information on the rationale for the new practice, and in some cases does not appropriately define the policy change. As an example, a Supervising Nurse reported that directives from the HCSD are often unworkable, because the memos are generated without consulting personnel who have to carry out the directive. When she calls Dr. Wheaton to seek direction, he tells her to do it differently than the published memo. It was her belief that different facilities are given different direction verbally.

Another example was a memo from Dr. Wheaton that prohibited PRN medication. PRN is medication that is used only as needed. There probably was a reason that resulted in this policy-memo change, however, the unintended consequence was confusion. PRN medications are necessary for routine care. For example, most pain and asthma medications are prescribed PRN as a matter of practice. When this memo was distributed, physicians were given no options for alternative methods of prescribing "as needed" medication. Because the memo did not make sense, physicians either ignored the memo or changed prescriptions to routine dosing, which is not always clinically appropriate and is possibly wasteful of staff time.

When Dr. Wheaton develops policies and procedures that impact institutional operations (sick call, transfers, etc.), there is no apparent participation by custody staff as would be evidenced by a sign-off on the policy. Training on new policy is never done.

Current Policy Manual

Because the policy manual most often referred to by staff was the *Medical and Dental Services Institution and Camps Manual* (dated October 11, 2002), we reviewed that manual as the standard policy and procedure manual. (There is a draft revision of this manual dated January 2, 2003, however this version has not been implemented.) We have detailed our concerns about this manual in the following information.

The current policies in the *Institution and Camps Manual* (10/11/2002) do not address key aspects of health care structure and services as outlined in the *NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities*. For example, the following are not addressed:

- Orientation Training for Health Services Staff (Y-27)
- Continuing Education for Qualified Health Care Professionals (Y-20)
- Medication Administration Training (Y-22)
- Daily Handling of Non-Emergency Medical Requests (Y-38)
- Sick Call (Y-39)
- Health Evaluation of Juveniles in Segregation (Y-40)

- Pharmaceuticals (Y-29)
- Infirmary (i.e., OHU) Care (Y-52), as well as others

Some policies include procedures that provide specific guidance to staff (Informed Consent, Section 6168), while other policies provide no procedure outlining how the policy is to be implemented (Sick call).

Many policies in the current *Institutions and Camps Manual* reflect irregular practice or less than acceptable standard of care. As examples:

One policy says if a ward refused preventive TB treatment or treatment for Hepatitis C, they should be given counseling. The policy offers no guidance as to what they should be counseled about. Additionally, wards who refuse TB prophylaxis are to be housed in an "infection control room" until proven non-infectious. The definition of "non-infectious" is unclear. If the ward had TB disease, they would not be given prophylaxis therapy. If the patient only has TB infection, they are not infectious to others. This policy is misguided, and demonstrates poor knowledge of TB infection and disease. However, since there is no other infection control policy or infection control manual to which CYA staff can refer, this would be the policy followed by CYA staff.

The tuberculosis screening policy is inappropriate and does not follow Centers for Disease Control (CDC) standards. The existing policy requires that a Mantoux (TB) skin test be performed upon intake, repeated every April during a statewide testing program, and repeated whenever a ward is transferred to a different institution or returns from out-of-court or "overnight absence." The test is repeated again 30 days after the transfer or absence. As wards are frequently transferred, this practice inevitably results in testing far in excess of Centers for Disease Control standards and is not clinically appropriate or sound from an infection control perspective.

The policy on examination after return from furlough, escape, or parole is not clinically sound. Notably this policy includes:

- Isolation upon return until "medically cleared."
- High-risk behavior requires a chemistry panel and encouragement to take an HIV test. (High-risk behavior is not defined.)
- A hepatitis panel if intravenous drug has occurred.
- Evidence of lice requires in-patient treatment

There is no clinical rationale for any of these practices.

The *Institutions and Camps Manual* policy on examination of food service workers requires a chemistry panel and a Mantoux test. There is no clinical evidence to support requiring these tests. A policy states that no ward with an infectious disease may be a food service handler. This policy applies to wards with communicable diseases that are not transmitted by food handling (TB infection, hepatitis B, C, HIV, etc.). This policy does not make sense in the light of how these infections are transmitted.

There is a policy describing a "Medical Utilization Review Process" which describes a process to ensure appropriate use of health care services and resources. However, for all practical purposes, this process does not take place in the facilities in a meaningful way.

The policy for medication administration permits officers or correctional youth counselors to deliver medication to wards if there are insufficient nurses. This is inappropriate.

Since medical clearance is required for wards that may be assigned to a work camp, clear medical policy guidelines should be provided in the manual.

The draft *Institutions and Camps Manual* policies (dated 1/2/2003) are more comprehensive and are cross-referenced with NCHHC Standards. However, as with the current policies, they do not provide procedural guidance as to how each policy is to be implemented. The result is no standardization of practice in the CYA.

Clinical and Nursing Treatment Protocols

The Central Office produced a *Treatment Guideline Manual* that has some useful guidelines. However, there is no evidence that anyone actually uses the manual, in part because it is not user-friendly. In addition, the choice of topics in this manual is not reflective of the types of conditions that affect, or are likely to affect, the wards. For example, it is unlikely that any of the wards will acquire strongyloidiasis, amebiasis, anthrax, or brucellosis (all topics in the *Treatment Guideline Manual*).

Also, clear and adequate information on the eight most common medical conditions or interventions based on CYA statistics (vaccination, TB screening, asthma, diabetes, hypertension, hypothyroidism, medical clearance for camp, and epilepsy) is lacking in the *Treatment Guideline Manual*. For other conditions that are referenced, such as HIV infection, the treatment information is not current and uses terminology that is obscure.

Some information in the *Treatment Guideline Manual* should be updated and peer-reviewed by persons knowledgeable in the areas of concern. Some information also needs to be rewritten for accuracy and pertinence to the CYA. For example:

- Folliculitis, furuncles, carbuncles and abscesses are different conditions that are medically treated differently. Folliculitis, which is seldom treated with antibiotics, and abscesses, which are often treated with antibiotics, should be separated from furuncles and carbuncles, which may or may not be treated with antibiotics. The choice of antibiotics for skin abscesses should be reviewed for appropriateness. Culture should be incorporated into evaluation of abscess due to the resurgence of Methicillin Resistant Staphylococcus Aureus (MRSA).
- The impetigo protocol is not clear. It appears that two antibiotics are recommended for treatment.
- The otitis externa protocol does not differentiate mild from severe disease and does not give guidance on when to use antibiotics. This will probably result in inappropriate overuse of oral antibiotics.

- The protocol on acute pharyngitis should be clear that treatment is begun only after a positive culture is obtained.
- The asthma protocol should be combined into a single protocol. It should be simplified so that it is understandable and gives clearer guidelines. We recommend utilizing the NCCHC guideline for asthma, or the *Guidelines for the Diagnosis and Management of Asthma*. The NCCHC Guideline can be obtained free from http://www.ncchc.org/links/clinicalguides.html. The Guidelines for the Diagnosis and Management of Asthma can be obtained from http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm. The CYA protocol should emphasize nurse education on inhaler use, peak flow assessment, and indications for using rescue vs. maintenance therapy and correctional issues such as when to permit keep on person medication. There should be guidance provided to nurses regarding how to assess wards during off-hours and guidance to physicians on telephone triage for this condition.
- There should be sections on hypertension and epilepsy. For hypertension and epilepsy, the NCCHC guidelines can be used. As an alternative, a guideline can be written referencing the "Joint National Committee for the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC-7), which can be located at http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm.
- Use of amitryptiline or imipramine should be discouraged for dyspepsia. We strongly urge reviewing the dyspepsia protocol with peer review. The protocol does not differentiate dyspepsia from peptic ulcer disease and therefore will result in confusion on issues of therapy.
- There are two diabetes protocols, which are not in agreement. This is very confusing. A single protocol should exist based on NCCHC guidelines or on guidelines from the American Diabetes Association (http://care.diabetesjournals.org/content/vol26/suppl_1/#POSITION_STATEMENTS). These protocols should be improved for clarity and direction.
- The protocol on diabetic ketoacidosis is mostly didactic and does not provide appropriate practical clinical direction. For example, one problem in the CYA is that providers do not seem to understand the simple clinical scenario that if the blood sugar is high (over 350 to 400), urine ketones should be checked to assess for ketoacidosis. This fundamental direction is not present in the *Treatment Guidelines Manual*. It is clear from chart reviews that some of the physicians do not understand, or ignore this fundamental issue.
- "Thyroid Malfunction" is the title for a protocol about thyroiditis, one of many thyroid conditions. It would be better to have protocols on hyperthyroidism and hypothyroidism. It was clear from chart reviews that one physician did not know the difference between these two common conditions.
- The section on anemia should be revised after peer review for content. The section on sickle cell anemia is fundamentally and clinically inaccurate. The statement that "Hydroxyurea is the only effective treatment" for sickle cell

disease is inaccurate and if used, this information will be harmful to wards. One ward that did have sickle disease was mismanaged cruelly, without adequate pain medication and fluids, nor timely evaluation for infection. The current protocol would not have helped in his care. This entire section should be revised since it gives incomplete and inaccurate information.

- The guidelines for head trauma and head injury are confusing and give poor direction. These should be revised with peer review.
- The protocol on HIV is out-of-date with contemporary standards of care and should be revised with peer review. This is not a condition that should be managed by in-house physicians in the manner indicated.
- The "Hepatitis Diagnosis and Treatment" protocol requires unnecessary testing that will raise costs. It calls for screening all wards that have elevated liver tests with a complete hepatitis panel that tests for hepatitis A, B, and C. It is not necessary to screen for Hepatitis A because chronic ongoing infection is rarely present and most wards will have already been vaccinated for hepatitis B and therefore test positive. Therefore, the complete panel will usually be unnecessary and raise the cost of the screening by approximately about $40 per test.
- Hepatitis C treatment should be addressed in a separate protocol. The manner of addressing Hepatitis C is superficial, clinically confusing, and will result in high cost without clear clinical benefit. This protocol should be carefully developed with peer review. We suggest that the CYA get consultation from the California Department of Corrections (CDC) Medical Division for this protocol.
- The "Hepatitis Check Sheet" is a very confusing protocol since it is not clear what it is for. This protocol should be eliminated or substantially revised.

There is a virtual lack of guidance for nursing assessments or procedures. At several institutions, staff reported that they were aware of Standard Nursing Procedures that consists of 5"x 8" cards with typed directions for the management of athlete's foot, poison oak, asthma, and head injury. These cards had dates ranging from 1987 to 2000. In some cases, typed sentences were crossed out with new directions documented. The protocols contain no references. Staff reported that they have received no training regarding these Standardized Nursing Procedures.

Credentialing

Credentialing is a review process that verifies the identity, training, experience and competence of an individual professional practitioner. Credentialing is an essential part of selecting professional staff to hire and will determine the composition and strength of the medical staff. In addition, the credential process normally grants "privileges" to practitioners. Privileges are medical or psychiatric procedures or practices that an individual professional is allowed to perform based on their training and experience.

Credentialing in the CYA is performed according to directions in the CYA Bylaws. However, the Bylaws are poorly written and provide incomplete direction for appropriate credentialing. Keys points of credentialing in the CYA as derived from the Bylaws are:

1. The CYA Personnel Selection Section provides the credentials committee with a list of applicants for a professional position.
2. The Credentials Committee consists of the Chief, HCSD, the Chief of Staff, and other members appointed by the Health Services Executive Committee.
3. The Chief HCSD is authorized to query the National Practitioner's Data Bank (NPDB).
4. A member of the Committee queries other societies and boards regarding the applicant.
5. Information from the NPDB is sent to the CYA Division of Personnel Selection Section in order for them to make their selection. There is no guidance on what information should be sent to the Personnel Selection Section.
6. The CYA Personnel Selection Section interviews candidates and they choose the physician(s).
7. The actual process of credentialing as performed by the credentials committee is not delineated. What that Committee does is determined in large part by the ability and knowledge of the Chief of Staff who is responsible for organization of the Committee. If someone inexperienced in credentialing is in that position, evaluation of candidates for staff will suffer.

Deficiencies in this process are described in the following:

1. Licensure and other professional regulation requirements are not specified in the Bylaws. It is not clear in the Bylaws whether it is a requirement to have a medical license or Drug Enforcement Agency license to practice in the CYA.
2. There are significant deficiencies in the existing credential application. The credential application does not include questions regarding substance control license verification, primary verification of license, queries regarding substance abuse or physical impairment to practice, prior malpractice claims, prior revocation or refusal to grant hospital privileges or prior felony convictions. All of these questions should be asked and it should be required to answer all questions on the form. There is a new proposed form that is satisfactory, but it is not yet being used.
3. Nowhere do the CYA Bylaws establish that a physician or group of physicians make the judgment on the competency of professional candidates. In fact, evaluation of competency is not described in the credentialing process. It appears that the role of the Credentials Committee is secretarial in nature. It is not even clear that their function is advisory. Their direction is to query professional information sources for information on the candidate. Based on the Bylaws, the CYA Personnel Selection Section is responsible for the judgment of deciding

which candidates to choose for professional service. Because the process is a civil service selection process, the role of the Credential Committee is to merely rank individuals. By written policy this process should be described. As well, there should be criteria for which a physician can be excluded from practicing in the CYA. Physicians should make judgments on competency of physicians and there should be the ability to exclude physicians from practicing in the CYA who are unlikely to know how to treat most medical conditions of the wards.

