SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	)	CASE NO. RG03079344

TWENTY-FIRST REPORT OF SPECIAL MASTER

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APPENDICES

I. INTRODUCTION

The Special Master submits for filing the Twenty-First Report of the Special Master. This report reviews the *Farrell* Medical Experts' comprehensive report of their 2011 round of audits as well as summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plans. The fifth comprehensive report of the Medical Experts (site visits, August 2011 to January 2012) is attached to this report as Appendix B. Consistent with an agreement by the parties, the Special Masterôs report limits the summarization of the experts' report and instead identifies the major areas of improvement as well as areas of concern.

The report begins with an update on the implementation of the Integrated Behavioral Treatment Model (IBTM) followed by the analysis of progress in the medical area. An update regarding a compliance finding from the Dental Expert is also provided. Issues relating to developments at the Ventura Youth Correctional Facility (VYCF), as well as when and how force is used are discussed next. The report concludes with a review of the recommendations made in the Eighteenth Report of the Special Master.

II. INTEGRATED BEHAVIORAL TREATMENT MODEL

A. Current Progress

The IBTM Project Consultants from the University of Cincinnati Corrections Institute (UCCI) conducted another site visit and training on January 10-13, 2012. The visit included coaching sessions on Pre-treatment and Advanced Practice lesson plans; meetings to discuss implementation concerns with the IBTM implementation team, O. H. Close Youth Correctional Facility (OHCYCF) and Central Office leadership and the

IBTM initial and expansion units; observations and feedback were provided regarding Cognitive Behavioral Treatment (CBT) groups[1] and initiatives such as Skill of the Week; a site visit of a Behavioral Treatment Program (BTP); and a conference call with the Special Master, Mental Health Expert, select implementation team staff and DJJ mental health administrators to review concerns regarding the draft Behavior Management System (BMS). The UCCI Consultants have submitted another quarterly report that represents a summary of services rendered within the last quarter (November 1, 2011ð January 31, 2012) and is attached to this report as Appendix A.[2]

Phase III of the current IBTM implementation plan focuses on expanding the IBTM into other units. The UCCI Consultants indicate that the addition of two more units at OHCYCF, Calavaras and Del Norte, has gone well. The units now provide the core CBT programs. The consultants indicate they are pleasantly surprised at how quickly the new units implemented the CBT groups.[3] ñSkill of the Weekò[4] groups are now being conducted on Butte, Amador, Calavaras and Del Norte as are Advanced Practice Sessions.[5] Staff at some of the specialized units at OHCYCF have also been trained in preparation for their units to implement CBT groups.[6] Approximately 20 staff from the four OHCYCF units and intake have been trained in both Pre-treatment and Advanced Practice facilitation skills, as have the IBTM project team trainers.

[1] The CBT groups currently implemented as part of the IBTM include Aggression Interruption Training and Counterpoint.
[2] Appendix A, UCCI Consultant Report, DJJ Quarterly Report 1 31 12.FV.docx
[3] UCCI Consultant Lori Lovins shared this information at the exit meeting for the UCCI visit in January 2012.
[4] Skill of the Week was discussed in the Twentieth Report of the Special Master, p. 3, footnote 3.
[5] Advanced Practice Sessions were discussed in the Twentieth Report of the Special Master, p. 3.
[6] The IBTM project team has been working with a Sexual Behavior Treatment Program (SBTP) unit to identify how the CBT groups can best support the SBTP curriculum.

In the initial units, challenges existed in ensuring that the groups were occurring consistently and without interruption. OHCYCF management addressed this issue and the problem was corrected. The Special Master has reviewed the group schedules of the four units where the CBT programs have been implemented and it appears that a few cancellations have occurred and when they did, they were made up.[7]

A resource guide for unit staff has been completed. Feedback from unit staff is that the guide is a helpful tool. In addition, an overview of the IBTM has been developed to help train unit staff in preparation for implementation of the IBTM. One of the innovations that is a unique contribution of Defendant in the implementation of CBT programs is the concept of ñYouth Assistants.ò

> Youth Assistants have been identified on Butte. These are Level A youth that have completed core programming and provide a supportive role to staff, currently limited to assisting with skill of the week sessions. A protocol has been designed by the IBTM (project team) and reviewed by UCCI on the selection, training, expectations and responsibilities of Youth Assistants. Other IBTM units should begin to incorporate this protocol and provide this leadership opportunity to youth on their respective units.[8]

The idea of Youth Assistants came from the request of a youth to help with the groups. IBTM project team members immediately saw the potential benefit of engaging youth and worked with the UCCI Consultants to develop parameters and guidelines for the program.

Training and coaching of staff has continued but the limited number of staff remaining on the IBTM project team has made it difficult to provide the level and type of coaching that is needed to ensure reinforcement of what is taught in CBT groups. Training efforts have included sessions on motivational interviewing, casework,

[7] *See* Amador-Butte Group Cancellation (1).pdf, Amador-Glenn Casework Schedule April 2011 thru February 2012.pdf. and Butte Casework Schedules 8-11 thru 2-12(1).pdf.
[8] Appendix A, UCCI Consultant Report, DJJ Quarterly Report 1 31 12.FV.docx, p.3.

cognitive behavior primer, crisis intervention and conflict resolution.[9] Nine staff successfully completed a Training for Trainers for Aggression Interruption Training (AIT). This training is particularly important because it will greatly expand Defendantôs capacity to train more units to facilitate this program.

As discussed in the Twentieth Report of the Special Master, an essential and missing element of the IBTM is a system that encourages staff to reinforce what youth are learning in the CBT classes. The IBTM project team has worked to develop a strategy to reinforce desired behaviors and to extinguish undesirable behaviors. The Mental Health Expert and the UCCI Consultant worked with the project team to develop a simple system that helps staff to understand the difference between positive and negative reinforcement and positive and negative sanctions for clearly targeted behaviors. Understanding how staff behavior either supports or undermines a youthôs efforts to change behavior is a key element of the IBTM. Training for the Reinforcement System will be provided for all staff beginning in April 2012.[10]

In addition, the UCCI Consultant, Mental Health Expert and the IBTM project team have worked to adapt a UCCI training called Core Correctional Practices for all DJJ staff. This training focuses on effective social reinforcement, effective disapproval, effective use of authority and relationship skills. This training and the Reinforcement System will be delivered together along with use-of-force training to help focus interactions between youth and staff on reinforcing behaviors and skills learned in the

[9] A total of 272 staff were trained at VYCF and the Stockton Training Center (STC). Another 23 staff went through a transition training at the training academy.

[10] *See* RS 5 (jtdoc)(1).doc. This training will be a part of the training on de-escalation of problematic situations and use of force. The training was scheduled to begin in the first quarter of 2012 but was pushed back due to suggested revisions of the reinforcement system by the Mental Health Expert and failure of the parties to reach agreement on the use-of-force policy.

CBT courses. The IBTM project team is to be congratulated for developing such useful training and tools to help staff target and support desirable behavior change in youth.

B. Issues to be Addressed

Defendant continues to demonstrate progress in implementing the key elements of the IBTM Implementation Outline.[11] The following is a discussion of some of the key issues that need to be addressed followed by a discussion of possible next steps for moving the implementation of the IBTM forward. The list of issues is not intended to include all issues that must be addressed in the implementation process.

1. Lack of a Clearly Communicated Mission

Given the turbulent environment that Defendant has had to operate in over the course of the *Farrell* lawsuit, it is understandable if staff are not yet clear what an IBTM is and why they should care about it. The Special Master has and continues to opine that senior leadership team members are not entirely clear themselves about what an IBTM is and, therefore, what it requires to fully implement.[12] There is a noticeable lack of a conceptual framework that is clearly articulated and shared with all staff and staff who have experience in implementing the elements of an IBTM. Further, the few staff that have a conceptual framework of any sort, work with fear of job loss. There is not a clear understanding of what is required to staff the IBTM project team. This issue is discussed in greater detail below.

[11] ORDER RE: INTEGRATED BEHAVIOR TREATMENT MODEL REPORT SUMMARY AND IMPLEMENTATION OUTLINE, May 2, 2010.

[12] The Special Master has asked the Secretary of Corrections and the Under Secretary of Corrections to fund visits to other effective state juvenile corrections systems for the Division Director and Facility Superintendents to experience an IBTM.

An IBTM overview has been created and presented to mid-level managers in DJJ. The Special Master has not seen the overview so she cannot comment about its content.

2. Staffing for IBTM Implementation

To make the type of culture change the IBTM demands of the mental health and safety and welfare remedial plans, it requires knowledgeable and skilled professionals who have demonstrated knowledge and experience working specifically with youthful offenders. Defendant has dedicated significant resources to create such an IBTM project team. In the past, the closure of DJJ facilities and resulting budget cuts have resulted in some loss of team expertise. Today the resources are significantly diminished both in number and expertise and threaten to be further diminished by staffing cuts in adult corrections.

Comparing October 2010 and February 2012 staffing levels, out of 29 positions on the IBTM project team, fully 10 have been eliminated and six are vacant.[13] Eliminated positions include instructional designers, office technicians, training officers and psychologists.[14] The IBTM project team is attempting to function with over 50 percent fewer resources than originally funded. Defendant opines that curricula are developed and other tasks completed so that staff is no longer needed. This ignores the fact that there are elements of the 2010 IBTM Order that have not yet been implemented and that resources are needed to maintain quality in the existing sites at the same time the program is implemented in other sites. It will also take greater staff support and training from the IBTM

[13] Three positions are not included in this because they were eliminated as a result of facility closures.
[14] *See* Positions Associated with IBTM (1).doc.

project team to implement programs at VYCF because the two members of the IBTM project team at VYCF have not been able to be as actively involved with the team due to travel restrictions and budget limitations.

The loss of needed staff, changes in leadership and the constant threat of bumping of staff have understandably limited the productivity of the team. The team has done an amazing job of continuing to meet milestones despite reduced resources and high levels of insecurity. That said, implementation progress could be faster if this team were properly staffed.

The Mental Health Experts, UCCI Consultants and the Special Master have all opined on several occasions that the continued change in resources and staffing threatens the ability of Defendant to implement the IBTM.[15] Despite these concerns, Defendant continues to choose to change the team composition and to reduce resources. It cannot be stated enough that it takes time to develop expertise and the loss of such expertise significantly reduces the possibility of achieving compliance in the implementation of the IBTM.

A recent development that threatens the implementation of the IBTM is the loss of key staff due to budget cuts in adult corrections. Psychologists, medical providers and administrative staff who have invested in the IBTM suffer the threat of being bumped by someone from adult corrections who may never have worked with youth and/or have any exposure to evidence-based practice with youthful offenders. It is not just a stable and skilled IBTM project team that is required but stable staffing in all the disciplines that collectively create the

[15] The experts, consultants and the Special Master have provided this feedback to IBTM staff as well as senior DJJ leaders verbally and in writing.

IBTM.[16] Successful implementation of the IBTM will not occur without stable staffing patterns of professionals who have demonstrated knowledge and understanding of the current evidence-based practices that work with youth.

While there are defined and measurable activities that Defendant can complete to achieve substantial compliance in the *Farrell* lawsuit, the work of the IBTM project team will likely never truly go away. Juvenile systems more advanced than DJJ are constantly refining their behavior model. All staff are trained in how to reinforce desired youth outcomes including support staff such as custodial and kitchen staff. There will continue to be the need for a training and development function for many years to come.

3. Clear Roles and Duties

As discussed in the Twentieth Report of the Special Master as well as the most recent UCCI Consultants report, and discussions with the Mental Health Experts, there appears to be confusion regarding roles and responsibilities among staff. The UCCI Consultants note that IBTM-trained staff members, when working overtime, do not believe it is their duty to cover IBTM responsibilities.[17] It appears that staff believe when they are in a custody role that they are not part of the IBTM. This appears to indicate that all unit staff do not understand their

[16] The differences between adult and juvenile corrections are significant enough that position classifications should be different enough to not allow for the practice of bumping between systems. In highly functional juvenile systems, all staff members are trained to interact with youth to support behavior change. It appears the practice of limited-term positions exacerbates this situation. Defendant indicated that there might be a window to change some of the limited term positions (which are vulnerable to being bumped by adult corrections staff) into permanent positions. Senior leaders above the Division Director in the chain of command support these efforts.

[17] Appendix A, UCCI Consultant Report, DJJ Quarterly Report 1 31 12.FV.docx, p.5.

role in the IBTM. All staff should be reinforcing the lessons being taught in the CBT groups.

There continues to be confusion regarding the exact role of mental health professionals in the IBTM. The response of psychologists varies from no engagement to active engagement. The Mental Health Expert will help Defendant with this issue after the completion of an inventory of all DJJ youth. The inventory of DJJ youth is being undertaken at the suggestion of the Mental Health Experts. Information from this inventory is needed before the role of psychologists in the IBTM can be determined.

Also, the knowledge level and the role and the responsibility of the various levels of management in the IBTM units are unclear to the Special Master. What are the responsibilities of the Program Administrator, Treatment Team Supervisor, Senior Case Manager and Senior Psychologist?[18] The UCCI Consultant team has noted that quality assurance functions should be transferred to unit level staff. A question remains regarding the role of the various levels of unit management staff. It appears to the Special Master that the level of understanding and ownership by the various levels of management for the IBTM is at best uneven and more often not clearly defined.

4. Lack of Substance Abuse Treatment

A deficit noted by the Mental Health Experts and the UCCI Consultant is the lack of a evidence-based substance abuse treatment program.[19] Defendant has

[18] It should be noted that this issue is not just limited to the IBTM units.

[19] The Mental Health Experts noted this deficit in their presentation to DJJ staff in December 2011 and it is also noted in the UCCI Consultant Report, DJJ Quarterly Report 1 31 12.FV.docx,

had substance abuse programs in the past but was directed by prior management to eliminate the program. The current experts and consultants are in agreement that an evidence-based substance abuse program is needed. Defendant has been reviewing various curricula and appears to have settled on a curriculum offered by UCCI. It is imperative that a substance abuse curriculum be implemented as quickly as possible.

5. Behavior Management System

Defendant has completed a draft of a Reinforcement System (RS) that is designed to help staff understand how to daily reinforce more pro-social behaviors and to create a more positive environment. It is basically a contingency management (Positive Reinforcement System) that is part of a larger behavior management system that will include the Disciplinary Disposition Management System (DDMS) and level systems. Staff will be trained on this tool at the same time they receive training on Core Correctional Practices and use of force.[20] The Mental Health Expert and the UCCI Consultant were actively involved in the development of the RS. This system is designed to help staff learn how to consistently support the behaviors youth are learning about in the CBT programs. This system will be piloted in the initial IBTM units beginning in March 2012.

6. Unstructured Youth Time

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p.5. This issue was also raised on a call between the Safety and Welfare Expert, the Mental Health Expert, the UCCI Consultant team and the Special Master.

[20] Core Correctional Practices Training is designed to provide staff with the tools that ñcan assist them with preventing and dealing with crisis situations, as well as providing interactions that will help to reduce recidivism." Core Correctional Practices, p. 4.

A recurrent concern of all the experts and the Special Master is what is labeled as ñprogram time.ò Program time is often unstructured time that amounts most commonly to watching TV. All the experts and consultants are in agreement that more of the youthôs time needs to be in structured activities that reinforce the learning in the CBT groups. Some unstructured time is appropriate but there remains far too great a percentage of youth time that is not supporting achievement of the youthôs targeted goals.

7. Case Management

As soon as the California Youth Assessment Screening Instrument (CA-YASI) is integrated into the case plan, it is time to develop clear protocols for case conferences and to enhance the quality of case plans. Too often the case plans reflect a lack of understanding of the role of the risk and needs assessment process in identifying targets for change and the identified youth goals are too vague to be meaningful. Case plans should be written so that the youth goals are clear and easy for all staff and youth to understand. Goals should be readily accessible (some programs post them for all to see on units) for all staff so they understand what behaviors they should be reinforcing.

Case conferences vary considerably throughout DJJ. While difference is not inherently bad, there should be a protocol for what issues are to be addressed, in what order and by whom. The Chief Psychiatrist has opined that it is essential that roles in the case conference be clarified and that a lead for the conference be established.[21]

[21] The Mental Health Expert facility assessments also pointed this issue out and it has been the observation of the Special Master.

8. Program Service Day

The many changes that are being made in the IBTM units have necessitated schedule changes. Changes scheduled to the case plan will require yet more changes. Many disciplines, especially mental health, express frustration that the current Program Service Day structure does not allow adequate access to youth. Defendant is to be congratulated for putting a structure in place that enhances the chance for meaningful activity for youth. That said, it is probably time to re-visit how the day is structured with all the disciplines. The Special Master has conferred with all of the experts in the litigation and they are willing to assist Defendant to modify the system as needed.

C. Next Steps

The Mental Health Expert, the Safety and Welfare Expert, the UCCI Consultants and the Special Master conferred on February 8, 2012 to discuss progress with IBTM implementation and possible next steps. All parties were in agreement that it is time for Defendant to begin work on the next implementation plan.[22] The current IBTM implementation plan does an excellent job of creating some of the basic systems and tools needed to effectively implement CBT groups, provides some reinforcement for learning in the CBT groups, as well as adds additional structured activities and creates quality assurance mechanisms. When completed, there will be an effective model for expanding these services to all units in DJJ. That said, there remain several steps that need to be undertaken to implement the full IBTM.

[22] The current plan is scheduled for completion by October 2012. See IBTM At-A-Glance (4)(1).xls.

The IBTM is more than just CBT groups. It is a way of assessing, understanding and interacting with youth that provides the interventions needed to meet a youthôs unique issues and needs. This requires excellent assessment, goal setting, consistent reinforcement for desired progress and constant monitoring and support for change. It requires that all staff from all disciplines speak the same language. Many of the elements of this framework exist but require refinement and some skill sets are missing or require enhancement. The next phase of planning must address how to ensure that all staff understand the concept of an IBTM, their roles in it and to provide staff the skills needed to successfully fulfill their roles.