4. There is no established written procedure or process for granting privileges. A physician who requested privileges was not granted them by the Credentials Committee, but the Chief overruled this recommendation. The rationale for this decision was not entered into the credential packet of the practitioner.
5. The credentials process does not ensure that physicians treating wards have core competencies in the specialty areas of medicine related to wards in the CYA.
6. The secretarial work delegated to the Chairperson of the Credentials Committee is substantial. This individual is elected from the medical staff and already has full clinical and sometimes administrative responsibilities at one of the facilities. This work should be the responsibility of the Chief of the Health Care Service and her/his staff.
7. No administrative support is provided to the Chief of Staff who is delegated with responsibility for the clerical function of collecting credential information and passing it on to the Selection Section. Existing credential files, ostensibly containing sensitive personnel information, are maintained in a cardboard box in a physician office.
8. Physicians do not understand or participate in the credential process. One Chief Medical Officer was unaware of the credential status of physicians working at his site. Several physicians we spoke with didn't know the meaning or purpose of credentialing. One doctor didn't remember if he filled out the forms. Another doctor, a CMO, didn't know what credentialing was all about. Another physician, who was not credentialed, remembers filling out a form but can't remember if he is credentialed. In addition, physicians do not completely fill out the application form. Some physicians do not answer questions such as "Has your license ever been revoked?"
9. Although the Bylaws authorize a National Practitioner Data Bank search, this is not occurring at all. All practitioner applications should include a query of their past history with the National Practitioner Data Bank.
10. It is also not established by policy, who will evaluate negative information obtained on the application and how the information will be evaluated. As an example, the proposed Application for Appointment to Medical Staff contains the following question: "Has your California license ever been revoked or had any restrictions placed on it ?" Based on the Bylaws, this information will be collected and passed on to the CYA Personnel Selection Section to pass judgment. Experienced professionals should make these types of judgments. There should be policy to delineate this.

11. Peer review should also be factored into credentialing decisions. There is no organized mechanism of peer review or other clinical reviews to identify critical physician deficiencies. Therefore, physicians may be credentialed who are unethical or otherwise deficient in medical practice. One glaring example is the case of the physician who for years had a policy of not prescribing narcotic medication to any ward for any reason. Such a physician should be reported to the California Medical Board for unethical practice. Yet, this practice was unnoticed for years and this physician was credentialed and in good standing in the CYA.

Not all CYA physicians are credentialed. However, the complement of non-psychiatrist physicians practicing in the CYA who are credentialed have varied backgrounds. There were credential files on 15 non-psychiatrist physicians. Of these, three were Board Certified in Pediatrics, one was Board Certified in Medicine, and two were Board Certified in Family Practice. Three physicians were trained in surgery but were not Board Certified, one was trained in Anesthesiology, and five physicians had internships only. This is not a good mix of training for a population of wards whose primary needs is for Pediatrics and Medicine or Family Practice.

Licensure Review

Licenses of professional staff were reviewed at each facility. With regard to licensure tracking systems, we were told that both the CMO and Health Care Services Division were responsible for tracking professional licensure. However, at several facilities, these tracking systems were not current. Some reflected licenses as outdated as 1999. However, when requested, all staff were able to produce current licenses except two psychology positions at the Northern Youth Reception Center. We were told that these psychologists are working under the license of another psychologist.

Orientation and Training

Current CYA policies (dated 10/19/2002) do not address orientation, training, and continuing education of health care personnel. Draft policies (dated 1/2/2003) state "Each institution shall develop and implement an orientation program for each employee." However, there is no guidance as to the required elements of orientation. In practice, each facility has developed their own orientation program that consists primarily of On-the-Job (OJT) training in the absence of statewide policies and procedures. One Supervising Nurse reported that she is expected to train her staff, but that she does not receive training from the Health Care Services Division.

Staff report that training is periodically provided by Cassie Jones RN, Statewide Public Health Nurse, regarding a variety of subjects related to public health, including annual staff recertification of TB skin testing, respirator fit testing, etc. According to staff, the training that provided, or coordinated by Ms Jones is the only consistent training provided in the CYA.

Position Descriptions

Position descriptions are functional job descriptions as opposed to civil service or union job classifications. They provide clarification regarding duties and are specific to the facility and to the position held. In general, the CYA does not have position descriptions for each job category, which can be used to orient new personnel, and guide temporary or agency health care personnel employed by CYA. At H.G. Stark, the Supervising Nurse had prepared position descriptions for approval by Headquarters, but the approval has not taken place and the position descriptions are not in place.

Recommendations:

Health Care Organization and Leadership

1. Re-evaluate the current Chief of the Health Services Division position, including whether the incumbent is the right person for this position.
2. Establish an organization structure that provides the Statewide Medical Director with supervisory responsibility over all physicians and dentists. The Director of Nurses should also have clinical authority and responsibility for nursing practice in the CYA.
3. Consider separation of clinical and administrative oversight of the medical program. Establish a statewide Administrator responsible for the administrative functions of the health care system. This could be the Medical Director provided that person is experienced in health care administration.
4. Establish a separate health care budget and accounting system, administered by the Medical Services Administrator. The health care budget should be itemized by type of expenditure (personnel, pharmacy, hospitalizations, physician fees, etc) so that these expenditures can be monitored and controlled.
5. Create a table of organization for the Health Services Clinical Division.

Administrative and Clinical Policies and Procedures

1. Establish a statewide, juvenile specific, health care policy and procedure manual that standardizes care statewide.
2. Ensure collaboration and sign-off by corrections at a senior administrative level of all policy and procedure.
3. The CYA headquarters HCSD should establish orientation and training programs for staff. In addition, facility health care leadership (medical, nursing) should establish local operating procedure describing how the statewide policy will be implemented at the facility.
4. Significantly modify the *Treatment Guideline Manual* to conform to accepted national standards of care, and to include all relevant conditions and processes of health care for juveniles. Ensure that the *Treatment Guideline Manual* has adequate peer review.

5. The Statewide Director of Nurses should develop and implement an appropriate statewide-standardized nursing protocol manual.
6. Eliminate the CYA Bylaws as the organizational structure of the medical staff. Substitute an HMO employee model with appropriate rules and regulations. Create simplified Bylaws to conform to Title 22 requirements for the CTCs only.

Oversight and Monitoring

1. Reassign credentialing to the Health Care Services Division to be the responsibility of the statewide Medical Director.
2. Ensure that the credentials process verifies that practitioners have up-to-date applicable licenses. Specify the requirements for practicing in the CYA.
3. Perform a National Practitioner Databank search for each physician on staff.
4. Evaluate all physicians regarding possible substance control problems, past or present problems with their license, physical or psychological impairments that may limit ability to practice, prior malpractice claims, prior revocation of license or revocation of hospital privileges, and any prior felony convictions.
5. Ensure that the credentialing process judges the competency of the prospective physician candidates and their ability by training, experience, and character to practice in the CYA. Consider outsourcing this function if the current arrangements do not change.
6. Guarantee the confidentiality and security of the credential files.
7. Initiate regular peer review and physician-directed evaluations of all physicians by the Central Office.
8. Establish an ethical standard, approved by the Director of the CYA and statewide Medical Director regarding pain management, physician practice, and physician autonomy.
9. The CMO and Supervising Nurse at each facility should establish licensure tracking systems and monitor to ensure that all staff has a valid license. In addition, the HCSD Statewide Medical and Nursing Director should audit licensure when making periodic site visits.

Orientation and Training

1. The CYA Headquarters Division should establish Continuing Medical Education (CME) guidelines for the medical staff.
2. The CYA Headquarters Division in collaboration with facility staff should create statewide-standardized job descriptions for every position in the medical area.
3. The Health Care Services Division Statewide Medical and Nursing Director should conduct periodic training needs assessments of staff. Training needs may be identified through auditing results as well as staff feedback regarding training needs.

3. Are the CYA's medical and dental records appropriate?

Conclusion:

The Unified Medical Record used by the CYA is a comprehensive and reasonably well-organized and adequate record-keeping system. There are some organizational issues, none of which makes the system inadequate.

Findings and Discussion:

Health Record Format and Content

The *Institutions and Camps Manual Medical and Dental Service* policies (10/1/2002, draft 1/2/2003) addresses the Unified Health Record, which is the primary method of record keeping used by the CYA. These policies discuss the initiation, transfer, storage and retrieval of health records when wards return to the CYA via parole revocation. The policies also address confidentiality of health record information and access and disclosure of confidential medical information.

The CYA Unified Health Record (UHR) is comprehensive. It is organized in the following manner:

- Ward name and allergies are noted on the front of the chart.
- Left side of record:
    - Alert Tab -This section contains Medical Restrictions, Medical Holds, Camp Clearance and Food Service Clearance;
    - Movement and Problem List Tab-This section contains the Movement and Problem List sheet which records the wards picture, admission and transfer dates and medical problems;
    - Database Tab -This section contains the following information: admission Ward Personal Information and Physical Examination, Ward Physical Condition, Intake Documents, County Health Records;
    - Public Health Tab -This section contains the wards Tuberculin Skin Testing, Immunization Record and History, Other immunization and public health records, and the Confidentiality Morbidity Report;
    - Medication and Treatment Records Tab -This section contains Medication Administration Records and Diabetic Record.
- Right side of record:
    - Top - Suicide Alert
    - Chronological Notes Tab-This section contains the Unified Health Record Transfer Review, Summary of Medical Record, Chronological Notes, and Prenatal Record

- Mental Health Tab-This section contains the Psychological Evaluation Report, Psychiatric Evaluation Report, YA-GAF Screening Report, SPAR: 5-Minute Suicide Watch Record, Mental Health Assessment, SPAR: Suicide Risk Screening Questionnaire, SPAR: Referral and Disposition, SPAR: Report of Suicidal Incident, SPAR: 15-Minute Suicide Watch Record, Other mental health reports.
- Dental Tab -The dental record.
- Diagnostic Reports Tab -This section contains x-ray and laboratory reports, electrocardiograms, electroencephalograms, audiograms and other diagnostic reports.
- Consultations Tab -This section contains consultant records, copies of off-site physician and hospital reports and records, and eye examinations charts.
- Consents and Authorizations Tab -This section contains Request for Court Order to Administer Anti-androgen Medication, Request for Court Order for Authorization for Treatment, Ward Rights, Involuntary Psychotropic Medication, Certification Hearing Notice, Notice of Certification, Correspondence, Subpoenas, Court Orders, Death Certificate, Autopsy Reports and Consents for HIV antibody testing, and HIV Counseling Forms.

Problems with Record Keeping

Although the organization and content of the health record by policy is comprehensive, there were some problems with its organization. These include the following:

1. The **Problem List** is not visible when the record is opened and often is not completed. This makes it more likely to not be reviewed or updated as necessary. In actual practice, we found this to be the case.
2. The **Consent for Medical Treatment** section is printed on the back of the Ward Personal History form (YA 8.252 (Rev 01/01). In practice, this form is being filed in the consent section of the record, not with the Database as dictated by policy.
3. The **Ward Personal History** form contains useful medical history information but is somewhat out of date with current consensus standards for preventive assessments of adolescents. A nurse collects the history, and there is no evidence in the records that the physician reviews or validates the information. It does not contain a signature line for a health care professional. During reviews of health records, none of the Ward Personal History forms were initialed as having been reviewed by a health care provider. This suggests this information is not considered when the physical examination is conducted.
4. The **Dental** section of the record is by policy not maintained in the Unified Health Record (UHR). This may result in the dental staff not being apprised of important medical information (allergies, need for antibiotic prophylaxis) that is learned after the medical reception process.
5. **Laboratory reports** are not consistently initialed and dated. This raises questions about whether or not they were reviewed and addressed by clinicians. HIV antibody test information is sometimes found in the consent section of the record

attached to the HIV testing consent form, rather than the diagnostic tests section of the health record.

6. **Consultant reports** are often not found in the record for wards that have gone off-site for care. In addition, we could seldom identify that the results of the offsite visit were documented as understood by the CYA facility physicians.
7. **Vaccination records** are inadequate and not well documented on a single record. A portion of the vaccination history is found in the Database section, and other information is found in the Public Health section. The vaccination history of every ward should be recorded on a vaccine administration record. Old records should be obtained from parents so that vaccination schedules can be updated.
8. **Parole revocators** receive only a brief questionnaire by a nurse using a "Transfer Information and Receipt of UHR" form. This form is inadequate because it does not update current changes in medical conditions and does not update outstanding appointments or laboratory records.
9. **Intake physical examination** forms do not include a section for a medical history by a physician. As a result, this seldom occurs. The physical examination form should be revised appropriately.
10. **Health record forms** are not referenced in the current *Institution and Camps Manual* policy manual. The exception is the Ward Personal Information form.

Transfer of Health Records

In the *Institutions and Camps Manual,* there are policies governing the transfer of health records. Staff reported that generally, health records are transported with the ward at the time the transfer takes place. There are occasions when the record was not transported with the ward, but this does not appear to be a significant issue.

Confidentiality of Health Records and Health Information

In the *Institutions and Camps Manual,* there are policies governing the access to and disclosure of confidential medical information (Section 6172). The policies are somewhat general. For example, they state that "Employees of the Department or the YPPB may access the health record if the requested information is necessary to perform their jobs" However, the policies do not state who makes the determination of the need to know, and who authorizes the release of information.

At N.A. Chaderjian, the staff reported that they provide the correctional staff a list of wards that have bloodborne infections such as HIV and hepatitis, by type of disease. Since not all wards are tested for all bloodborne infections, in practice this may undermine the concept of Universal Precautions, which states that all body fluids are treated as potentially infectious, not just the bodily fluids of infected individuals.

Recommendations:

1. The policy manual section related to the health record should be revised to incorporate the following:
    a. Move the problem list to the front of the record and require that providers update it as clinically indicated
    b. Separate the ward Consent for Treatment form from the Ward Personal Information form
    c. Revise the contents of the Ward Personal History form to include juvenile pertinent information
    d. Dental records should be maintained in the Unified Medical Record at all times. Dental staff should periodically review updated medical information
    e. Review and consider revision of the vaccination record to incorporate all vaccination information on a single form
    f. Revise the Intake Examination form to include a section for a medical history.