Two of the most significant areas that need to be addressed are the design and clarification of the model for mental health units and coaching and training staff on the menu of cognitive behavioral skills needed in a behavioral treatment model.[23] The current IBTM Implementation outline describes Dialectical Behavior Therapy as the chosen modality for mental health units. This issue will need to be re-assessed in light of the population inventory that is in progress. It is the belief of the Mental Health Expert and the DJJ mental health leadership that there will be a significant reduction in the number of mental health units. This will influence the design of the IBTM for the mental health system.

Work will need to be done to develop and to enhance behavioral skills that staff uses to address targeted youth behaviors. Many staff do not have the skill level to assist

[23] ORDER RE: INTEGRATED BEHAVIOR TREATMENT MODEL REPORT SUMMARY AND IMPLEMENTATION OUTLINE, May 2, 2010, Exhibit B, IBTM Implementation Outline, p. 5-6.

with issues such as self-monitoring and self-regulation or stress management.[24] There will need to be a reinforcement system designed to support staff to develop and to use very different skills from the institutional management skills often used today. The move from institution management to behavioral health management will require coaching in addition to didactic training.[25] Supporting staff to develop these skills will require a shift to coaching. The IBTM project team is currently not trained nor equipped for this effort. This effort may require re-thinking the current staffing model for residential units. The current model creates an unfortunate and unnecessary divide between custody and treatment that is not consistent with an integrated behavioral health model.

III. MEDICAL CARE

The Medical Experts, Joe Goldenson, MD, and Madie LaMarre, MN, FNP-PC, completed their fifth round of audits between August 2011 and January 2012. During their audits, the Medical Experts visited the VYCF and the Northern California Youth Correctional Complex (NCYCC), which includes the N.A. Chaderjian Youth Correctional Facility (NACYCF) and the OHCYCF.[26] The Experts also visited DJJôs Central Office. Their comprehensive report was completed in February 2012 and is attached as Appendix C.

A. Facility Compliance

[24] *Ibid.* Examples of cognitive behavioral skills included in the 2010 ICDTP Order include: Interpersonal/Social Skills, Stress Management Skills, Self-Regulation Skills, Self-Monitoring Skills, and Cognitive/Thinking Skills.
[25] Twentieth Special Master's Report, p. 4.
[26] On Defendantôs request, beginning the third audit round, the Medical Experts assessed for and assigned a single compliance rating for NACYCF and OHCYCF which are now identified in the expertsô reports and the Special Masterôs report as NCYCC. For consistency and to place the progress of Defendantôs remedial effort into proper context, this Special Masterôs report contains a discussion of the overall rating of each of the three remaining facilities on an individual basis.

The Medical Experts have found that DJJ has improved and sustained improvements in health care services in both VYCF and NCYCC since their last round of audits. The overall numerical ratings for VYCF and NCYCC were 85% and 91%, respectively. On an individual facility basis, VYCF and NACYCF improved their overall ratings from partial compliance to substantial compliance in this round of audits.[27] OHCYCF has maintained its rating of substantial compliance this round making it the third round of achieving substantial compliance. The following is a table of the facilitiesô overall numerical ratings during the recent three rounds of audits:

	Third Round	Fourth Round	Fifth Round
VYCF	79%	87%	85%
NACYCF	81%	81%	89%
OHCYCF	88%	88%	92%

In their comprehensive report, the experts acknowledged and commended Defendantôs efforts for continuing to make improvements while confronting challenges from having to make structural changes due to the declining youth population as well as the closure of Preston Youth Correctional Facility (PYCF) and the Southern Youth Correctional Reception Center and Clinic (SYCRCC).

During this round of audits, the Medical Experts transferred clinical monitoring of four of 18 aspects of cares to DJJ for self-monitoring, subject to further review and testing by the experts. The four aspects of care are: pharmacy services, credentialing, peer review and quality management. The staff of the California Department of Corrections and Rehabilitationôs Office of Audits and Court Compliance (OACC) and DJJôs health care staff, who served as subject matter experts (SMEs), completed an

[27] VYCF had a score of 87% last round but the medical experts withheld a rating of substantial compliance due to a high rate medical appointment rescheduling and cancellation of appointments. *See* Seventeenth Report of the Special Master, March 2011, p. 4.

internal review of VYCF health care program in 2011. The internal review of NCYCC, initiated in July 2011, had not been completed as of the Medical Expertsô visit to DJJ Central Office in December 2011.

The following is a summary of the rating assigned by the experts and by the DJJ internal review in the 18 aspects of care reviewed during their fifth round of audits:

Audit Item	**VYCF**	**NCYCC**
Facility Leadership, Budget, Staffing, Orientation and Training	89%	100%
Medical Reception	80%	85%
Intrasystem Transfer	96%	96%
Nursing Sick Call	75%	73%
Medical Care	92%	96%
Chronic Disease Management	94%	95%
Infection Control	100%	100%
Pharmacy Services	100% (DJJ Self-Monitor Item)	100% (DJJ Self-Monitor Item)
Medication Administration Process	92%	100%
Medication Administration Health Record Review	82%	89%
Urgent/Emergency Care	80%	86%
Outpatient Housing Unit	Not Monitored Due to Infrequent Use	88%
Health Records	100%	100%
Preventive Services	84%	94%
Consultations	85%	95%
Peer Review	100% (DJJ Self-Monitor Item)	100% (DJJ Self-Monitored Item)
Credentialing	100% (DJJ Self-Monitor Item)	100% (DJJ Self-Monitored Item)
Quality Management	80% (DJJ Self-Monitor Item)	80% (DJJ Self-Monitored Item)
Overall Rating	**85%**	**91%**

B. Central Office Compliance

In addition to facility ratings, the Medical Experts again provided ratings for DJJ Health Care Services on twenty ñquestionsò or topics under two categories: (1) organization, budget, leadership and staffing (13 topics) and (2) statewide pharmacy

services (seven topics). Ratings are reported in cumulative compliance percentages of the 13 and seven topics that the experts find in substantial compliance.

Overall, Health Care Services scored 85% (17 of 20 topics). This represented the combined score of 77% (10 of 13 Questions) for health care organization, budget, leadership and staffing; and 100% (7 of 7 Questions) for statewide pharmacy services. This score represents a significant improvement from the previous overall score of 50% when DJJ achieved substantial compliance with five of 13 topics (38%) related to organization, budget, leadership and staff and with five of seven (71%) statewide pharmacy services topics.[28]

The Medical Experts found Health Care Services to be in substantial compliance pending development and implementation of two structural elements of the remedial plan: standardized nursing procedures and a system for establishing fiscal accountability for the health care program.

A review of the three health care organization, budget, leadership and staffing topics where Defendant did not achieve substantial compliance ratings disclosed the following:

- Failure to receive substantial compliance in all three topics is attributed to staff turnover in key positions by the medical experts (Statewide Medical Director, Statewide Director of Nurses, and the Health Care Administrator). For the Statewide Medical Director position, the Medical Experts opined that turnover in this position has delayed implementation of the few remaining structural aspects of the remedial plan such as establishing a system to evaluate staff productivity and fiscal accountability. For the Statewide Director of Nurse position, the Medical Experts opined that, even though the position had been filled, the turnover has prevented the implementation of nursing standards. Some nursing standards were developed prior to this report.[29] This item could be deemed in substantial compliance if Defendant implements the nursing standard by July 31,

[28] *See* Seventeenth Report of the Special Master, p. 5.
[29] These standards were recently sent to the Medical Experts for review.

2012. The Medical Experts have repeatedly raised this issue during their previous audits and have offered their assistance in the development of the nursing standards. The Special Master urges Defendant to seek guidance and assistance from the Medical Experts in this regard. With respect to the Health Care Administrator position, which is a Career Exempt Appointment (CEA) position and must be approved by the Department of Personnel Administration (DPA), Defendant is waiting for DPAôs approval before it can recruit for a candidate. In the meantime, Defendant has created and filled a Staff Services Manager position to assist with administrative duties for the medical services, which appears to be prudent under the circumstances.

- The Medical Experts identified areas for further improvement while assigning substantial compliance rating in the topic of developing and implementing a structured audit process to identify areas for improvement and formulate corrective strategies. The Medical Experts noted that a Quality Management Plan had been developed and a Health Care Services (HCS) Quality Management Team (QMT) is to coordinate and facilitate the performance of quality improvement activities at each facility. Under the current plan, the HCS QMT collaborates and coordinates with the OACC to conduct structured clinical audits approximately six months before the Medical Expertsô audits. While strongly in support of this plan, the experts found inconsistencies between their ratings and those of the self-audit team at VYCF. The audit at OHCYCF was not completed in a timely manner. Clearly staff turnover in leadership positions impacted the ability of Defendant to ensure accurate and timely self-auditing. The experts and Defendant have agreed upon a self-audit process, which is discussed below.

C. Areas for Improvement and Implementation Successes

Now that the three DJJ facilities have achieved substantial compliance, the experts indicate that Defendant is capable of self-monitoring of the facilities. The experts conclude that the key remaining challenges for Defendant are to ensure that systems are in place to make certain that health care services continue to be delivered in the most cost-effective manner and to continue development of a quality improvement program. To achieve these objectives, the experts recommend Defendant develop and establish management controls and monitoring systems to sustain reform and to ensure youth continue to receive quality medical services in a cost-effective manner. Specific recommendations that merit particular attention include:

- Establish standardized definitions of health care utilization and staff productivity measures; provide staff training; and implement a system for systematic data collection and analysis for each discipline (e.g., medicine, nursing, dental, pharmacy and mental health). These data should be used as a basis for decision-making regarding staffing and contract services.

- Ensure that the quality management, clinical monitoring and peer review processes focus on areas identified as requiring improvement during clinical monitoring.

- Develop and implement standardized nursing procedures to provide clinical guidance to nurses in patient evaluation. This is a requirement of the Health Care Services Remedial Plan and the experts have repeatedly made this recommendation in previous rounds of audits.

- Address the expertsô concern in the medical reception process at VYCF for which the score dropped from 95% to 80%. This was primarily due to health care providers not elaborating on positive responses to symptoms for the purposes of establishing a medical diagnosis (e.g. chest pain, headache, etc); and not consistently evaluating and treating women with vaginal discharge. This latter issue was a finding last year which remained unchanged. The expertsô rated the facility to be in substantial compliance pending improvements in the facilityôs medical reception process.

D. Returning Monitoring to Defendant

Based on the findings and conclusion of the Medical Experts in their latest round of audits, the Special Master believes it is appropriate for the parties to develop a plan to return monitoring responsibility for health care services to Defendant. The expertsô review at the facility level, which measures the adequacy and quality of clinical care provided to youth, found that Defendant has achieved an overall rating of substantial compliance at all facilities. The quality of clinical care provided to youth by Defendant is substantially compliant with the Health Care Services Remedial Plan. At the Central Office level, Defendant has achieved compliance in 100% of topics under statewide pharmacy services and 77% of topics under health care organization, budget, leadership and staffing for an overall substantial compliance rating of 85%. Topics that remain in

partial compliance are those that indicate the systems and processes needed to sustain the current quality of clinical care to youth are in place.

Defendant has begun taking actions to address the remaining topics under organization, budget, leadership and staff that have not achieved substantial compliance. It is important to note these topics are related to functions that are more administrative in nature and thus have greater impact on efficiency and economy of care delivery rather than on adequacy and quality of care. The expertsô report identified various areas where opportunities exist to achieve greater efficiency. Defendant should consult with the Medical Experts to develop staff utilization data and processes to identify and implement measures to deliver health care services in a more cost-effective manner. Defendant should also seek advice and input from the experts as it continues to develop and implement an effective internal quality improvement program to include nursing standards.

Based on the findings in this round of audits, Medical Expert Dr. Joe Goldenson indicates he believes it is no longer necessary that he audits medical records to review clinical care. Medical Expert Ms. Madie LaMarre also indicates that it is not necessary for her to proceed with a full audit next round providing that Defendant develop and implement statewide nursing standards and demonstrate capability for meaningful self-monitoring and quality improvement in a timely fashion. If these conditions are met, Ms. LaMarre indicates that the extent of her involvement in the next round of audits will be limited to inquiries and spot checking of certain items to ensure youth continue to receive adequate medical services despite a significant reduction in medical staff and ensuring substantial compliance on the remaining Central Office items.

The Special Master urges Defendant to work closely with the Medical Experts to address any concerns they may have and to facilitate a smooth transition of the monitoring process. DJJ medical and OACC staff should complete a review six months prior to the return of Ms. LaMarre. Defendant is to be congratulated for a finding of substantial compliance for clinical care for youth.

IV. DENTAL CARE

In the Twentieth Special Master's Report, the Dental Expertôs third round of audit findings were discussed. The Dental Expert gave VYCF a conditional substantial compliance rating. The Dental Expert indicated that if Defendant could address the issue with broken appointments at VYCF, it would achieve substantial compliance.

> In order for the conditional substantial compliance rating to be converted to substantial compliance, Defendant must submit data to the expert within 90 days following the receipt of the Dental Expertôs report on October 6, 2011 showing a significant and sustainable reduction for the audit item regarding broken appointments.[30]

On February 29th, the Dental Expert submitted a supplemental report that indicates Defendant has addressed the problem of broken appointments at VCYF and thereby achieved a substantial compliance rating for the facility.[31] The Dental Expert again acknowledges the hard work and effort on the part of Dr. Viviane Winthrop, Supervising Dentist, to accomplish this result. The hiring of the second dental assistant at VYCF was also helpful in this effort.

A. Returning Monitoring to Defendant

The Dental Expert worked with Dr. Winthrop in the last audit round to begin the transfer of some monitoring to Defendant. The Dental Expert has indicated he will work

[30] Twentieth Special Master's Report, p. 37.
[31] *See* Follow-up Dental Report Ventura 2-29-2012 Final Draft.doc

with Dr. Winthrop in the coming months to identify an internal monitoring protocol for Defendant. The Special Master will work with the parties and the Dental Expert to address the transfer of monitoring from the expert to Defendant.

V. VENTURA YOUTH CORRECTIONAL FACILITY

A. Historical Overview

The issues confronting VYCF have been discussed at length in the Special Masterôs Eighteenth, Nineteenth and Twentieth Reports. The issues first surfaced when concerns were raised during the Case Management Conference on March 28, 2010 about education staffing at the facilityôs BTP units. In April 2010, the parties, the Safety and Welfare Expert and the Special Master made a site visit to VYCF and identified several issues. Actions were proposed and agreed upon to improve the operations of the BTP units and to provide mandated educational services to youth in VYCF.

In her Twentieth Report, the Special Master acknowledged that Defendant has taken the problems at VYCF seriously and has made progress in addressing issues that the Court outlined in the Order Granting Motion to Enforce Court-Ordered Remedial Plans and to Show Cause Why Defendant Should Not Be Held in Contempt of Court, August 4, 2011 (August 2011 Order). The Special Master indicated that progress had been made in ñtraining BTP unit staff, management and educators about the BTP program protocol, and in the creation of more program and recreation space and training staff on how to document youth activities.ò[32]

The Special Master cautioned that there is much more to be accomplished, as it was clear that some youth in restricted programs were not receiving the full complement of education services. Moreover, although the WIN system data suggested that the

[32] Twentieth Report of the Special Master, p. 32.

facility was in compliance with the minimum requirement of three hours of out-of-room time, the Special Master found that most of the time, the youth were engaged in unstructured activities. An audit by Defendantôs OACC raised questions about the accuracy and reliability of the WIN data as there were significant variances between the WIN data and the information on living units' logs. The facilityôs inability to integrate a small population of youth in the BTP, who were transferred from the Hemen G. Stark Youth Correctional Facility, into the general population poses further challenges in the management of restricted programs.

In addition, noting that the superintendent position has been vacant for some time and Defendant was in the final stages of selecting a superintendent, the Special Master stated that a critical issue confronting Defendant is a strong and stable leadership team. On January 3, 2012, Defendant appointed Victor Almager, an experienced correctional administrator, as the Acting Superintendent. Based on observations made during recent site visits by the Special Master and the Deputy Special Master, the Special Master found the new Superintendent to be an effective leader who has proactively taken actions to affect positive changes during his short tenure. The actions and accomplishments are discussed in latter sections of this report.

B. Improvements in the High Core Units

In her Twentieth Report, the Special Master noted that it is logistically difficult, if not impossible, to provide youth with the full complement of mandated education services at the high core units given the high number of youth placed on Temporary Detention (TD) and Treatment Intervention Plan (TIP) and the shortage in education staff. In addition, there were other situations such as the entire living unit being placed

on lockdown or program change protocol status creating additional challenges in delivering education services. Moreover, in a report issued on October 10, 2011, auditors from Defendantôs OACC found that one of the high core units, Casa Los Caballeros (CLC) was operating as a BTP and regularly programmed youth in groups segregated by ethnicity/gangs.

The Deputy Special Master conducted a site visit to VYCF on October 6 and 7, 2011 and found that youth in the two high core units were involved in disproportionate share of TD/TIP incidents, as indicated in the following table:[33]

	August 2011	September 2011	October 2011
TIP Incidents	12	4	0
TIP Incidents	116	81	106
Total TD/TIP Incidents in High Core Units	128	85	106
Total Facility TD/TIP incidents	231	155	203
Percentage of TD/TIP Incidents in High Core Units	55%	55%	52%

Given the high number of placements at the high core units, the VYCF School Principal indicated that he did not have sufficient staff resources to provide one hour of one-on-one education services to each youth on TD or TIP after three school days, let alone a full complement of mandated education services. On November 2, 2011, Acting Deputy Director Mike Minor issued a memorandum to the Superintendents and the Principals instructing the facilities to ñprovide full access to education to all youth including youth on TD/TIP after the third school day.ò Clearly, VYCF must significantly reduce the number of TD/TIP incidents in the high core units to comply with the Deputy Directorôs directive to provide mandated education services to youth.

[33] Data compiled by OSM from DJJôs monthly reports of TD/TIP placements.

On January 9 and 10, 2012, the Special Master, the Deputy Special Master, the Plaintiff and Defendant and its counsels visited VYCF and found conditions vastly improved in the two high core units. The closure of the SYCRCC resulted in staff transfers which resulted in nearly full staffing at VYCF. The Deputy Special Master observed that the staff in the high core units were much more involved in engaging youth in structured activities. For example, the high core units formed a football team, which provided a strong incentive for youth to make positive behavior changes. CLC was no longer operating as a BTP and youth at both high core units were fully integrated when participating in educational and other structured or unstructured activities.