2. Establish policies requiring clinicians to initial and date review of laboratory, diagnostic and consultant reports.

3. The CYA HCSD should clarify policies regarding access to the health record, and clarification of authority to release confidential medical information.

4. Does the CYA appropriately screen incoming wards for medical and dental concerns?

Conclusion:

All newly incarcerated wards and parole revocators are medically screened. This screening, however, is inadequate because the current practice fails to thoroughly describe the medical conditions of wards, and fails to initiate appropriate treatment plans.

In addition:

- Intake screening laboratory testing does not conform to contemporary standards of care for adolescents.
- Parole revocators receive only updated laboratory tests, and are not physically examined. This should not be a discretionary examination.
- Sexually transmitted disease screening is inadequate for males.
- There is inadequate linkage with referral juvenile detention facilities and inadequate acquisition of medical information from civilian providers.
- Dental screening is appropriate and adequate for new intakes.

Findings and Discussion:

Reception Screening

The purpose of the medical reception process is to accurately diagnose current and potential health problems, and to develop an appropriate treatment plan that serves as a blueprint for care throughout the ward's stay in the CYA. The medical components of the CYA reception process are adequate. However, in practice, we found that medical examinations were cursory and insufficient, and treatment plans inadequate. Medical treatment plans initiated at the reception centers were not consistently implemented.

Wards are admitted to the CYA through one of three reception centers: Northern Youth Correctional Reception Center and Clinic (NYCRCC), Southern Youth Correctional and Reception Center and Clinic (SYCRCC) for males, and Ventura Youth Correctional Facility (VYCF) for females.

The medical reception process consists of the following:

- Vital signs, height, and weight

- Visual acuity and hearing screening
- Tetanus toxoid, hepatitis A and B vaccinations
- Ward Personal Information (medical history)
- Voluntary HIV counseling and testing
- Laboratory testing (CBC, serum chemistry with liver function tests, urinalysis,)
- Communicable disease screening (TB skin testing, syphilis screening, chlamydia and gonorrhea for females)
- Physical examination
- Pap smear and pregnancy testing for females
- Dental screen and examination
- Mental health screening and examination.

In addition, consents for treatment are obtained from all wards age 18 or above. Staff attempt to contact parents or guardians to obtain verbal or written consents for treating wards less than 18 years.

General Issues with CYA Reception Screening

The Medical Problem List is not consistently completed and is located in a section of the record that does not make it readily visible to clinicians or nurses.

The medical history information is collected by a nurse but not reviewed or validated by the physician conducting the physical examination. At a minimum, the physician should review and validate the medical history information with the ward. For wards with significant health problems, the physician should independently take a thorough medical history, which is not currently being done. Nurses also use a second form labeled the "Intake Questionnaire" form. Each of these forms results in a nurse-derived medical history.

The existing screening process contains very little preventive educational information for the wards, does not integrate vaccination information into the medical record in a useful format, and does not result in identifying wards who would benefit from preventive medical or counseling services. The Ward Personal Information Form should be modified and integrated into the treatment planning for each ward.

The actual physical examination of incoming wards is inadequate. Newly incarcerated wards receive a physician history and physical. There is a pre-printed physical examination form that physicians use for this purpose. In all of the records that we reviewed, the physician history as documented on these pre-printed forms was either incomplete or non-existent. Important historical information, if taken, is documented on a separate progress note. In reviewing records, this gives the impression that the physician is not taking any history at all. In most cases, physician history was incomplete or not done.

The physical examination form is a check-the-box, yes-no type form. This yields mindless data entry, and does not result in the physicians following up with important and necessary examinations, and occasionally results in inaccurate or incomplete entries. As examples, one ward diagnosed with severe asthma (he had been recently hospitalized)

who was not stable was listed as having normal lung examinations and did not even have a peak flow measurement taken. The rationale for the diagnosis of severe asthma was not indicated on the form. So, the reviewer is left with documentation that says the ward has severe asthma, but there is no evidence in the history or physical examination that there is a problem. One ward with a history of a cardiac murmur was listed as having a normal heart examination. There are multiple examples of this in record reviews. This leaves an overall impression that the examinations are not being done at all or are sloppy.

There are issues with timeliness of reports that impact the initial evaluation. Wards who have newly or previously positive TB skin tests receive a chest x-ray. However, reports may not be received for 1-3 weeks, which does not assure that active tuberculosis will be ruled out in a timely manner.

There is currently little-to-no collaboration with Juvenile Hall facilities in Los Angeles County. These facilities have useful and important screening and medical information to convey to health care staff. There are some communications to the Southern facility, but there should be a formal and routine linkage to county juvenile facilities that send wards to the CYA, so that useful and important medical information can be conveyed in an expeditious manner. This linkage could also be cost effective by reducing redundant testing for individuals for whom testing was performed at the Juvenile Halls.

Laboratory Testing

Reception laboratory screening is meant to screen for those age/gender specific conditions that affects the wards coming into the CYA. The intake blood tests currently performed do not conform to contemporary standards of care as based on recommendations from the U.S. Preventive Health Services Task Force, and supported by consensus statements of the American Medical Association (Guidelines for Adolescent Preventive Services- GAPS).

Currently, the CYA performs the following tests for all incoming wards:

- Complete blood count (CBC)
- Chemistry panel (chemistry 19)
- Urinalysis (at northern only)
- RPR (a screening test for syphilis)
- Voluntary HIV test
- Mantoux skin test for tuberculosis

Additionally, females receive a chlamydia and gonorrhea test, and a Pap smear. If their ALT (a liver function test) is abnormal on their chemistry 19 panel, they get a complete hepatitis panel, including Hepatitis A, B and C tests.

Some of these tests are unnecessary and should be eliminated because they have associated cost, their use is not supported by evidence, false positive testing will result in additional unnecessary testing, and the testing takes staff time.

Some tests should be added, specifically, chlamydia and gonorrhea testing for males.

The following comments address specific testing:

Complete Blood Count, (CBC). All incoming wards get this test. The only reason to utilize this test as a screening test is for iron deficiency anemia. The burden of disease in this population is too low to justify mass screening. Screening, therefore, is of little use in the adolescent population. There is fair evidence to support screening for anemia in pregnant women, but a CBC is included in the CYA prenatal test requirements. No professional group recommends mass screening of juveniles with a CBC. The United States Preventive Health Services Task Force gives CBC testing a "C" recommendation, which means that there is insufficient evidence to recommend for or against screening. Customarily this test is around $4 a test. We would not recommend mass screening with this test.

Chemistry 19 panel, (Chem 19). A chemistry panel is a group of multiple chemistry tests performed on a blood sample. The only test in this group panel for which there is a recommendation is for total cholesterol. The National Heart Lung and Blood Institutes' recommends screening with a total cholesterol for persons over 20 years once every five years. GAPS recommends that adolescents over 19 be screened for cholesterol at least once. They also recommend that all adolescents whose parents have elevated cholesterol or any family history of cardiovascular disease also be screened. GAPS also recommends that all adolescents with any risk factor for cardiovascular disease (smoking, hypertension, obesity, diabetes mellitus, excessive consumption of dietary fat) also be screened at any age. These criteria should be incorporated into an algorithm for intake screening rather than mass screening of all wards with a comprehensive test.

At the Ventura facility, wards with an abnormal liver function test (one component test of the chemistry 19 panel) are referred for a complete hepatitis panel. This is unnecessary in our opinion. Only hepatitis C testing is useful if chronic hepatitis is suspected. Hepatitis A is not useful to screen for as a chronic illness as it rarely causes chronic complications. For persons with modestly elevated liver enzymes, hepatitis A is not recommended. Most wards have been vaccinated for hepatitis B at intake and therefore will show evidence of antibody. If a ward has been vaccinated for hepatitis B, only hepatitis C testing is useful. The cost of testing for a complete hepatitis panel is around $50 versus approximately $9 for a hepatitis C antibody.

Based on 2 & 3 above, we would eliminate mass screening utilizing the chemistry panel. We recommend screening wards over 19 years of age with a total cholesterol (using the least expensive testing method), and recommend screening wards with a family history of early heart disease or high cholesterol or with any risk factor for heart disease with a total cholesterol. The number screened probably will be 20% of wards or less. Consideration should be given to screening only wards with a history of intravenous drug use for hepatitis C, but this should be done by directly testing for hepatitis C (ELISA) only ($8) versus screening all wards with a chemistry panel ($8) with a follow up of all abnormal liver functions with a complete hepatitis panel ($54).

A urinalysis test is performed on all wards. There is no evidence for mass screening with a urinalysis and no professional group recommends routine mass screening with a urinalysis. We recommend discontinuing this test.

Mantoux (TB) skin test. The Mantoux skin test is performed every time a ward transfers to another facility, even if the prior test was within a year. Some wards are tested as frequently as a week apart. This is not in keeping with current Centers for Disease Control Recommendations. Information on screening and treatment of persons with tuberculosis infection and disease in correctional facilities can be located the Centers for Disease Control website at http://www.cdc.gov/nchstp/tb/pubs/corrections/default.htm. The multiple repeat testing of wards should be eliminated and accurate record keeping of testing that is performed should be instituted. We recommend that wards be tested with a two-step test at intake and then once annually at the anniversary of their incarceration regardless of transfers. Accurate record keeping and linkage with Juvenile Hall facilities will assist in reducing redundant testing.

Sexually Transmitted Disease (STD) screening. The GAPS recommendations include screening sexually active youth (male and female) at whatever age for syphilis (RPR), gonorrhea and chlamydia. They also recommend screening all youths with risk factors for HIV. HIV testing does appear to be offered, but chlamydia and gonorrhea testing is only done for females. RPR testing for syphilis is being performed for all wards. Chlamydia and gonorrhea testing is already being performed at Juvenile Hall facilities, and appropriate linkage to other this county system and other county systems who refer to the CYA will improve public health data collection as well as reduce cost of testing by eliminating redundant testing. The addition of STD screening for males will raise costs. But, this cost increase may be offset by the savings of not doing the unnecessary tests as listed above.

All sexually active females should undergo a PAP test. It appears that this is being done.

Vaccination

Vaccination of adolescents is an important preventive and public health measure. Vaccination histories are being obtained at intake but are sometimes incomplete and are recorded in more than one location in the health record. The vaccination history of every ward should be recorded on a vaccine administration record. Old records should be obtained from parents so that vaccination schedules can be updated.

An appropriate form for this purpose can be obtained at the web site http://www.immunize.org/catg.d/p2023b.pdf. There is a statewide effort by the California Department of Health to track immunization histories of children. The California Statewide Immunization Information System (SIIS) is a program to improve immunization rates by creating a statewide registry of childhood immunization. The CYA should ask to participate in this program so that the registry is available at intake facilities and that all vaccinations are entered into the registry.

Vaccinations should be provided in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control. Their latest immunization schedule for adolescents can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5204-Immunizational.htm. Currently, the CYA does not appear to be updating the tetanus vaccine, is not vaccinating persons with sickle disease with pneumococcal vaccine, and is not vaccinating high-risk wards against influenza. Attention to vaccination should be greater.

Vaccination is provided to wards against hepatitis B. This vaccine is free for some wards under the Vaccine for Children program. All wards that have not yet been vaccinated with hepatitis B should be vaccinated. The National Childhood Vaccine Injury Act requires that all health-care providers give parents or patient's copies of Vaccine Information Statements before administering each dose of the vaccines listed in the schedule. Additional information is available from state health departments and at http://www.cdc.gov/nip/publications/vis.

Sexually Transmitted Disease and Blood-borne Disease Detection

Sexually transmitted disease screening and blood-borne disease detection is a public health activity and should be collaboratively developed with public health officials. No current arrangements exist with local or statewide departments of health in developing or tracking sexually transmitted diseases. Positive test results are reported to the State Department of Health.

The Centers for Disease Control recommends that correctional facilities and local departments develop written collaborative agreements for tuberculosis. The same should be done for sexually transmitted diseases. In this regard, it makes sense for the CYA to enter into collaborative discussions with the Los Angeles County Department of Health or the State of California Department of Health regarding sexually transmitted disease screening and tuberculosis screening.

Most of the juveniles entering the CYA come from the Los Angeles County juvenile hall system. Testing done in these institutions does not need to be repeated in the CYA. Thus, this collaboration would save money overall, if the CYA were to engage in clinically appropriate sexually transmitted disease screening. Additionally, juveniles who are identified with a contagious disease at a juvenile hall can get appropriate follow-up in CYA facilities.

We met with representatives of the LA County STD program and with Dr. Carmel Kadmka from the LA Juvenile Hall. Dr. Kadmka indicated the issue of communication between the Juvenile Halls and the CYA had been a problem in the past. Senator Burton had initiated a task force on communication issues between the Juvenile Halls and the CYA. There was a list of recommendations, but, according to Dr. Kadmka, nothing resulted from these discussions. Dr. Kadmka indicated that there was no participation from the medical leadership of the CYA in these meetings. The CYA sent a nurse to this meeting; physicians never attended. This is a lost public health opportunity for the CYA.

The CYA performs appropriate screening for sexually transmitted diseases for females. However, males do not receive screening that is consistent with contemporary standards of care. Based on recommendations by the US Preventive Health Service Task Force, (the most conservative recommendations), routine screening for syphilis, gonorrhea and chlamydia is recommended in selected high-risk male populations. The CYA juvenile population is high risk as evidenced by prevalence statistics from the LA County Juvenile Hall. According to these statistics, 5.4% of males in the Juvenile Halls tested positive for chlamydia, and 14% of females tested positive. At these numbers, both males and females should be considered high risk and screening for both groups is warranted. Currently, the CYA screens males only for syphilis.

A collaborative screening study with a Board of Health group apparently was done in November 2000 at the Northern Reception Center. CYA should evaluate this study and consider screening males who have not been previously screened at County facilities for chlamydia and gonorrhea.