The number and duration of youth in restricted programs sharply declined in November 2011. In part, the decline was caused by several youth who repeatedly engaged in multiple TD/TIP incidents being transferred to the BTP units. The fact that staff were more involved in engaging the youth in structured activities also contributed to the decline in placements to restricted programs. Another factor was a memorandum issued by Acting Deputy Director Mike Minor to the Superintendents on November 9, 2011, eliminating all TD placements effective November 14, 2011. From an operational standpoint, this memorandum has had no effect on the OHCYCF or the NACYCF as both facilities have long discontinued the practice of placing youth on TD. At VYCF, the total number of TIP placements dropped from 203 TD/TIP placements in October 2011 to 92 TIP placements in November 2011, a reduction of more than 50% in one month. Further analysis of the November 2011 data disclosed that:

- TIP placements at the two high core units declined even more drastically. The two high core units had a total of 38 TIP incidents in November 2011 in comparison to 106 TD/TIP incidents in October 2011, 85 incidents in September 2011 and 128 incidents in August 2011.

- The length of stay per TIP incidents also sharply declined. Of the 38 TIP placements that occurred in the two high core units in November 2011, only three incidents resulted in the youth being placed on TIP for more than three days with an overall average of 1.54 days per placement. On a facility-wide basis, the average length of stay per TIP placement for August, September, and October 2011 was 9.83, 4.0, and 3.75 days, respectively. The average length of stay per TD placement was shorter at 1.84, 2.80, and 3.31 days for August, September and October 2011, respectively, but still considerably higher than the November TIP average length of stay.

DJJ's monthly report for TIP placements for December 2011 has been deemed unreliable because the VYCFôs WIN system did not function properly from December 22, 2011 to January 5, 2012. Defendant indicates the problem has been rectified for the month of January 2012. The January 2012 data shows a similar pattern as the November 2011 data. The January 2012 TIP report showed a total of 49 TIP placements in the two high core units during the month and only four placements resulted in a stay of more than three days and thus may require special accommodation providing that the youth involved are non-high school graduates or did not pass the General Educational Development (GED) test to receive a California High School Equivalency Certificate.

Given the recent decline in the number and duration of TIP placements in the high core units, the VYCF School Principal indicated that the available teaching resources are sufficient to accommodate youth with the current amount and duration of TIP placements.[34] The Education Experts are scheduled to audit VYCFôs education program from March 5 to 7, 2012 and the experts will examine this issue in greater detail.

In addition to the significant reduction in TIP placements, the Special Master found the number of youth transitioned from the high core units to the low core units to be another positive indicator of the improved effectiveness of the programs in the high

[34] Based on conversation between Principal Art Westfield and Deputy Special Master John Chen.

core units. According to the unit logs, a total of 11 youth have successfully transitioned to the low core units from January 18, 2012 to February 10, 2012.[35] While VYCF has not regularly produced data to enable comparison with prior periods, the number by itself suggests that staff are actively working with youth to enable successful transition to a less restrictive setting with more program opportunities. The evidence of youth movement to low core units also provides a strong incentive for the remaining youth in the living units to adopt positive behavior changes. However, it should be noted that the same number of youth (11) were transferred from the intake, low core and mental health units to the high core units during the same timeframe.[36] The fact that an equal number of youth were transferred in and out of high core units may be coincidental, but VYCF management should review procedures to ensure that youth are transferred to high core units based on youth treatment needs rather than the availability of bed spaces.

C. Challenges with the BTP Units

As noted in the Twentieth Report of the Special Master, Defendant has been making a concerted effort to improve the conditions at the BTP units by providing BTP training to staff in the living units and adding group recreation spaces. As of November 2011, almost all of the facilityôs vacancies, including teaching positions, have been filled through transferred staff from the closure of SYCRCC. The modular classrooms were fully installed on December 22, 2011 and used as classrooms beginning in January 2012.[37]

[35] *See* email from Cesar Sigala to Treatment Team Supervisor Richard Gutierrez on February 28, 2012.
[36] *See* another email from Cesar Sigala to Treatment Team Supervisor Richard Gutierrez on February 28, 2012.
[37] *See* email from Mark Blaser to Deputy Special Master John Chen on February 24, 2012.

These efforts appear to have had little impact on youth treatment and services at the BTP units. During their site visit to VYCF on January 9 and 10, 2012, the Special Master and the Deputy Special Master found that the conditions at the two BTP units had changed little. The problem appeared to be particularly acute at the Monte Vista (MV) unit where a group disturbance occurred in late December 2011. On January 3, 2012, two youth assaulted the BTP Treatment Team Supervisor (TTS) that resulted in the lock down of the entire living unit until January 5, 2012 while the incident was under investigation.[38] During the lockdown period, the youth were confined to their rooms in their underwear with a blanket and all their personal belonging, except for some hygiene items, were removed from their rooms.[39] When the Deputy Special Master visited the facility on January 9, 2012, the unit was still on program change protocol (PCP) status and the same TTS was assaulted by another youth in the morning. When on PCP status, the non-high school graduates were allowed to attend classes and received one hour of out-of-room time. The high school graduates and those with GED were allowed two hours of out-of-room time each day. On January 9, 2012, while some of their personal belongings had been returned, the Deputy Special Master observed that much of the youthôs belongings were still in plastic bags locked in an office in the Day Room. Youth interviewed, especially those who asserted that they have no involvement in the staff assault incident, were highly agitated and critical of staff about being placed on lockdown and program change protocol status. The PCP lasted until January 26, 2012.[40]

[38] Telephone conversation between TTS Jeff Bryant and Deputy Special Master John Chen on March 1, 2012.
[39] *Ibid.*
[40] *Ibid.*

The conditions were slightly better at the El Mirasol (EM) unit, which was on regular program status. However, the 20 youth in the living unit were segregated into five program groups plus three youth were placed on ñprogram soloò status, which made it extremely difficult to provide meaningful program or services. Of the 20 youth, 11 were high school graduates and apparently were only provided with three hours of unstructured out-of-room time daily. For the non-high school graduates, staff interviewed stated that many youth are not motivated and often refused to attend classes, especially during the first two class periods. Therefore, despite the availability of teaching staff and classrooms, youth attendance was very sporadic.

Defendant previously asserted that many of the problems in the BTP units is caused primarily by a small group of youth transferred from the Hemen G. Stark Youth Correctional Facility who are deeply entrenched in racial and gang conflicts. As of January 9, 2012, there were estimated to be nine youth in this group who were housed in the EM unit as Program Group 2. Seven of the nine youth in this program group are high school graduates.

The Deputy Special Master visited VYCF again on January 23, 24, and 25, 2012 and found the conditions at the two BTP units essentially remained the same. On January 23, 2012, the MV unit was still on PCP status as a result of the two assault incidents against the TTS on January 3, 2012 and January 9, 2012. The Deputy Special Master observed that all appliances and all furniture in the Day Room had been destroyed in the previous group disturbance incident and the Day Room only had the metal tables and chairs that were bolted to the floor.

When the Deputy Special Master visited the living unit on the morning of January 24, 2012, staff informed him that the unit had six separate program groups, three youth on program solo status, and three more on suicide watch. It is logistically impossible to provide meaningful treatment and services under these conditions. At least three teachers showed up for the first class session, but only one youth in the living unit opted to attend class. The other teachers and the classroom Youth Correctional Counselor apparently had no task for the entire class period.

The Deputy Special Master visited the EM unit on the evening of January 23, 2012. The unit had five separate program groups and two youth on program solo status that day. Youth interviewed stated that besides attending class on a sporadic basis, almost all of their out-of-room time consisted of unstructured recreational activities. Staff informed the Deputy Special Master that they are reluctant to interact with youth due to safety concerns caused by recent staff assault incidents.

D. Informal Agreement Reached by the Parties

On January 26, 2012, the date of the scheduled hearing on the August 2011 Order, the parties met and agreed to defer the hearing for 60 days to afford Defendant more time to address the issues identified by the Plaintiff and the Office of the Special Master during their site visit to Ventura on January 9 and 10, 2012. The parties also informally agreed on the specific actions to be taken to improve the operations of the BTP units, including the creation of a separate group within the BTP that is composed of not more than 15 youth who have exhibited a long history of violent behavior and who have been resistant to change for more than a year.

E. Actions Undertaken by the New Superintendent

The Special Master has found Superintendent Almager to be highly proactive in addressing the myriad of issues confronting the VYCF, particularly in the BTP units. The facility administrators and staff alike commented positively on the Superintendentôs leadership style and expressed confidence that he could be counted on to fairly support the staff in their decisions and actions. Staff also stated that the Superintendent is a very capable administrator and actively engages managers and staff at all levels and disciplines for input and ideas to improve the operations and processes at the facility and at the living units. Staff from the BPT units further noted that the Superintendent made his presence felt by routinely visiting the livings units to talk to staff and youth regarding the conditions in the units. In the first two months of his tenure, the Superintendent has identified issues and problems at the facility and developed plans and implemented them to improve the operation of the facility to provide better treatment and services to youth. The actions to date include:

- Due to staff shortages and lack of staff interest in assignment to the BTP units, previously, the two BTPs at VYCF had only one Senior Youth Correctional Counselor (SYCC). On January 16, 2012, the Superintendent selected and appointed a new SYCC to the MV living unit.[41] The SYCC is a critical position responsible for providing daily guidance and direction to the staff in the BTP units.

- The Superintendent, facility administrators and the BTP treatment team members conducted a site visit to the BTPs at the two northern facilities to identify best practices. After the site visit, weekly conference calls were scheduled for each Wednesday among all facilities to discuss BTP-related issues and concerns.[42] For example, during conference call on February 22, 2012, Superintendent Almager made a proposal to pool all bed spaces in the three DJJ facilities and place youth based on treatment needs to the most appropriate living unit. The group adopted the Superintendentôs proposal.[43] At the invitation of Defendant, the Safety and

[41] Telephone conversation between TTS Jeff Bryant and Deputy Special Master John Chen on March 1, 2012.
[42] *Ibid*
[43] *See* minutes of BTP conference call, February 22, 2012.

Welfare Expert, the Mental Health Expert and the Office of the Special Master started to participate in the weekly conference calls on February 29, 2012.

- The Superintendent has conducted a series of strategic planning sessions with facility administrators and treatment members to identify means to achieve the purpose and objectives of the BTP units.[44] The Deputy Special Master participated in and observed the first two initial planning sessions at the invitation of the Superintendent and found them to be highly productive. The planning sessions identified issues and problems to be addressed and actions or measures to be taken to address them. Example of actions taken that resulted from the planning sessions include:

    - Initiated a review of the treatment plans and referral packets and files for each youth in BTP units.[45] On February 7, 2012, the Superintendent sent a memorandum to each youth in the BPT units to inform them of the purpose of the review and that the youth who successfully met their individualized treatment goals would be transitioned out of BPT.[46]

    - Developed a protocol that identified the role and responsibilities of the referring units with respect to the youth in the BTP units.[47]

    - Expanded the role and involvement of the Gang Institution Coordinators (GIC) and the Conflict Resolution Team (CRT) members in the BTP referral, treatment and transition process.[48]

    - Assessed each BTP youthôs treatment needs in relationship to the cognitive behavior programs (e.g., Counter-point and AIT).[49]

    - Clarified the purpose of the weekly Interdisciplinary Treatment Teams meeting to manage transition planning for BTP youth.[50]

    - Identified youth work assignments to maintain the cleanliness of the living units.[51]

[44] *See* memorandum of February 23, 2012 from Cynthia Brown and Victor Almager to Acting Director Mike Minor regarding Behavior Treatment Program Update.
[45] *Ibid.*
[46] *See* memorandum of February 7, 2012 from Assistant Superintendent Cynthia Brown and Superintendent Almager to all youth in BPT units.
[47] *See* memorandum of February 23, 2012 from Cynthia Brown and Victor Almager to Acting Director Mike Minor regarding Behavior Treatment Program Update.
[48] *Ibid*.
[49] *Ibid*.
[50] *Ibid*.
[51] *Ibid*.

- A review was performed on the VYCF BTP Rules and Regulations (May 1, 2010) revision). The document is currently being updated to provide clarity and to improve communication between youth and staff.[52] This document apparently has not been widely distributed in the past as many staff were not aware of its existence.

In addition, under the direction of the Superintendent, VYCF made an assessment of the infrastructure of the living units. A two-phase plan was developed to improve the appearance, cleanliness, safety and functionality of the living units. Examples of work to be performed include removing and reinstalling plumbing fixtures, fixing broken windows, removing light fixtures and capping electrical outlets, painting walls and removing graffiti. The facility has already begun to proceed with the needed improvements with the assistance of Defendantôs Division of Adult Institutionsôstaff.[53]

The Superintendent is also receptive to ideas and suggestions on ways to improve the operations of the facility or to promote positive youth behavior. During the month of February, the Special Master and the Mental Health Expert visited VYCF and observed that the facility implemented a new procedure allowing youth in low core units to move about in the facility grounds without staff escort. Not only saving staff time and resources, this provides an added incentive for other youth to strive to get into low core units. As of February 28, 2012, no incident had occurred as a result of this new procedure with less restriction on youth.[54]

F. Recent Improvements in BTP

On February 17, 2012, the Deputy Special Master visited VYCF and observed improvements at both BTP units. The improvements were particularly remarkable at the

[52] *Ibid*.
[53] *See* memorandum of February 16, 2012 from Assistant Superintendent Cynthia Brown and Superintendent Victor Almager to all VYCF staff and youth.
[54] Telephone conversation between Superintendent Victor Almager and Deputy Special Master John Chen on February 28, 2012.

MV unit that was on PCP status for most of January 2012. As discussed above, the 19 youth in the unit were previously segregated into six program groups with three on program solo status and three on suicide watch on January 23, 2012. By February 17, 2012, the unit was consolidated into three program groups with only one youth on program solo status. This number of groups makes it easier for staff to provide programs and to interact with youth.

During the time of the Deputy Special Masterôs visit to the unit, an African-American youth who previously was on program solo status was programming together with four Hispanic youth in the Day Room. The African-American youth, a transfer from the Hemen G. Stark Youth Correction Facility, is one of the youth deemed to be extremely high risk. Since arriving at VYCF in April 2010, he has spent almost all of his time in the two BTP units. His projected board date (PBD) is February 2015 but his actual confinement time (ACT) has been extended to March 2018 due to behavior issues after his confinement. When interviewed on January 24, 2012, this youth was extremely critical of staff and conditions in the living unit. On February 17, 2012, the youth told the Deputy Special Master that conditions have improved significantly and that he is getting along well with staff and youth in the living unit. He was extremely complimentary of the new SYCC for consistently talking with him, listening to his concerns and arranging a work assignment for him to clean the living unit. He said the SYCC is the best he has ever had in DJJ.

VYCF also successfully transitioned one youth from MV to one of the high core units, Casa de Alma (CDA) in February 2012. Immediately after his transfer, the youth was involved in two one-on-one fights instigated by other youth in the unit. In addition,

the transfer apparently caused a group disturbance incident in CDA that involved approximately 30 youth on February 15, 2012.[55] After being placed on PCP status, CDA returned to normal program status six days later on February 21, 2012. Considering the number of youth involved in the disturbance and that it was during a three-day holiday weekend, the staff should be commended for their timeliness in returning the unit to normal program. Moreover, after an assessment of the circumstances surrounding the incidents, VYCF retained the transferred youth in CDA rather than returning him to BPT. The youth has been integrating with other youth in the unit without further incidents.[56]

In addition, through its review process, VYCF has identified a list of another seven BTP youth as being ready to be transitioned to either high core or low core units.[57] The fact that there may be a possibility for a youth to be in low core unit should raise question about the appropriateness of his BTP placement. The list of youth has been submitted to the Juvenile Justice Administrative Committee (JJAC) for review and approval in its next meeting to be held in early March 2012.[58] It is important to note that the list of seven youth includes four youth transfers from the Hemen G. Stark Youth Correctional Facility who were previously deemed to be the most difficult and thus need to be placed into a more specialized BTP unit.[59] Based on the latest evaluation, Superintendent Almager believes that the specialized BTP unit is not warranted at this

[55] Conversation between TTS Jeff Bryant and Deputy Special Master John Chen on February 17, 2011.
[56] Telephone conversation between Superintendent Victor Almager and Deputy Special Master John Chen on February 28, 2012.
[57] *See* email of February 21, 2012 from Denise Pascascio to Mark Blaser.
[58] *See* memorandum of February 23, 2012 from Assistant Superintendent Cynthia Brown and Superintendent Victor Almager to Acting Director Mike Minor regarding Behavior Treatment Program Update.
[59] Telephone conversation between Superintendent Victor Almager and Deputy Special Master John Chen on February 27, 2012.

time.[60] The parties and the Special Master supports and agrees with the Superintendentôs decision on this matter.[61]

At the EM unit, the number of program groups declined from five groups and two youth on program solo status on January 23, 2012 to four groups and one youth on program solo status on February 17, 2012.[62] The treatment team members are continuing to identify ways to further consolidate the program groups. If JJAC approves or partially approves VYCFôs request to transition seven BTP youth to other living units in VYCF or in the northern facilities during its next meeting, the conditions at EM will continue to improve.

G. Challenges and Opportunities

The Special Master is impressed and encouraged by the progress and improvements at VYCF since Superintendent Almagerôs appointment to his position. Conditions in BTPs should continue to improve under his leadership as staff of different disciplines and different living units learn to work cohesively in identifying the treatment needs of youth and to assist them in developing pro-social knowledge, skills and behaviors. In April 2012, the Mental Health Expert will again be on-site at VYCF to provide guidance, support and training. A staff psychologist with BTP experience in the OHCYCF is being transferred to VYCF in early March 2012.

The Special Master believes VYCF could benefit from additional support and assistance from the Central Office in the following areas:

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[60] *Ibid.*

[61] This matter was discussed during a conference call between the parties and the Special Master on February 22, 2012 and the Plaintiff agreed that the specialized BTP is premature and unnecessary at this time.

[62] Conversation between TTS Jeff Bryant and Deputy Special Master John Chen on February 17, 2012.