Many juveniles housed in the Juvenile Hall system are transferred to the CYA and repeat testing should be avoided by improved communication with the Juvenile Hall system. Wards entering the CYA all get an RPR test for syphilis, which is appropriate given the high-risk nature of the population. Collaboration with the Juvenile Hall facilities could reduce redundant testing of wards and improve public health tracking.

All wards should be evaluated for HIV risk by counseling and a questionnaire during the intake process. All wards that have risk factors for HIV should be offered an HIV test. It does appear that wards are screened for HIV in the CYA on a voluntary basis, but it would be useful to review the content and effectiveness of the counseling provided to the wards as well as the effectiveness of identifying those at high risk.

Oral Screening and Oral Health Care

All new incoming wards currently receive a dental screening examination and a series of bitewing x-rays to evaluate the condition of their teeth. This program is appropriate and adequate, but should include parole revocators who have not been in the CYA for a year.

Reception Screening for Parole Revocators

The *Institution and Camps Manual* policy regarding requirements for newly incarcerated wards requires a "complete baseline health evaluation, including a dental examination." However, in practice this policy is not being applied to parole revocators.

At NYCRCC and SYCRCC, the reception process described above applies to wards newly admitted to the CYA. However, wards who return as parole revocators receive only a brief questionnaire by a nurse utilizing a "Transfer Information and Receipt of UHR" form. This form is inadequate because it does not update current changes in medical conditions and does not update outstanding appointments or laboratory records.

Parole revocators do not receive an updated physician history and physical, regardless of how long it has been since the previous admission, and regardless of their physical condition. We were told that parole violators receive a physician review if they have a medical problem. However, based on chart review, this happens infrequently. An examination is almost never included for individuals who return as parole revocators. Physicians ostensibly perform chart review only. This has resulted in missed diagnoses and missed opportunities to identify serious problems. A physician with the intent of updating the ward's medical condition and preventive screening history should examine parole revocators.

Recommendations:

Guidelines for Screening

The basis of a screening instrument should be the Guidelines for Adolescent Preventive Services (GAPS) and the United States Preventive Health Services Task Force (USPHSTF) guidelines for preventive services. GAPS guidelines were developed by the American Medical Association with contributions from a Scientific Advisory Panel composed of national experts. GAPS information can be found at the following URL http://www.ama-assn.org/ama/pub/category/1980.html.

The USPHSTF is a large panel of physicians and scientists working with support from the U.S. Department of Health and Human Services. This group was convened to review evidence for over 100 common interventions and provide guidance on appropriate preventive services. USPHSTF information can be found at http://www.ahcpr.gov/clinic/cps3dix.htm. A subscription to USPHSTF guidelines can be obtained for $60. These guidelines are developed by public sector; unbiased consensus panels and their recommendations should be incorporated into the screening instrument used by the CYA.

In addition, we recommend the following:

1. All parole revocators should have an updated medical history and physical exam upon arrival. Testing should be repeated as clinically indicated.
2. Improve the presentation of intake historical information in the medical record. Enforce the use of medical problem lists. This form should be visible when the record is opened.
3. Use a standardized immunization record, a copy of which should be provided to the ward upon parole.
4. The CYA should participate in the California Statewide Immunization Information System.

5. Ensure that TB screening x-rays are performed and reported timely. These should be available within 72 hours from identification of a positive tuberculin skin test.
6. Separate consent forms from medical data forms in the medical record.
7. Revise the intake history form to conform to contemporary standards and based upon prevalence of disease in this population. This form should be based on recommendations of the U S Preventive Services Task Force Guide to Clinical Preventive Services, 3rd edition (USPHSTF), and the Guidelines for Adolescent Preventive Services (GAPS) by the American Medical Association.
8. Combine the physician intake history with the examination form.
9. Ensure the adequacy of physician intake examinations by regular peer review of this process.
10. Provide age and gender specific preventive health counseling to wards at intake. Appropriate counseling topics should be based on GAPS and the USPHSTF guidelines as referenced elsewhere.
11. Establish ongoing collaborative links and meetings with representatives of the Juvenile Hall systems and with the LA County Department of Health and the health departments of other major cities in areas referring wards to the CYA.
12. Modify the laboratory screening panel to conform to recommendations of the USPHSTF and GAPS.
13. Initiate chlamydia and gonorrhea screening of asymptomatic males at risk who have not been screened at county facilities.

5. Do wards have appropriate access to timely medical and dental care of an appropriate quality?

Conclusion:

CYA policies and procedures, and actual practice do not ensure that wards have timely access to medical care. This is evidenced by:

- Lack of medical autonomy
- Insufficient ward orientation to health care
- Inadequate access to sick call
- Inadequate medication administration
- Untimely radiology and consultant reports which delay necessary medical care

Findings and Discussion:

The provision of timely access to medical care requires medical autonomy and cooperation from security staff. A consistent theme reported by staff throughout our visits was lack of cooperation from security in carrying out medical activities, such as arranging for wards to be available for medical appointments, emergency evaluations after mace events, appropriately conducting sick call or administering medications to wards in a timely and efficient manner. Staff reported that security considerations are so highly valued that delivery of health care services are a far secondary consideration, and result in a lack of custody support and commitment to delivering health services.

Examples include the following:

- At Herman G. Stark, staff reported that when there was a disturbance in one part of the facility, all movement of wards is stopped. In some cases, medical staff must report to the disturbance to be available in case of injury. This adversely affects the delivery of health care services across the facility.

- At Heman G. Stark the medical staff maintain a Mace Log. From the period of January 1-February 4, 2003, the log contained the names of 270 wards from different housing units who were maced by correctional staff. Macing occurred on 34 of 35 previous days. Medical staff report that wards are supposed to be showered as soon as possible after macing and be brought to medical for an evaluation. However, wards are not always showered prior to being brought to medical. Delays in showering results in chemicals being left on the skin for long

periods of time and in one case caused severe chemical burns on the face of a ward.

- At N. A. Chaderjian, staff reported that when they appear on the housing units to deliver medications or conduct sick call, the correctional staff sometimes ignores them for 10-20 minutes. They reported that if they try to stand up for medical care, they are retaliated against or called a whiner.

- At Ventura YCF, staff reports a lack of cooperation from security to administer medications in a timely manner in the housing units.

- The CMO at one facility complained of security interference with medical decision-making. At that facility, the superintendent made it clear to the physician that the superintendent was in charge. This CMO did not have the autonomy to make medical decisions, including decisions about off-site medical care.

- At another facility, the CMO felt that the ability of physicians to have autonomy in medical decision-making depended on the Superintendent. He indicated that he would "feel nervous" if the current Superintendent left.

- At the Preston and Stark facilities, the physicians were extremely passive and endured or encouraged bad practices that resulted from strict, high security environments. As an example, one physician who had worked at the facility for 25 years did not know whether inmates were permitted to keep inhalers on their person. He stated that the number one priority was security and that sometimes this conflicted with medical treatment. This type of passivity does not foster autonomy in medical decision-making.

Access to Care

In addition to cooperation from security staff, adequate access to health care requires that the following elements be in place:

- Orientation of wards to health services upon arrival
- Sick call with examination in an appropriate clinical setting, including wards in segregation
- Laboratory and diagnostic testing
- Access to pharmaceuticals
- Hospital and specialized ambulatory care
- Secondary care (CTC or OHU)
- Continuity of medical care following intrasystem transfer

Each of these elements is discussed below.

Orientation for Wards to Access Health Services

The method of orientation of wards to health services varies per facility. In most facilities, wards are verbally oriented to health care services by correctional or health care staff, with no written material provided. At Herman G. Stark YCF, nurses conduct verbal orientation weekly on Thursday, even if the ward arrives on Monday. There are no written materials available in English or Spanish to be distributed to wards.

NCCHC Standards (Y-33) requires that information about the availability of health care services must be communicated orally and in writing to juveniles in a form and language they understand, within 24 hours of their arrival at the facility.

Sick call

The primary mechanism for access to health care is the sick call system. The current CYA policies do not address access to sick call. NCCHC Standard (Y-39) requires that qualified health care providers should conduct sick call in a clinical setting according to the number of juveniles in the facility. In facilities with >100 juveniles, sick call should be conducted 5 days per week. In addition, NCCHC Standard (Y-38) requires that juveniles should be given an opportunity to submit sick call requests daily.

Review of actual practice showed that in most facilities, sick call is conducted for each dormitory, 1 to 5 days per week. For example:

- At NYCRCC, the ward orientation manual states that sick call is conducted three days a week in each living unit. In actual practice, sick call is conducted once weekly for each living unit. In the Cheyenne unit, according to a correctional officer who works both day and evening shift each week, sick call is conducted on Tuesday. Wards must sign up for sick call on Saturday or Sunday. In the Seminole unit, according to correctional officers and wards, sick call is conducted on Thursday, and wards must complete a sick call request form on Wednesday evening. We interviewed one ward that complained that sick call was offered only once weekly.
- At Preston YCF sick call is conducted twice weekly.
- At Ventura YCF sick call is conducted twice weekly for males and three times weekly for females.
- At Southern YCRCC sick call is conducted five days a week.

At most facilities, wards obtain access to sick call by completing a sick call request form provided by the correctional officers. Correctional officers are responsible for ensuring that adequate numbers of sick call request forms are present in the dormitory. Correctional officers collect completed sick call request forms, which does not permit confidentiality of the wards' complaint. The sick call request forms are submitted to the

health care unit and triaged by the nurses. At NYCRCC, wards are only permitted to sign up for sick call once weekly. This does not ensure appropriate access.

Nurses usually conduct sick call, except at H.G. Stark where the physicians and the nurse practitioner conduct it. Examinations are not performed in a confidential setting with adequate lighting, medical equipment, and with access to handwashing following examinations. With the exception of H.G. Stark, health care records are not routinely brought to the living units to be available for the sick call evaluations. This does not permit the staff to evaluate the medical complaint in light of recent, potentially related complaints. The sick call evaluation is documented on the request form that is placed in the record.

At NYCRCC, sick call is conducted in satellite examination rooms in the dormitories. We inspected the examination rooms in two of six dormitories. Each room contained an examination table, sink, soap and paper towels, two chairs, locked cabinet containing one or two over-the-counter products, and a cabinet with a few supplies such as gloves, tongue depressors, etc. According to the nursing staff, additional examination equipment (stethoscope, blood pressure cuff, otoscope, etc.) is brought to the area when sick call is conducted.

At Ventura YCF, in the Specialized Counseling Program (SCP) dormitory, there is a renovated closet that is being used as a satellite medication room, but not for sick call. , Nurses are asked by security to go to the ward's individual room to examine the wards, despite the availability of the clinic room in the immediate area. The clinic room from which medications are passed is a cramped and cluttered space. There is some medical equipment such as a scale, otoscope, and ophthalmoscope. However, no exam table is present and the room is not used for examination for security reasons. Dr. Susan Clay reported that she has discussed renovation of the rooms with security but has not received support and cooperation regarding this and other matters.

The CYA has no policies or practices for the health evaluation of juveniles placed in segregation. Due to the possibility of injury and depression during periods of isolation, NCCHC Standards (Y-40) require that when juveniles are placed in segregation, correctional staff must notify health care staff immediately, so that the wards' health record can be reviewed to determine if any known contraindications to segregation exist.

All juveniles placed in segregation (including protective custody) should be evaluated daily by qualified health care professionals. The health care provider should document these checks on a log or cell card, and any health care provided should be documented in the juveniles' health record. None of these practices exist in the CYA.

Pharmaceuticals

Generally, all classes of medication are available to wards in the CYA. However, notable exceptions include a lack of appropriate pain medication at one facility, and lack of

access to asthma medication at many facilities. We evaluated the Pharmacy/Medication Administration services the following manner:

- Interviewing the pharmacists and nurses responsible for administering medications
- Inspecting the medication administration room and pharmacy
- Reviewing the controlled substances and standard ward inventory (SWI) accountability
- Observing medication administration process
- Reviewing medication administration records (MARs)

The State of California has a statewide contract with McKesson for wholesale purchase of pharmaceuticals. Each facility employs an in-house pharmacist on a full or part-time basis to procure and dispense medications (except Preston CYF). Most facilities stated that they have a licensed pharmacy or drug room. We could not verify this for all facilities. The CYA policies reference an approved Youth Authority Formulary, however in actual practice, there is no adherence to a statewide formulary.

As a general comment, the manner in which pharmaceuticals are procured, inventoried, and dispensed in the CYA is inefficient and wasteful. Examples of the inefficiency and waste of the system include the following:

- At the NYCRCC, population 334, a full-time pharmacist is employed, working 4 ten-hour days. The pharmacist dispenses medication twice a week (Tuesdays and Thursdays) for each patient prescription via a cassette replacement system. This means for every 30-day prescription, the pharmacist dispenses medications 8 times a month (i.e., twice weekly), rather than dispensing the amount prescribed once (up to 30 days).

- At the Northern California Youth Correctional Center in Stockton, the pharmacist dispenses medication daily, via a cassette system.

- At Herman G. Stark, the pharmacist fills the prescription for one week at a time. This practice is extremely labor intensive and inefficient.

- At the SYCRCC, the pharmacist is employed part-time, working four 5-hour days. She dispenses few prescriptions. The nurses stated that they administer the majority of medications from large stock bottles. Upon inspection, the cabinets in the medication rooms contained large bottles of medications containing thousands of doses of medication. Although the administration by nurses of single doses of medication from a stock bottle is permissible in some states, the practice of having nurses administer virtually all medication doses from a stock bottle is highly unusual and can lead to medication errors on the part of the nurse. In addition, it raises the question as to what the pharmacist actually does during the 20 hours worked each week. We interviewed the pharmacist who denied that the

nurses administer most medications from stock bottles. She indicated that this was done only recently because she was on vacation for three weeks. However, the large inventory of stock medications stored in two rooms located next to the OHU and in the Intensive Treatment Program (ITP) dormitory support the information the nurses conveyed.