- Provide stability in staff assignments, particularly those in the BTP and high core units. DJJ is currently undergoing the post and bid process for its living units. VYCF expects to complete the facilityôs process by the end of February 2012.[63] In light of the progress being made at the BTP and the high core units, it would be beneficial to maintain continuity in staffing, particularly in TTS, SYCC and YCC positions.

- Provide BTP training to the treatment team members. Since the Central Office staff provided the BTP training in June 2011, VYCFôs BTP units have a new TTS and two new SYCCs. In addition, a review of training records disclosed that approximately 50% of staff at the EM unit who attended the BPT training are no longer working in the unit.[64] More staff turnover is expected as the facility is undergoing the post and bid process. It is important for the Central Office to provide the training again as soon as the post and bid process is completed and staff assigned to their units.

- Prioritize the upcoming Core Correctional Practice, use-of-force and Reinforcement System training for BTP and high core units at VYCF.

- Invest financial resources to continue to upgrade the look and feel of the facility to a more treatment-oriented setting. Superintendent Almager should be commended for initiating plans and actions to address the basic infrastructure needs of the facility. The Special Master believes that much more could be done with a modest investment to make the facility and the living units to a setting more conducive to youth programs and treatments. Some examples include acquisition of computer equipment, books and less prison-like furniture.

- Build on the current success at the high core units through implementation of the IBTM at the CLC living unit. Defendant has already begun taking action on this matter but, given the location of VYCF in proximity to the Central Office and the IBTM staff, the Central Office needs to devote adequate resources to provide guidance, support and assistance to ensure the success of the project.

- Work with the Mental Health Expert to develop a system or a process to promptly transition youth out of BTP based on youth readiness rather than artificial barriers such as the timing of JJAC meetings or availability of bed spaces in high core units. If necessary, Defendant should contact the Plaintiff for exception on the

[63] *See* memorandum of February 23, 2012 from Assistant Superintendent Cynthia Brown and Superintendent Victor Almager to Acting Direct Mike Minor regarding Behavior Treatment Program Update.

[64] Conversation between Assistant Superintendent Cynthia Brown and Deputy Special Master John Chen on February 17, 2012.

number of beds in high core units on a temporary basis to accommodate the placement of BTP youth.[65]

- Ensure the accuracy and reliability of WIN data by reviewing and resolving the issue identified by the OACC auditors regarding the apparent discrepancy between WIN and unit logs on out-of-room time.

VI. USE OF FORCE

The Special Master finds Defendant continues to make a concerted effort to implement an effective use-of-force model. Defendantôs efforts are guided by a Force Prevention Plan, agreed to by the parties, that delineates the vision, goals, tasks to be performed, deliverables and performance indicators for effective management of use of force in DJJ.[66] The plan prescribes a fairly aggressive timetable to complete all identified tasks by the end of 2011-12 fiscal year except for Law Enforcement Training and Research Associate (LETRA) training, which is to be completed in two phases. The first phase delivers LETRA training to staff in mental health units, behavior treatment units and high core units by July 6, 2012. Staff in the remaining units will receive LETRA training by July 6, 2013.

Staff in the DJJ Policy Unit tracks the tasks, timeline and deliverables of the Force Prevention through project management software. A schedule of the progress for each task under the plan as of February 28, 2012 is attached as Appendix C.

A review of the progress of the tasks showed mixed results, which is not surprising considering the complexity of the tasks involved. Some of the items, particularly those that can be completed by DJJ staff without outside involvement, have been completed within the projected completion date. For example, as reported in the

[65] This matter was discussed during a conference call between the parties and the Special Master on February 22, 2012 and the Plaintiff agreed that the bed space cap could be exceeded if approved by the Plaintiff to accommodate BPT transfers.
[66] The plan was agreed to in mid-November 2011.

Twentieth Report of the Special Master, the task of preparing a Crisis Intervention Plan for every youth in Defendantôs system was completed by October 31, 2011 and the living units conducted weekly interdisciplinary team meetings starting August 1, 2011. Both tasks were completed by the target date in the Force Prevention Plan.

While Defendant completed these tasks timely and met the literal requirement of the Force Prevention Plan, the Special Master questions the effectiveness of the implementation of some elements of the plan. During one of his site visits to VYCF, the Deputy Special Master found that the facility had no mechanism in place to ensure that the Crisis Intervention Plan is updated at each case conference as directed by the Acting Deputy Director.[67] Indeed, a review of the Crisis Intervention Plans in several units indicates failure to update plans appears to be common and some youth have no plan.[68]

Clearly, there is a lack of understanding by some of the staff on the purpose and intent of the plan. The Deputy Special Master has discussed the matter with the Superintendent and the Acting Director who indicate action will be taken to ensure that each youthôs Crisis Intervention Plan is updated after each case conference and after each force incident with youthôs participation. The Special Master reiterates her previous recommendation that Defendant consider devising a system to monitor quality,

[67] Memorandum of July 15, 2011 from Michael Minor, Deputy Director (A) to Superintendents and Assistant Superintendents regard Crisis Prevention Support Plan.

[68] The Deputy Special Master reviewed approximately 40 youth records from four living units (Monte Vista, Buena Vista, CDC, and Alborado) and found no evidence of periodic updating of the plans. For example, for the 19 youth plans reviewed at Monte Vista, only two had indication of being updated since October 12, 2011 and both youth were transferred from SYCRCC after the initial due date of the plan. One youthôs plan was last updated more than a year ago on January 13, 2011. At Alborado, some of the youth have no Crisis Intervention Plan in place even though they have been in the unit for several months. At one of the BPT units, a staff member was unaware that the living unit had a Crisis Intervention Plan binder, which apparently has not been updated since it was compiled in October 2011.

consistency, and timeliness of the Crisis Intervention Plan at all facilities[69]. The Special Master recognizes that effective use of the Crisis Intervention Plan will increase as staff is trained in core correctional practices and use of force.

Similarly, although the weekly multi-disciplinary meetings have been taking place since August 2011 at each living unit to improve communication, to discuss training interventions and to discuss youth behavior issues,[70] there still appears to be a lack of clarity at some of the living units regarding the purpose and intent of the meeting. At VYCF, the BTP units started to clarify the purpose of the meetings only after the new Superintendent was appointed on January 3, 2012 and started to make inquiries.[71] In a memorandum of February 8, 2012 to superintendents and assistant superintendents, the Acting Deputy Director prescribed a tracking process whereby each facility submits a monthly report in a ñcheck the boxò form. While this monthly report is a positive step as it requires each facility to provide a confirmation that the weekly meetings are being held, there is little assurance that these meetings achieve the intended objectives. Again, the Special Master reiterates her previous recommendation that Defendant consider devising a quality assurance system to ensure meaningful and productive outcomes through these weekly meetings.[72]

The Special Master also found the projected timeline for some of the tasks in the Force Prevention Plan to be too optimistic. For example, the plan calls for the revised Crisis Prevention and Management Policy to be finalized and issued by January 3, 2012

[69] *See* Twentieth Report of the Special Master, p 21.
[70] *Ibid*.
[71] *See* Memorandum of February 23, 2012 from Assistant Superintendent Cynthia Brown and Superintendent Victor Almager to Acting Director Michael Minor regarding Behavior Treatment Program Update.
[72] *See* Twentieth Report of the Special Master, p 21.

and training on the new policy to start through block training on January 30, 2012. Defendant presented several draft versions of the revised policy to the Plaintiff for review and concurrence prior to January 3, 2012. Despite the best efforts of the parties, there were fundamental differences that needed to be resolved, which prolonged the process. The issue of using chemical agents on mental health youth was difficult, especially since Defendant, under the guidance of the Mental Health Expert, is in the midst of a youth population inventory. It is the belief of the Mental Health Expert and the DJJ mental health leadership that there will be a significant reduction in the number of youth designated as mentally ill and, therefore, in the number of mental health units. Nevertheless, the parties did reach a compromise on the final policy language, which should be finalized and released in early March 2012. The Special Master commends the parties for their diligent efforts in this regard.

Similarly, the Force Prevention Plan anticipated developing a plan to implement a BMS and to provide training to all direct care staff on the plan by May 1, 2012. After review of the initial draft, the Mental Health Expert suggested narrowing the scope of the plan to focus only on teaching staff how to distinguish between reinforcement strategies and sanctions. Recognizing that the greatest reduction of use of force results from staff reinforcing desired behaviors in addition to sanctioning undesirable behavior, the plan was revised to focus more specifically on the skill set required by staff to do this.[73] The Reinforcement System training will likely not be completed by May 1, 2012 and there will be other elements of the BMS that will need to be developed which will require training at later dates.

[73] This issue is discussed on p. 4 *supra*.

In addition, Defendant has failed to revise the use-of-force review process by the projected timeframe of March 1, 2012. Defendant contracted with a force expert suggested by Plaintiff to provide guidance and training to develop a multi-disciplinary force review model that places primary emphasis on prevention and de-escalation. The model was supposed to be completed and implemented by March 2, 2012 after appropriate training to individuals on the force review committees.