- Inventory control of pharmaceuticals is virtually non-existent at most facilities we visited. The pharmacists use an automated pharmacy program (CIPS) to log prescriptions. Though this system apparently has the capability to produce some utilization reports, none of the facilities we visited review aggregate pharmacy data with an eye toward utilization. Some pharmacists (Northern Reception) did not even understand what the reports meant. No facility was capable of producing an inventory of stock medication. None of the facilities could provide reliable costs for pharmaceuticals and the breakdown of categories of pharmaceuticals being used. The lack of cost data is important, because, in general, there was excessive stock at several of the facilities we visited, particularly at Southern, Paso Robles, and Stark. We estimate conservatively that there is excess stock of over $400,000 statewide. Because there is no inventory control of stock, it is not possible to evaluate whether loss of medication is occurring. In addition, we found frequent examples of expired medication in pharmacy rooms. This practice results in waste and increases cost unnecessarily.

- At El Paso de Roblas YCF, the pharmacy contained boxes and bags of medications stored on the floor. Many of the medications had expired, or were about to expire.

- When wards transfer from facility to facility, dispensed medications are not transferred with the ward. Because the medication cannot be legally administered to another ward, it should be returned to the pharmacy or destroyed. However, at Preston Youth Correctional Facility, the medication room contained bottles of medications of wards who had left the facility, but whose medication was being administered to newly arriving wards that had been prescribed the same drug. Given that some of the medications are extremely expensive (e.g., Zyprexa, which cost $400-$800 per bottle), it is understandable that the nurses wanted to use the medication rather than waste it. However, it is not legal to do so.

- At most facilities, the pharmacist assumes no responsibility for checking expiration dates of medications stored in crash carts and satellite locations outside the pharmacy. For example, at Herman G. Stark YCF, several expired medications were found in the SWI in the housing units (injectable solu-cortef) and main medical unit refrigerator (compazine, Wycillin injectable, and Sulfacetamide ophthalmic solution). The chief pharmacist and nurses acknowledge this as a problem. However, the chief pharmacist states she is not responsible for the medications once they leave the pharmacy.

- There is no pharmacy or nursing accountability system for inventories of stock medications that are kept outside the pharmacy. The pharmacists do not require that the nurse document to whom each dose is administered, to provide an accounting for all medications. This leaves the system vulnerable to theft on a large scale. When discussed with individual pharmacists, they indicated that they did not have enough staff to maintain such accountability systems.

- In contrast, the pharmacist at Herman G. Stark requires the nurses to sign out dispensed medication when the medication is taken to the housing units. The pharmacists and nurses jointly count the medication pill by pill, in each dispensed package. The pharmacist and nurses stated that this system was instituted because of discrepancies in what the pharmacy dispenses and what nurses receive.

- There is a satisfactory accountability system at most facilities for Drug Enforcement Agency (DEA) controlled substances. These substances were kept in double-locked cabinets, with the exception of Herman G. Stark, where these medications were located in an unlocked cabinet.

- At the Preston facility there is no pharmacist. The doctor writes the prescription on a pad and the prescription is delivered to the Ione pharmacy and the pharmacist fills the medication from stock at the facility. The only verification on the record is the doctor's note and the MAR that is transcribed by a nurse. The pharmacy does not print out MARS.

- Prescription forms are not uniformly utilized in the CYA. Therefore, the only documentation of record for a prescription may be the medical progress note. Documentation of prescriptions is inadequate. There is neither acceptable policy nor practice in this area.

Medication Administration

There is no existing policy to guide the practice of medication administration. As a result, sites have developed unique practices, many of which are inappropriate and unsafe. Mostly, nurses perform medication administration, but in some situations, untrained officers perform this function.

In the CYA, there are three primary mechanisms to administer medications to wards:

- One mechanism is a centralized system in which general population wards come to a central area where a nurse administers the medication from a medication room.
- In the second mechanism, nurses carry medication to the housing units. In lockdown units, the nurses deliver the medications.
- The third mechanism is for officers or correctional youth counselors to administer medication. This practice varies from site to site, is unsupervised, and is inappropriately done.

At NYCRCC, wards do not carry any identification on their person, thus nurses cannot confirm the identity or ID number of the ward. This may result in a ward receiving the medication of another ward, either because two wards have the same or similar name, or one ward could pose as another. Nurses reported that recently, a ward requested the medication of another ward. Fortunately, a correctional officer correctly identified the ward, and he was not given medication. However, the lack of identification could result in this occurring again.

The nurse pours the psychotropic medications from stock bottles in advance of the ward coming to medication administration. This is called pre-pouring and is not an acceptable practice. If the ward does not pick up the medication, it is poured back. Other medications are in unit dose containers and are opened at the time of administration. The nurse does not document administration at the time the medication is given, but waits until the end, then checks to see whose medication is left. This is not acceptable nursing practice. The nurse performs oral cavity checks on the wards following medication administration.

At SYCRCC, medication is administered from a centralized medication room adjacent to the OHU. It is cluttered and cramped. The floors and cabinet doors are not clean. The nurses reported that orderlies are not permitted to come into the medication room and that nurses are responsible for keeping it clean. There was a schedule of cleaning activities posted, but it consisted primarily of keeping countertops clean, and not terminal cleaning of the floors, walls and other surfaces.

The medication administration process at SYCRCC was observed. The nurse stated he pre-pours medications from large stock bottles, and that if the ward does not appear for medication administration he destroys the medication. This practice is wasteful, particularly for expensive psychotropic medications such as Zyprexa, Risperdal and Geodon. Wards present themselves at the window with a picture ID card that permits the nurse to verify the identity of the ward. The nurse did not use the Medication Administration Record (MAR) to verify the medication at the time the medication was administered, which may lead to errors. Documentation of medications took place at the end of medication administration instead of at the time of administration. In addition, at SYCRCC, according to the Supervising Nurse, all psychotropic medications are crushed, including sustained release medications. The practice of crushing sustained-released medications defeats the purpose of these time-release medications more expensive medications.

In some facilities, nurses transfer medications from legally dispensed and properly labeled containers to small manila envelopes that are not properly labeled. This is not a legal practice and should be discontinued.

We reviewed the MARs. In general, they were legible and complete, and contained signatures of nurses who administered medications. However, the nurses did not employ a uniform process for transcribing orders, or for indicating a medication was changed or

discontinued. This resulted in some MARs appearing disorganized and in some cases illegible. For example, a nurse crossed out discontinued medications with a magic marker that often obliterated the medication name, dose, and prescribing information. Documentation of changes in, or discontinuation of medication should not result in obliteration of any information on the MAR, which is a legal document. At Preston, dates of medications were written in pencil and then changed if the medication was renewed.

At Chad, MARS for psychotropics and other nurse-administered medication is kept in a book in the health care unit. Correctional Youth Counselors (YCC's) administer all other medications, including antibiotics, antihypertensive medications, etc. Some the counselors reported that they had received no medication administration training. All other MARS are kept in the housing units with the correctional staff. Inspection of several of these MARS showed that many spaces were blank, which indicates that the ward did not receive the medication, or received the medication but it was not documented. Once these MARS are completed, they are forwarded to the pharmacy, but are not filed in the health record. The result is that there is no documentation in the record that the ward received the medication. Thus health care staff lacks knowledge regarding whether the ward is actually getting his medication. One of the experts asked Dr. Lai how he knows that wards are getting the medication that is prescribed. He replied that he only knows by asking the ward. This is unacceptable practice. Dr. Lai says that for renewal of medication for chronic disease, wards must place a sick call request.

At Ventura YCF, medication is administered on the units. In the Specialized Counseling Unit, there is a half door through which medications could be passed. This would present an ideal opportunity for the efficient administration of medication. However, the nurses report that instead of having the wards line up at the window where the nurses could review the MAR, prepare the medication, and administer it to the patient, security staff requires the nurses to go door-to-door.

To administer medications, the nurse empties the unit dose medications into a small manila envelope. The nurse then crushes the psychotropic medications. Some patients refuse their medications because they are crushed and mixed together. The nurse places the envelopes in a carrying cart and walks down the hall door-to-door. The correctional officer opens the door, and the nurse gives the ward a cup who fills it up with water in the cell. The ward then takes the medication with the nurse present. This is a cumbersome system.

Supervision of Pharmacists and the Pharmacy Program

The work hours of pharmacists is related more to their availability than to facility need. At several facilities, there is either no pharmacist coverage or coverage is part-time and unreliable. In addition, there is no statewide oversight of pharmacists, no performance measures for pharmacists, and no reporting requirements. Pharmacy and Therapeutics Committee meetings occur, but are chaired by a physician without experience in management. Chief Medical Officers ostensibly supervise the pharmacists, but, based on information available in their credential files, they lack experience in pharmacy

management. As a result, pharmacists are left to supervise themselves. This was the impression given to us in interviews with individual pharmacists. Each facility, therefore, has developed unique inventory control systems and unique methods for distributing and packaging medication. Because there is no management supervision, the role of the pharmacist at individual facilities may be the subject of dispute between the pharmacist and nursing staff.

Access to Medication

Generally, wards have access to prescribed medication. There were some significant exceptions.

The first involves the treatment of pain, particularly at the Preston facility. At Preston, the CMO, as a matter of practice, does not utilize narcotic pain medication in the treatment of pain. He admitted to one of the experts that he has not prescribed narcotic medication at the facility since 1989. This came up when we discovered in our audit that no narcotics were stored at the facility. The physician described to one of the expert reviewers that he never used narcotics based on his adamant belief not to use narcotics for this population. One ward at that facility with sickle disease was therefore not treated with appropriate narcotic medication during an acute sickle crisis. These episodes are extremely painful events and require narcotic type pain medication for appropriate care. In addition, there have been wards with fractures at this facility. Not to treat these groups with narcotic pain medication, when necessary, is unprofessional conduct, unethical, and cruel. This practice should be stopped immediately as a matter of principle. The state of California Medical Board has guidelines in the treatment of pain that should be evaluated in review of current CYA practices. (See http://www.medbd.ca.gov/consumerguidelines.htm.) The fact that such a practice exists is evidence of the lack of supervision of medical staff.

The second exception to adequate access to medication involves the treatment of asthma. Asthma is the most common chronic medical condition for wards in the CYA. Use of maintenance inhalers (steroid inhalers) is not a generally accepted practice at all facilities. For example, at Preston, steroid inhalers are not used as a matter of practice. This is inappropriate care that is not in keeping with contemporary standards of care. In addition, when rescue inhalers are prescribed, wards are not permitted to keep these items on their person resulting in periods when they are untreated and dependent on security officers for access to medication.

Some facilities permit wards to keep this medication on their person. This decision is made by correctional staff or is a matter of historical practice. At Stark, for example, the Treatment Team Supervisor is a correctional officer who decides whether wards can keep inhalers on their person. This is not a legally or medically prudent practice and results from a lack of physician autonomy in medical decision-making. All wards with moderate asthma or recent attacks should have keep-on-person access to medication.

The third exception involves an unusual directive by Dr. Wheaton. He prohibited the practice of prescribing "as needed" medication. This is a standard and necessary practice in medical practice. The memo detailing this prohibition provides no rationale for this practice. Typically, PRN medication is used for many pain medications as well as for asthma inhalers. This directive places all of the physicians in a position of being unable to appropriately prescribe multiple different types of medication in a medically appropriate manner.

Formulary Issues

While there is a formulary in place for the CYA, no institution we visited actually used the formulary in routine practice. When individual facilities send non-formulary requests to the Central Office, they never get an approval in return. As a result, no one takes formulary issues seriously. In general, pharmacists order any medication prescribed by the CMO. Pharmacists do not participate in the non-formulary process. Non-formulary utilization of medications is not tracked.

A drug formulary is useful to provide an acceptable range of medications that are necessary to routinely treat the population in question. Cost factors in choosing which medications to include on the formulary are important considerations. Updating formularies and monitoring compliance with formularies was a recommendation of the State of California Auditor in its publication, *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements.* This is not occurring in CYA facilities.

In general, when formularies are in place, a physician still can use any required drug by placing a non-formulary request. Though Central Office leadership told us that this practice is in place, there is no policy or practice in place to support this contention. Thus, there is no supervision of provider practice in prescribing medication.

Narcotic Control and Medication Storage Issues

Control of narcotics was appropriate at most facilities, except Stark, where narcotics were kept in an unlocked cabinet in the clinic room. All narcotics should be maintained in a double-locked arrangement whether in the clinic or in the medication room. There are multiple areas in clinics and OHUs where medication is stored that are not inspected by a pharmacist. Only pharmacy rooms have licenses.

The CYA should consult with the Board of Pharmacy as to whether the practice of storing large quantities of stock medications, including narcotics, and dispensing these medications outside of a licensed pharmacy is appropriate or legal. In addition, clarification should be sought regarding inspection requirements, including determining the responsibility of the pharmacist to develop an accountability system for stock supplies and check drug expiration.

At the Southern facility, the license for the pharmacy is a "Drug Room Permit." This room is actually used as a pharmacy and probably requires a different license. A similar situation may exist at other facilities. CYA pharmacists define their own role, and do not offer assistance or become involved in supervising the storage of medication in clinical area outside of the pharmacy.

Diagnostic Services

All facilities had a contract with a reference laboratory for laboratory testing. Some laboratory tests at the Northern reception center are performed on site. There did not appear to be a problem with clinical staff getting laboratory results.

Radiology services are available at all sites, but there are administrative problems that result in untimely services. Specifically, wards with fractures do not often get timely x-rays. At Preston, Stark, and Chad it takes about a week or longer to get an x-ray reviewed by a radiologist. This is not timely, since most films are taken to rule out fractures. X-rays to rule out fractures should be taken and reviewed within 24 hours.

At Stark and Preston, the doctors read their own films and only selectively send films out for radiology over-read. This isn't appropriate. All films should be over-read by a radiologist.

At the Stark facility a portable x-ray unit is used. This unit is not inspected and staff does not use appropriate shielding or monitoring when x-rays are taken. An officer station is adjacent to the area where films are taken. Persons in proximity to x-ray exposure should be monitored for radiation exposure.

We were asked whether new radiology equipment should be purchased. In our opinion, existing equipment should first be inventoried. A licensed and reliable radiology equipment maintenance contractor should service all equipment and provide an opinion about each piece of equipment's serviceability and obsolescence. Then a utilization of services should be completed. How many films are taken per day? Once that data is available, it should become clearer regarding whether new equipment is needed.

Hospital and Specialized Ambulatory Care

There are adequate arrangements at all sites with local hospitals and specialists for hospital and off-site specialty care. The *Institutions and Camps Manual* defines the Utilization Review process. This is a process to ensure appropriate use of health care services and resources. Staff physicians must complete a request for offsite care and submit it to the CMO at each facility. CMO's by policy decide whether the offsite request is approved, or whether a subsequent review occurs with Central Office staff.

Not all physicians or CMO's are aware of this policy, and referrals off-site do not occur in a standardized fashion. Each site has its own unique referral process largely dependent

upon the CMO and Superintendent. The Central Office could not produce any list or log of cases that had been reviewed on a statewide basis. Off-site requests are not formally documented on an off-site request form in a standardized manner. There is no formal practice of providing information to the consultant for their evaluation of the ward. Nor is there a formal process for obtaining information from the consultant regarding evaluations of wards.

There is no prioritization for necessity of off-site medical problems. It was difficult to evaluate timeliness of offsite care because there is a lack of offsite tracking at most sites. For those sites that do track off-site visits, review of off-site trip sheets and medical records revealed that there were several wards whose condition required an urgent off-site trip rather than an elective one and there were several wards whose off-site care was not timely. For example:

- A ward with a week-old metacarpal fracture was not sent to an orthopedic surgeon for five days. A delay of this extent may result in mal-union of the fracture.
- A ward with a history of esophageal stricture was unable to swallow. It took 34 days to see a gastroenterologist to evaluate for dilation. His weight was not monitored in the interim period. This is an unacceptable delay.
- A ward waited 15 days to see an ophthalmologist to evaluate a possible retinal tear. This is an unacceptable timeframe in which to evaluate a retinal tear and placed the ward at risk for loss of vision.
- A ward waited 13 days to evaluate a hand fracture. This is unacceptable and could result in mal-union.
- A ward that had an echocardiogram scheduled didn't have it done for two and a half months upon which time he was transferred. The institution to which the ward was transferred did not complete the appointment and the appointment was lost to follow up.
- A ward with papillary carcinoma of the thyroid had a recommendation from an oncologist for follow up testing. The testing and follow up were not done. The CYA physician note states, "Treatment and test apparently are cancelled or delayed because of insurance issues." This is inappropriate follow up. Care for wards should not be denied based on their medical insurance status.
- A physician referred a ward for surgery for a hernia on November 8, 2002. A subsequent note in the medical record stated, "when consult dated 11/8/02 has been scheduled, will post to UHR." A physician saw the ward on December 20, 2002 and the doctor's note recommended "reassurance." He was never scheduled for the evaluation of his hernia. There was no explanation as to why the surgical consult was not completed.
- A ward developed abdominal pain on February 16, 2002 and was sent to a local emergency room. The pain continued and the CMO recommended on April 26, 2002 that a gastroenterology consultation be obtained. On July 13, the appointment was scheduled for September 10. The gastroenterologist

recommended a radiographic procedure that was done December 13. This is an excessive delay for a work up. As well, the follow up of the patient at the facility was poor.

- A ward saw an optometrist at one of the facilities on December 3, 2001. The nurse note connected with this visit stated, "need referral to outside ophthalmologist secondary to high IOPs." IOP stands for intra-ocular pressure and can be a sign of glaucoma. Failure to appropriately treat glaucoma can result in loss of vision. The patient went offsite on January 11, 2002 and returned with a recommendation for further testing (visual field examination) before the ophthalmologist saw the patient again. The ward returned to the ophthalmologist on March 18, but the note said that he never had his visual field test completed. He went for visual field testing on March 28, 2002. On June 25, 2002 the medical record clerk noted that the follow up ophthalmology appointment was yet to be scheduled. In the meantime the patient continued to be followed by the onsite optometrist, who referred to an ophthalmologist on September 19, 2002, because the intra-ocular pressures were getting higher. A follow up note documented that, "as per computer info, this ward is on pending list. Awaits appointment date." This care is careless and places the ward at risk for loss of vision.
- A ward with hepatitis C was referred to a gastroenterologist on February 25, 2002 but didn't go for the appointment until December 2, 2002, a period of 9 months. This is an excessive delay. The gastroenterologist ordered a liver biopsy, which was done on December 24, 2002. Apparently, the test was done, but there was no documentation of the results in the record as of February 3, 2003.

When wards do go off-site for care, we could seldom identify that the results of the offsite visit were documented as understood by the CYA facility physicians. Examples of this include the following:

- A ward was hospitalized for a seizure and cardiac arrhythmia. There was no documented evidence in the record that the physician understood what had transpired in the hospital for this patient.
- A ward hospitalized in the intensive care unit for life-threatening asthma returned to the facility with medication orders from the hospital. The CYA facility physician changed the orders without explanation, and did not document understanding of what had transpired at the hospital.
- A ward was diagnosed with hyperthyroidism at the Southern facility. He was sent to an endocrinologist and was followed appropriately for four visits. The endocrinologist recommended medication. The recommendation also indicated that if the medication did not work as intended, the ward would need radioactive iodine treatment. At the last visit, a 3-month follow up was recommended. The patient was transferred to the Preston facility and follow-up of this patient never occurred. After transfer to Preston, the patient had

laboratory test evidence that he was either overmedicated or that he no longer need medication. Nevertheless, the medication was continued for 8 months. The physician didn't appear to understand how to treat the ward and yet the ward was not sent to see the endocrinologist.

- A ward sustained a jaw fracture as a civilian on February 27, 2003 and had surgery with insertion of a plate on February 28. He was incarcerated on March 18, 2003. A dentist noted that he had an infection in the area of the fracture. The patient went to University of Southern California Hospital on March 19, 2003. However, there is no report of this visit in the record, and no follow up monitoring of the patient. On April 16, 2003, penicillin was started without a documented explanation. On April 23, 2003, a note in the medical record states, "Dr. Moose from USC called and informed us that ward is to be scheduled for surgery to remove a plate placed 8 weeks ago in his mandible. The bur plate is source of low grade infection." The CYA physicians did not document understanding of what was occurring to the patient.
- A gastroenterologist recommended stool guiac testing for a ward that had been evaluated for abdominal pain. There was no follow-up at the facility.

Physicians at the Stark facility described interference by the Superintendent in sending wards off-site for care. Given that most sites do not track off-site events, it is not possible to describe whether this occurs with any regularity.

Correctional Treatment Centers

Beginning in 1987, the California Health and Safety Code section 1250 required that wards who need professionally supervised health care beyond that normally provided in the community on an outpatient basis, must be treated in a licensed Correctional Treatment Center (CTC). The regulation does not regulate outpatient care, specifically care provided in outpatient housing units. As section 1250 of the Health and Safety Code specifies, "This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards that may be receiving outpatient services and are housed separately for reasons of improved access to health care."

Outpatient housing units are defined in the regulation as special housing for wards whose "condition would not normally warrant admission to a licensed health care facility and for whom housing in the general population may place them at personal or security risk."

In July 2000, the Youth Law Center petitioned the Superior Court of the State of California to mandate the CYA to comply with licensing requirements of the California Health and Safety Code regulations on CTCs. A judgment entered December 11, 2000 and amended June 19, 2002, stipulated that CTCs would be licensed in a timeframe as follows:

- Stark would be licensed on January 21, 2003.
- Ventura would be licensed on March 31, 2003.

- Northern California Youth Correctional Center licensed by April 30, 2004.
- A temporary facility licensed at Southern by August 15, 2002.

In addition, the CYA was to develop, "an ongoing case-by-case system to assess the need for inpatient medical care services by July 30, 2002." However, to the best of our knowledge, there has been no needs assessment for CTC beds for physical health purposes.

In reviewing the court's decision in the mandate, the following statement is made, "The CYA provides inpatient medical and mental health services in 11 facilities that come within the statutory definition of a correctional treatment center." However, during our visit, we did not find any wards that were candidates for housing in a CTC for reasons associated with physical, as opposed to mental, health. Nor did we identify physical health treatment that rose to the definition of need requiring a CTC.

Of the 33 charts reviewed, only 3 would have been candidates for a CTC at some time during their incarceration. During our entire visit to 6 facilities, we did not encounter a single individual who would have been a candidate for a CTC during the time of our visit. Excluding mental health conditions, use of existing Outpatient Housing Units (OHUs) would suffice for most wards with medical requirements. (See the following section on "Outpatient Housing Units.") In fact, most wards housed in the OHUs do not have serious medical conditions that require 24 hour nursing. The most common use of OHUs, at Northern Reception for example, is for suicide watch. Excluding mental health needs, most OHU admissions were for holding a person requiring fasting prior to a next-day test. Following that, patients were placed in the OHU for observation after minor procedures. None of the cases reviewed on this log required 24-hour nursing supervision. At Chad, all of the wards housed in the OHU were there because of healing fractures that favored protected housing. For all of these individuals, if they were civilians they would have been sent home. For physical health, as opposed to mental health, therefore the need for CTCs in the CYA is minimal.

Because of their age, adolescents do not have high rates of chronic debilitating disease that requires continual medical monitoring. Adolescents are in relatively good health compared to adults. According to McAnarney's *Textbook of Adolescent Medicine,* acute nonfatal injuries account for the largest number of hospital days. In the CYA, while these injuries are treated in hospitals when indicated, the recuperative phase can be managed in settings similar to OHUs. Also, according to McAnarney, "Adolescents are more likely to be hospitalized for psychiatric conditions than are any other age group." Thus, the CTC requirements are greater for mental than for physical health and this is where the emphasis for CTCs should be.

While the current need for CTC beds for physical health is minimal, the Central Office leadership has devoted virtually all of its working time and effort in establishing these units to the neglect of higher clinical priority areas. In addition, the entire organization of the medical staff and the clinical program has been designed on a model based on the Central Office leadership's interpretation of CTC requirements. A well-functioning

outpatient medical program, including well run OHUs, are what the wards of the CYA need. Instead, Central Office leadership devotes its entire energies to designing the entire medical program for the CYA as if it were a CTC. This may be a result of inexperience of the Central Office leadership in managing correctional health care programs.

The current plan for development of CTC beds is sufficient to address the medical needs of the wards, provided that the Ventura facility has beds for females.

Outpatient Housing Units

OHUs function as a level of care below a CTC. According to CYA policies Section 6209, the OHU is to be used to admit any ward who requires more treatment or observation than can be easily performed on a living unit to inpatient status (for example, wards scheduled for day surgery or wards pending admission to an acute care hospital). Policies do not specify the types of medical and nursing care to be provided in the OHU, nor procedures for admitting, monitoring and discharging patients from the OHO.

OHUs should be governed by policy and procedure in a manner equivalent to infirmary care as defined by the NCCHC. The NCCHC Standard on Infirmary Care (Y-52) requires the following:

- Written policy and defined procedures specifying the types of medical and nursing care provided in the infirmary. They contain a definition of the scope of medical and nursing care provided at the facility infirmary.
- A physician is on call 24 hours a day.
- A registered nurse who is there daily supervises the infirmary.
- Sufficient and appropriate qualified health care professionals are on duty 24 hours a day.
- All juveniles are within site or hearing of a qualified health care professional.
- There is a manual of nursing care procedures.
- A complete inpatient health record is kept for each juvenile.
- Admission to and discharge from infirmary care by order of a physician only (or other qualified health care professional where permitted by state law). Actual practice is consistent with this policy.

Continuity of Care Through Intrasystem Transfer

Wards in the CYA are frequently transferred from facility to facility. It is important therefore, for health care staff to interview the ward regarding current health problems, and review of the health record to note the medical history, continue medications, previously ordered laboratory tests, or consultations.

CYA policies address this subject in the Unified Health Record Section (6169). The policy addresses the actual transfer of the health record. The only reference to the health care staff duties is that the physician/dentist will "review the UHR to determine immediate and future medical, mental health and dental needs." The policies do not

address the specific measures to be taken upon arrival. Therefore the actual process varies from site to site. In addition, medications are not transferred with the wards. This may result in missed medication doses and is wasteful.

Review of records and interviews with staff confirm that intake practices vary from site to site. At all facilities, the nurse completes the "Transfer and Receipt of Unified Health Record" form. The form does not contain a space for vital signs or current symptoms, although the nurse often records this information in the progress notes.

In addition to completing the form, at some facilities, the nurse interviews the ward on the day of arrival regarding current medical problems; obtains weight and vital signs; and plants a TB skin test. If the ward is on medication, the nurse calls the physician to obtain a verbal order. Sometimes wards arrive late in the evening without medication and nurses report that they call the physician to obtain a new order for the medication.

At other facilities, the nurse only conducts a record review on the day of the ward's arrival. For example, at Preston YCF, the nurse and physician conduct a record review of newly arriving wards on the day of arrival. Wards arriving from non-reception centers are seen on the day of arrival. Wards arriving from reception centers are seen the following day. This practice does not make sense.

Problems associated with intrasystem transfer involve failure to refer wards with medical problems in at timely manner. For example, a ward that arrived at Preston in January 2003 complained of genitourinary problems. The nurse told the ward to sign up for sick call rather than referring the ward to the physician. Another ward arrived on numerous psychotropic medications including Depakote, Seroquel and Klonipin. The ward's health record was not reviewed and the UHR transfer form was not completed until the following day.

Recommendations:

1. Ensure that physicians have autonomy to practice medicine.
2. Revise policies to incorporate sick call procedures that include the following:
    a. Wards are able to confidentially sign up for sick call seven days per week
    b. Wards have access to sick call a minimum of five days per week
    c. The health record is present for all clinical encounters
    d. Sick is conducted in a medical setting with adequate privacy, lighting, equipment and access to handwashing facilities, etc.
    e. Nurses who conduct sick call are trained in health assessment and nursing
3. Revise policies to ensure compliance with NCCHC Standards regarding access to care and medical rounds for juveniles in administrative or disciplinary segregation.

4. Standardize the contents of emergency bags to include appropriate emergency medications. Audit and inventory these bags on a regular basis.
5. Inventory large x-ray and other capital equipment. Service and maintain this equipment.
6. Improve radiological services so that wards with suspected fractures or other urgent conditions could obtain an x-ray with an over-read by a radiologist within 24 hours.
7. Institute tracking of all offsite encounters and monitor the timeliness and appropriateness of off-site medical care.
8. Create priority rankings for scheduling off-site medical care so that wards with serious or urgent medical needs are scheduled for care in a timely manner.
9. Review and revise pharmacy policies and procedures to address the following areas:
    a. Create, implement and monitor formulary use of medications.
    b. Eliminate inefficient pharmacy practices such as dispensing medications daily or twice weekly, or having pharmacists and nurses count each pill in a prescription. Ideally medications would be dispensed once for the prescribed period.
    c. Establish inventory controls of medications that are stored in or outside the pharmacy.
    d. Establish pharmacy accountability for checking expiration dates of medications stored in medication rooms or crash carts.
    e. Implement training for clinicians regarding appropriate pain management. The HCSD should conduct periodic reviews to monitor for the appropriate use of pain medication.
    f. Change current rules regarding keep-on-person asthma medication, so that wards with asthma have ready access to their inhalers.
    g. Improve inventory control of pharmaceuticals.
    h. Standardize the job descriptions of the pharmacists and institute supervision for this group.
    i. The Health Care Services Division should work with custody to arrange for transfer of medications with the wards from facility to facility.
8. Establish policy delineating medication administration and standardize practices. These practices should include:
    a. All wards are issued and present a picture identification card that is presented at the time of medication administration
    b. Nurses using the Medication Administration Record at the time of administration to validate physician orders

c. No pre-pouring of medications or transferring medications from a legally dispensed medication to improperly labeled envelopes

d. Documentation of medications at the time they are administered

e. All medications should be administered by nurses or personnel who have been trained and demonstrate competency to administer medications

f. Medications should be administered from the main clinic or a designated area in the dormitories. Except in lockdown areas, nurses should not be required to go cell to cell.

g. A schedule of sanitation in all medication rooms that includes floors, walls, cabinets and countertops

9. Establish a needs inventory for CTC beds and adjust provision of beds to those needs.

10. Establish OHU beds and standardize practice by creating policy and procedures for those units that are in compliance with NCCHC Standards.

11. Standardize policies regarding intrasystem transfer of wards. Revise the form to include vital signs and weight, current symptoms, and medications.

6. Does the CYA respond appropriately to medical and dental emergencies?

Conclusion:

CYA policies and procedures, and training do not adequately prepare staff to respond to emergencies.

Findings and Discussion:

The current CYA policies regarding response to medical emergencies (Section 6209) address the following:

- Response of nursing staff covering the infirmary in the event of an emergency in the in the housing units
- Admission of a ward needing further observation, pending admission to an inpatient setting or scheduled for day surgery
- Psychiatrist review of the health record of newly arriving wards
- Emergency care other than wards
- Notification of unusual occurrence, serious medical problem, or injury

The policies are brief, and do not address orientation and training of correctional or health care staff regarding emergency response, including first aid and cardiopulmonary resuscitation, use of emergency equipment, and emergency drills. In addition, NCCHC Standards (Y-42) require that procedures are developed regarding the following:

- Emergency evacuation of the juvenile from the facility
- Use of emergency medical vehicle
- Use of one or more designated hospital emergency department(s) or other appropriate health facilities
- Emergency on-call physician and dentist services when the emergency health facility is not located nearby
- Security procedures that provide for the immediate transfer of juveniles when appropriate

There are no local operating procedures regarding emergency services at CYA facilities. Facilities do not routinely conduct emergency response drills. Emergency equipment generally consists of an emergency bag, oxygen, and automatic external defibrillator (AED). Selected facilities have a crash cart with emergency medications. There is no standardized list of emergency bag contents.

Staff physicians are on-call after business hours, weekends, and holidays. However, some facilities have no physician back up if the physician is on vacation. In such circumstances, the nurses report that they send the ward to the local emergency room for conditions that cannot wait until the physician returns.

All facilities have contracts with local area hospitals for emergency care and there have been no identified problems in getting wards seen in local area hospitals.

The health care leadership of the CYA has not developed comprehensive Nursing Protocols or a training program for nurses to use in assessing potentially urgent conditions. This leads to deficiencies in nursing assessments. At the NYCRCC, a ward complained to the nurse of chest pain. The nurse obtained vital signs, but did not listen to the patient's heart and lungs. The nurse did not refer the patient to the physician.

Use of Mace

Mace is used extensively in the California Youth Authority. At the Heman Stark facility, for the one month of records we reviewed, almost 10 wards a day sustained mace exposures. This is a high rate of mace exposures. Yet there is no specific medical policy governing treatment of individuals who sustain mace exposure. Mace is an irritant gas used for its incapacitating effects. It irritates the skin producing dermatitis, redness and sometimes blistering. The higher the humidity, the greater the severity of skin lesions. With repeated exposures, mace can act as an allergen, producing serious allergic reactions with repeated exposure. Allergic sensitization can affect officers as well as wards. Injury to the eye and irritation of the lung tissue can also occur. Death has been reported with prolonged exposure to mace. Because oil traps mace in the skin, individuals should not wash with soap after exposures. Removal to fresh air and copious irrigation with water should occur.

There is no standard procedure guiding the treatment of individuals who sustain mace exposure. As well, according to staff we interviewed, post-exposure medical treatment is subject to security requirements such that not all individuals who are exposed are presented to medical for treatment or are presented in a delayed fashion for medical evaluation. Review of the medical records did reveal one individual who appeared from his picture to have sustained 2nd or 3rd degree burns from the effects of mace. The extent of medical complications from mace exposure in the CYA are not known because not all wards are brought for treatment, and follow up of those wards who are exposed is not thorough or tracked.

Recommendations:

1. CYA Headquarters should develop and implement policies and procedures that address the following:

- Types of medical equipment (AED, oxygen, emergency bag, etc.) to be available at each facility to appropriately respond to emergencies
- How frequently the equipment should be checked by medical staff
- Notification of medical and security personnel in the event of an emergency (physician on-call, poison control, security staff, etc)
- Orientation and training of staff about emergency equipment and emergency procedures
- Periodic emergency drills involving correctional and health care staff
- Cardiopulmonary Resuscitation (CPR) training for health care and correctional staff
- Medical treatment of wards exposed to mace to include the timeframe appropriate for evaluation and treatment and follow up care.

2. CYA Headquarters should incorporate emergency management into Peer Review and Continuous Quality Improvement (CQI) activities system wide.

3. Medical units should track all mace episodes and follow up these individuals medically so that

7. Does the CYA have appropriate medical and dental quality-control procedures, and have such procedures been appropriately implemented?

Conclusion:

Currently, there are no meaningful quality control procedures in policy or in practice in the CYA.

Findings and Discussion:

Quality Improvement

Current CYA policies do not address quality improvement activities. The draft *Institutions and Camps Manual* policies (1/2/2003) reference a Quality Assessment and Improvement Committee (page 8) as a standing committee of the Clinical Health Services Staff (CHSS).

However, review of the CYA Bylaws section 7.2.1.1 state that the CHSS shall have the following standing committees; Executive, Credentials, Patient Care Policy, Infection Control, Pharmacy and Therapeutics, and Mental Health. It does not mention the Quality Assessment and Improvement Committee.

Infection Control

There is no active infection control program statewide. Some facilities have an infection control manual updated in 1994. We understand that a revision of the manual is underway, but has not been published. There is a statewide public health nurse who tracks statistics and coordinates training, but we found no evidence of meaningful statewide infection control activity. The Infection Control Committee, according to the CYA Bylaws, directs the statewide infection control program. However, the Infection Control Committee does not provide any direction that is evident to individual facilities.

Dr. Briones is Chairman of the Statewide Infection Control Committee. He indicated that at meetings, the top issues discussed were tuberculosis, blood borne pathogens and HIV, but admitted he didn't know exactly what was discussed. He knows that the CYA doesn't follow the Centers for Disease Control guidelines on tuberculosis, but he doesn't want to be critical so he hasn't done anything about the CYA guidelines. He admitted that he doesn't feel he has any way to change anything, so his approach is to just listen. He did not display an understanding of basic infection control principles.

Infection Control activity depends on the initiative and leadership provided at each individual facility. There are, however, no regular meetings for infection control at any of the facilities we visited.

Tuberculosis Statistics

Statistics for infection control should be maintained in a manner such that the prevalence rate of each disease can be obtained. This requires definitions for each statistical category. Currently, for tuberculosis, the statistic maintained is "PPD Administered." (PPD is a tuberculosis skin test.) However, because usually more than one PPD is applied to each ward per year, it is difficult to obtain a prevalence rate for this condition.

Tuberculosis Form

All wards coming into the facility receive a tuberculosis skin test. The form to document this screening activity could be modified by the following:

- Eliminate the word "routine" and substitute "intake." Keep the word "annual."
- Add a section about country of birth, specifically asking "Were you born in the US?" This is important because, increasingly, new cases of tuberculosis are reported from foreign-born individuals, and it is important to track those cases coming from other countries, especially Mexico.
- Instead of asking, "Does ward have a history of previously positive tuberculin skin test?" ask these three questions:
    - Have you ever had TB disease?"
    - Have you ever been exposed to a person with infectious TB disease?
    - Have you ever had a history of a previously positive tuberculin skin test?

Employee TB Stats

Employee skin testing should be recorded with the following statistics.

- Total individuals (not tests applied) tested over a calendar year period
- Number of positive skin test results (10 mm for routine and 5 mm for immunocompromised)
- Number of individuals with a positive skin test result who were referred for follow up evaluation in the community
- Number of positive individuals for whom active disease was ruled out. This should be a requirement.
- Number of individuals who have had active disease diagnosed

Ward TB Stats

For tuberculosis screening of wards, the following statistics should be maintained:

Upon Intake:

- Number of wards who enter the CYA (i.e., new intakes or parole violators not tested in CYA within the prior year)
- Number of wards who enter the CYA with a previously positive skin test
- The number of wards who receive skin testing upon entry
- The number of wards tested with a positive test
- The total number of previous positives plus new positives divided by the number of intakes = % positivity
- Number of positives referred for preventive therapy
- Number of those started on preventive therapy who complete therapy
- Number of individuals with active disease diagnosed.

For Annual Testing:

- Total numbers of wards receiving an annual follow up tuberculosis skin test.
- Number of wards with a documented prior positive skin result
- Number of wards with a newly positive skin test result.
- Number of wards with a newly positive skin test divided by the number tested = conversion rate
- Number with newly positive skin test referred for preventive therapy
- Number referred for preventive therapies who complete therapy.
- Number with active disease diagnosed

Recommendations:

1. Revise policies and procedures to ensure compliance with NCCHC standards regarding a Comprehensive Quality Improvement Programs (Standard Y-06). Quality Improvement should include:

    - Infection Control
    - Mortality Review
    - Peer Review
    - Drug and Formulary
    - Compliance with policies and procedures

2. The HCSD should develop and implement Quality Improvement training to health care staff.

8. Are wards receiving medical and dental care commensurate with community standards?

Conclusions:

Dental care that is provided is commensurate with community standards with the exception of Chad where only emergency care is provided. Medical care, especially care for wards with chronic disease, was generally poor and was not commensurate with care as provided in the community. Constitutional health care requires correctional systems to provide adequate care for patients with serious medical problems. In practice, this will usually involve wards with chronic illnesses or emergent conditions. The CYA has not developed and published acceptable guidelines for the treatment of wards with chronic illnesses. Nor have they developed a system of care that appropriately treats and monitors wards with serious and chronic medical conditions. In addition, there is no system for periodic health assessments or physical examinations to screen wards for serious illnesses.

Findings and Discussion:

Most facilities have a list of persons with chronic illness, but there is no standardized manner of tracking persons with chronic illness at all facilities. There should be standardized protocol requiring interval visits, and interval examinations and testing. Chronic care is poor in the CYA. In some cases, bad care is combined with indifference toward the wards. This only compounds bad clinical care.

Appropriate chronic illness care consists of several elements. These include:

- Examinations
- Interval follow up
- Testing
- Provision of medication
- Appropriate history
- Modification of therapy for persons in poor control
- Physician knowledge base

Records of 29 persons with chronic illness were reviewed. Appropriate examinations were evidenced as performed in only 17% of charts. Interval examinations for the disease in question occurred in only 10% of charts I examined. Appropriate testing occurred in only 14% of charts. Medication was provided as indicated in 38% of charts. An appropriate history was documented in only 14%. And there was an attempt to modify therapy for poor control in 25% of records. This reflects the absence of a chronic illness program.

Intake Examinations

The intake examination form is a check box format. On almost all charts I reviewed all the boxes were checked normal, even when wards had obvious physical problems. This gives the impression that physicians do not adequately examine new wards at intake. As examples:

- A ward assessed as a severe asthmatic did not have a peak flow and had a normal examination.
- A ward that was assessed with a diastolic heart murmur had the cardiac examination box checked normal.
- A ward's intake physical examination had all boxes checked normal. On the same day a nurse took vital signs that were very abnormal. The vital signs could have resulted in an examination that would have uncovered the ward's hyperthyroidism, which was not picked up for several months.
- A ward with sickle cell disease and a history of hip surgery had all boxes checked normal.
- A ward with chronic tympanic membrane perforations (ear) that would have been evident on physical examination was documented as having a normal examination.
- A ward was incarcerated who had a recent jaw fracture and surgery. The examination boxes were all checked normal; there was no mention of the recent jaw fracture. At admission the dentist ordered special films of the jaw because he suspected an infected fracture site. The jaw was subsequently discovered to be swollen and the ward needed to be sent offsite to a specialist for surgery because of suspected infection.

Chronic Illness Examinations

In addition, for all other health care encounters in the CYA, there is a paucity of routine examinations of wards even when wards obviously require such examinations. I witnessed physicians performing sick call. At several sites physicians did not examine wards even when it was indicated to do so. Typical physician ward encounters consist of the physician asking the wards some questions and writing a note. Examinations that would have been appropriate for the chronic illness in question were not done. Further examples of this problem were discovered on chart reviews. These include:

- A patient with new onset high blood pressure who was not examined. This same ward had hypertension documented in the record for a period of 3 months. A doctor ordered medication by phone, and did a brief examination about 3 weeks later. Otherwise, there were no physical examinations of this ward.

- Aside from the intake examination, a ward with asthma had only one physician examination from April 2002 to April 2003.
- A complicated patient with a heart murmur and an abnormal electrocardiogram had an inadequate physical examination at intake and was not examined or followed up for over a year. He suffered a seizure for which he was hospitalized. After hospitalization for a serious problem, there was no physical examination for 2 months. On multiple subsequent occasions, the ward complained of symptoms that could have been referable to his heart condition, but no physical examination was done. The ward was transferred to the Chad facility sometime in November of 2002 and didn't have a physical examination as of my visit sometime in May of 2003.
- Another ward with asthma had only one physical examination for a year and a half period. During this time period, the ward suffered an acute asthma attack that was managed by nurses. He was gravely ill and was hospitalized in an Intensive Care Unit. He had his only physical examination (aside from the intake examination) a week after he returned from the hospital.
- One diabetic patient with finger-stick blood sugars of 494 and 560 (these are extremely high and abnormal values) did not get prompt physician examinations. On multiple occasions, this ward had abnormal blood sugar values that were managed mostly by nurses.
- For almost a year, a ward had poorly controlled diabetes. The physician's notes for this year period consisted of documenting "uncontrolled diabetes mellitus", without examining the ward and without changing therapy.
- A ward was documented as having epilepsy. Aside from the intake examination, there were no physical examinations for a year since the intake examination.
- Another ward documented as having epilepsy and on treatment did not have a physical examination for almost two years. During that time period the ward had a seizure as documented by a Medical Technician. The ward's medication had just previously been discontinued and the doctor restarted the medication by phone, but there was no examination of the ward.
- A ward with a high pulse rate (116) that subsequently was diagnosed with hyperthyroidism, was evaluated by a nurse. The nurse ascribed the increased pulse to high blood pressure even though the ward did not have that condition. A physician did not examine the ward for 3 days.
- A ward with sickle cell disease had obvious signs and symptoms of an acute sickle cell crisis. These crises are extremely painful and disabling. The ward endured the crisis for about 8 days before he received a physical examination. This constitutes cruelty. During this crisis, the ward had evidence of symptoms and signs sufficient that should have resulted in his transfer to a hospital. After this acute event, the ward had several other complaints that were evaluated without physical examinations.
- A ward with a history of thyroid cancer was re-incarcerated. He did not receive a physician examination for an 8-month period until he was paroled from the facility.

- A ward was referred to a physician by a psychiatrist for an abnormal blood glucose (331) that was new. The ward had lost 20 pounds of weight. The doctor reordered the blood tests but did not examine the ward. After a repeat blood test re-affirmed that the ward had diabetes, the doctor started insulin, but still did not perform a physical examination of the ward. The ward has yet to have a physical examination since his diagnosis.
- A ward with asthma that complained of trouble breathing was evaluated by a nurse. Peak flow testing was abnormal. It appears from the documentation that the nurse started medication. There was no evidence of a physician examination for about a month.

Interval Follow-up

Wards with chronic illness should be seen at regular intervals for follow up examinations, testing and updates of treatment plans. This is not done in the CYA. There is no system for chronic disease monitoring on an interval basis. As a result, none of the wards with chronic disease are seen unless they complain of a problem. At some sites, in order to get medication renewed for their chronic disease, wards must put in slips for sick call. This lack of a system for chronic illness monitoring results in poor care.

Documentation of chronic care management and follow-up is haphazard and lacks documentation of key elements that should be followed at interval visits. Most correctional systems utilize either flow sheets or chronic disease forms to prompt physicians in appropriate interval testing and examinations. These types of aides are particularly useful for medical personnel who are not up-to-date on chronic disease management.

Chronic Illness Testing

Current consensus recommendations from nationally recognized professional associations, recommend certain interval testing accompany the monitoring of certain chronic illnesses. There is no system in place that ensures that this is done within the CYA. As examples:

- Virtually none of the wards with asthma have their peak flow tested on a routine basis during sick call or physician encounters.
- With a few exceptions (Ventura), wards with diabetes mellitus do not have routine testing (microalbumin, finger-stick blood glucose, fasting lipids, or routine eye examinations) that is recommended for persons with their illness.
- Cholesterol screening is not routinely done when indicated. When it is done and results are abnormal there is no follow up.

Medical History

Physicians do not take an adequate history of ward's medical conditions. The intake examination form does not include a section for the history. As a result, physicians at the intake evaluation do not take a history. As a result, important historical information about a ward's medical condition is not available to medical staff. Examples of this include the following.

- There were virtually no wards that had a documented history of their asthma taken by physicians.
- A ward with a diastolic heart murmur had no history taken regarding possible related symptoms. After an abnormal electrocardiogram is also obtained, there was no history to try to identify possible problems. During his subsequent CYA incarceration, this ward had symptoms possibly referable to his heart (chest pain and dizziness) on 4 separate occasions, but did not have a history taken by a physician.
- No ward with diabetes had a documented adequate history of their diabetes care in the medical record.
- None of the wards from charts I reviewed with epilepsy had an adequate history of their epilepsy taken.
- Wards with significant illness (cancer, sickle cell disease, severe asthma, diabetes, etc.) coming into the CYA at intake facilities do not have documented histories that clarify the nature of their illnesses.

Therapy of Persons with Chronic Illness

In addition to these components of a chronic illness program, care of persons with chronic illness should be guided by appropriate standards of care. Based on chart reviews, most wards in the CYA did not have their chronic illness treated in a manner consistent with national consensus guidelines. Asthma, diabetes, epilepsy, sickle disease and hypertension were not managed appropriately. Problems in this area include:

- All 3 long-term patients with diabetes, whose charts I evaluated, had deterioration of their diabetes while housed in the CYA. Two of three wards deteriorated significantly. Physicians did not seem to have knowledge of how to provide basic diabetes care. One of the patients, based on my interview with him, seemed to have better basic knowledge of diabetes than the physician treating him. There was no documented evidence that physician histories or examinations were in keeping with recommendations from national consensus standards of care.
- One ward with hyperthyroidism was mismanaged. Physicians managing this patient continued anti-thyroid medication when it was dangerous to do so.
- A ward with sickle disease was incompetently managed.
- Physicians did not refer wards requiring specialized care to consultants. This includes patients with thyroid cancer, Grave's disease (hyperthyroidism), and a ward with a cardiac condition.
- Wards with high cholesterol were not evaluated or treated even when it was indicated.

Physician Knowledge Base

Treatment of persons with chronic illness requires a level of fundamental knowledge on the part of the physicians. Based on chart reviews, several physicians in the system do not appropriately treat chronic illnesses. Review of the credentials verifies that their training is insufficient. While they could augment their skills or have mentoring from better physicians in the system, this is not occurring. The current expectation is that every physician independently understands how to treat all of the conditions of the wards. This is not practical or reasonable given the group of practitioners in the CYA. There are several options in addressing this problem:

- Hire only practitioners who are board certified in a primary care field (Pediatrics, Internal Medicine or Family Practice). This may be impractical.
- House all wards with chronic medical conditions (by classification) into fewer (3) facilities so as to concentrate them in facilities with better-trained physicians. This is a preferable option since it requires no change in the configuration of staff and has no cost. There are classification issues.
- Institute staff training to provide a fundamental understanding of basic chronic care treatment.
- Develop simplified understandable chronic disease protocols or use existing appropriate protocols.
- Develop a system of ensuring that these protocols are followed by using forms and/or flow sheets. We strongly suggest that the NCCHC chronic disease protocols be used or modified for use in the CYA. Additional protocols would be necessary. Someone knowledgeable and trained should develop these in the area of concern. There is staff within the CYA system that could contribute to this effort. The California Department of Corrections (CDC) has useful chronic disease forms and protocols.
- Establish a system of peer review and physician evaluation to promote better care.

Prevention Services

Four of the top six causes of death for adolescents involve behavioral patterns rather than medical conditions. Data from the Centers for Disease Control from 1996 demonstrates that death from accidents, homicides, suicides, and HIV account for 77% of all deaths in the 15-24 year old age group in the United States. As well, much of the physical harm, poor social outcomes, increased mortality, and behavioral problems that affect adults are the result of behaviors developed in adolescents. Long standing violent behavior, obesity and physical inactivity, cigarette smoking, unwanted pregnancy, unsafe sexual practices,

and illicit substance abuse (including alcohol use) all result in increased adult morbidity and mortality. The behaviors initiated during adolescence become the causes of health or disease as adults. For these reasons, any program of adolescent health care must include a program of prevention and incorporate development of healthy behaviors.

The United States Health and Human Services (in the Guide to Clinical Preventive Services) and the American Medical Association (in its Guidelines for Adolescent Preventive Services) strongly support preventive services for adolescents. The emphasis of their prevention programs lies in screening interventions and behavior change. Behavior change is a recent but important element of preventive services. To quote the U.S. Preventive Health Services Task Force,

> *Although immunizations and screening tests remain important preventive services, the most promising role for prevention in current medical practice may lie in changing the personal health behaviors of patients long before clinical disease develops.*

Historically, in traditional medical programs, preventive services have not been stressed. The necessity of intervening with behavioral change models in otherwise "healthy" individuals was questioned. However, evidence now exists that prevention interventions reduce death and morbidity or are highly likely to be effective in reducing the harmful condition or behavior. Work by the U.S. Preventive Health Services Task Force and the American Medical Association resulted in identification of those preventive measure likely to reduce age related causes of morbidity and mortality. For adolescents, a program of prevention should include the following elements:

1. Measurement of height
2. Annual measurement of weight (BMI) and blood pressure
3. Updates for vaccinations (Td, Hepatitis B, Hepatitis A, MMR, Varicella, Rubella)
4. Papanicolaou tests for females
5. Chlamydia, gonorrhea, HIV and syphilis screening as indicated by risk group
6. Intake and then annual Mantoux skin test for tuberculosis
7. Screening cholesterol test as indicated by the National Cholesterol Education Project
8. Screening for alcohol and other drug use and counseling on high risk behavior as indicated
9. Screening for depression and risk for suicide and treatment if indicated
10. Screening for tobacco use and counseling on smoking cessation
11. Sexual behavior screening and counseling for STD prevention
12. Injury and violence prevention counseling

13. Opportunity for obtaining an appropriate diet and regular physical activity and counseling on the importance of appropriate diet and exercise
14. Annual dental visits with prophylaxis
15. Opportunity to floss teeth and fluoride toothpaste

The current health care program in the CYA is seriously deficient in the area of preventive services. As detailed elsewhere, the CYA does perform preventive screening at intake. With some minor modifications (detailed in the intake screening section of this report), the CYA program could be consistent with national standards. However, there is a virtual absence of a program of screening for behavioral medical health problems and counseling to change those behaviors. There is no attempt to change harmful adolescent behaviors or to promote health promoting behaviors. We did not identify any evidence of a program of meaningful counseling or prevention at any of the facilities. Physical activity is not specifically promoted for all wards, and collaboration with medical personnel to ensure healthy diet practices is non-existent. While individual practitioners may be providing information to wards on a case by case basis, counseling activity is not promoted or given any support or substance. Given the age of the wards and the potential for future benefits of such a program, this deficiency is a major lost public health opportunity.

Recommendations:

1. Develop a chronic illness program in the CYA.

2. The chronic illness program should include clinical guidelines that are benchmarked against national consensus standards. We recommend utilizing the chronic care guidelines as provided by the National Commission on Correctional Health Care and other national guidelines already cited.

3. Institute training of physicians in chronic illness management. Utilize flow sheets and other devices that prompt physicians to monitor interval testing and examinations in a specified manner.

4. Establish peer review and other auditing processes that regularly examine the effectiveness of chronic illness care.

5. Increase the numbers of physicians with training in the management of chronic illnesses of this population (Internal Medicine, Family Practice, and Pediatrics or Adolescent Medicine). In lieu of this, re-classify wards who have chronic medical conditions to facilities where this expertise exists.

6. Increase the use of appropriate medical subspecialty professionals when the condition of the ward is beyond the scope of managing by the current physicians.

7. Develop policies and procedures for periodic health assessments

8. Review existing preventive health programs for adolescents and develop from that review a program of preventive health in collaboration with mental health, medical and corrections.

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