The force expert did attend the force review committee meetings at the NCYCC on February 2, 2012 and at VYCF on February 10, 2012. The Special Master attended the meeting at NCYCC and the Deputy Special Master attended the meeting at VYCF. Both had the impression that, while the force expert offered valuable insight that could enhance the review process, the sessions did not provide training. What is needed is training that provides more specificity on the conceptual changes to the current process with actual case samples to illustrate and emphasize opportunities for de-escalation and prevention. It does not appear that the contracted expert is able to provide this type of training. Defendant, through no fault of their own, was not able to meet the projected implementation timeline.

Defendant continues to aggressively pursue all tasks within its control identified in the Force Prevention Plan. For example, one of the tasks in the plan is to provide Core Correctional Practice Training through block training. As scheduled, Defendant has identified a work group and modified the curriculum to include more of a treatment emphasis and is ready to deliver training to staff. Similarly, Defendant apparently is on target to complete training on psychotropic medication to all targeted staff by March 21, 2012. Defendant is also experimenting with the use of positive incentives at the

Sacramento Hall in NACYCF and Casa Los Caballeros at VYCF, meeting another plan milestone.

The Special Master wishes to acknowledge and commend the efforts of the Defendantôs Use-of-Force Project Manager, who has been working diligently and tirelessly on this project and other projects at DJJ. The Project Manager is a dedicated and talented individual. With experiences working in different capacities at DJJ facilities as well as the knowledge and insight gained through this project and other *Farrell*-related projects, this individual is instrumental in the success of the project to date. The Special Master believes this individual is uniquely qualified to spearhead Defendantôs current effort to implement a new force review model by developing training guidelines and serving as a trainer and a coach of the review model.

VII. CONCLUSION

Defendant continues to demonstrate progress in achieving substantial compliance in medical and dental care. The Dental and Medical Experts are preparing to transfer monitoring of the Medical Remedial Plan to Defendant in anticipation of achieving substantial compliance in all areas. In both areas, experts are monitoring a few remaining issues. Defendant needs to demonstrate the sustainability of the high quality of clinical care being provided to youth ensuring that effective monitoring and decision-making tools are in place.

Defendant has also continued to demonstrate progress in addressing how to respond to situations that potentially could require use of force by staff. The parties' recent agreement on modifications to the DJJ Crisis Prevention and Management Plan is a critical step in defining how to prevent the use of force and when force is necessary,

how it is to be imposed. Defendant has developed an excellent training package that includes strategies to reinforce desired behavior and to respond to inappropriate behavior.

Defendant has made progress in addressing problems in the BTP units at VYCF. Appointment of skilled staff, demonstrated interest and leadership by the Superintendent, support from Central Office to provide learning between facility BTP units and facility repairs are some of the steps that are resulting in a reduction in the number of program groups so staff can work more effectively with youth and youth being moved off the BTP to regular programs.

Most of the recommendations from the Eighteenth Report of the Special Master have now been completed. These recommendations largely address how to more effectively address issues of force and how to improve the VYCF BTP units. Some recommendations are not implemented as suggested because the parties reached agreement on a different strategy. The recommendations from the Eighteenth Report of the Special Master are listed below. Fully completed items are italicized, those in bold have had no action and those in regular typeface have shown significant progress.

1. *Revise the Crisis Prevention and Management Policy to show a continuum of interventions, and include immediate force as the most restrictive intervention method.*

2. *Revise the Crisis Prevention and Management Policy to ensure that a Crisis Prevention Plan is completed for all youth with 60 days of arrival at a facility.*

3. *Complete a Crisis Prevention Support Plan for all youth designated mentally ill and/or disabled within 90 days and all remaining youth within 180 days.*

4. Revise the use-of-force review process to focus on training staff to reduce their reliance on force and to learn how to de-escalate and prevent use of force through cognitive behavioral management practices.

5. *The Use-of-Force-Implementation Committee and IBTM staff adopt a recommendation for behavioral management training that teaches how to de-*

escalate and prevent the need for force. The recommended training should be provided to all direct care staff, within 180 days. Scheduling preference should be given to staff at VYCF.

6. *Immediately issue a directive to stop using chemical agents on single youth or female youth who do not engage in assaultive behaviors or pose an imminent danger to self or others.*

7. **Conduct a pilot project that reduces the use of chemical agents on a mental health unit and substitutes the behavioral management strategies.**

8. *Design and provide training and coaching in the behavior management skills as identified in the Integrated Behavioral Treatment Model (based on knowledge acquired through recent Dialectical Behavior Therapy (DBT) pilot projects).*

9. Examine the role of mental health professionals and explore means to increase their involvement in force incidents involving youth with a disability and/or mental health designation.

10. *Provide DJJ Education Services with an exemption from the hiring freeze so that youth in all of DJJ's facilities will receive at least the mandated 240 minutes of education services per day, including youth on the BTP "high core" units and youth on Temporary Detention and Temporary Intervention Programs.*

11. *Provide immediately training to all staff on VYCF's BTP units, VYCF's managers and administrators and all staff on other facilities' BTP units so that the facilities BTP units operate consistently with the rehabilitative intent of the BTP policy.*

12. *Negotiated placement of planned modular buildings at VYCF and other sites, which will afford education staff additional instruction space, and unit staff additional program treatment and/or group space must be completed no later than January 2012.*

13. **Provide training regarding the IBTM to senior headquarters and institution staff as well include Youth Correctional Officers in IBTM training and Cognitive Behavioral Primer.**

Finally, Defendant is to be congratulated for the continued progress in implementing cognitive behavioral groups, reinforcement programs and quality assurance measures in the existing IBTM pilot units as well as the expansion to two additional living units. This significant progress is greatly jeopardized by the continued failure to adequately staff the IBTM project team and the failure to develop a clear mission that

clarifies that the IBTM is not a treatment program only of concern to youth counselors, psychologists and educators, but is a way of interacting with youth that must be modeled by all staff who have any contact with youth, no matter how limited.

The Special Master respectfully submits this report.

Dated: April 12, 2012

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Nancy M. Campbell
Special Master

CALIFORNIA DIVISION OF JUVENILE JUSTICE

UNIVERSITY OF CINCINNATI QUARTERLY REPORT

January 31, 2012

Submitted by: Lori Lovins, MSW, LISW-S

Project Description

The University of Cincinnati Corrections Institute (UCCI) is working with the California Division of Juvenile Justice (DJJ) in the implementation of evidence-based cognitive behavioral programming. UCCI's involvement with DJJ began with assisting them to develop an implementation plan for the Integrated Behavioral Treatment Model (IBTM), which was to be submitted by October 1, 2010. The IBTM is critical to the six remedial plans submitted to the courts in response to the Farrell lawsuit. Monitors appointed by the court are overseeing implementation of the IBTM, as well as the six remedial plans. While several components of the IBTM had been implemented prior to October 1, 2010, other components had not or had been implemented with limited fidelity. The IBTM Implementation Plan specifies what components are in place and what components will be addressed with the assistance of UCCI.

Two facility units housing high risk youth at OHCYCF in Stockton, CA were selected by DJJ as the initial implementation sites. Eventually, the program components successfully implemented at these sites will be implemented DJJ wide. This will allow for program adaptations to be made before wide-scale implementation occurs. Likewise, these sites can serve as model training units for DJJ. The development and implementation of evidence-based programming involves a collaborative effort between DJJ headquarters, OHCYCF unit staff, and UCCI. A multidisciplinary implementation team (MIT) was developed, as well as subcommittees charged with addressing programming deficiencies. IBTM deliverables were identified for each subcommittee, which are outlined in the IBTM Implementation Plan. Subcommittees met regularly during the design/development phase to address program needs and ensure deliverables were being met. Now that implementation is well underway, the subcommittees meet as needed, and the MIT continues to meet regularly to oversee the implementation process.

The following report represents a summary of services rendered by UCCI within the last quarter (November 1, 2011—January 31, 2012). Included in this is a January site visit, which will be summarized here. The report will also specify progress being made toward meeting IBTM goals, continued areas of need, as well as upcoming tasks.

January Site Visit

A site visit was conducted by Lori Lovins January 10-13, 2012. This visit included the following primary activities: 1) Half day coaching sessions on Pre-treatment and Advanced Practice lesson plans, 2) Meetings with the MIT, OH Close/DJJ leadership, and the IBTM initial /expansion units to discuss implementation concerns, 3) Unit observations whereby core CBT groups and initiatives

such as Skill of the Week were observed with feedback, 4) A visit to the Behavioral Treatment Program (BTP), and 5) A conference call with Nancy Campbell, Dr. Gage (mental health expert), select MIT staff and DJJ mental health administrators to review concerns posed with the draft Behavior Management System. Site visit findings will be discussed below.

Progress in Implementation of the IBTM

DJJ established a multidisciplinary implementation headquarters team, as well as 4 subcommittees: *1) Assessment and Case Planning; 2) Treatment/ Scheduling; 3) Behavior Management; and 4) Quality Assurance*. Both DJJ headquarters staff and unit staff are represented on these committees to develop strategies for program implementation. The IBTM is currently in Phase III, which involves extension of program implementation beyond the initial IBTM units. Currently, IBTM programming and coaching is being conducted on the following OH Close units: Butte, Amador (formally Glenn), Calavaras and Del Norte. Expansion of the IBTM began on the latter two units October, 2011; one is a low core, and one a high core unit. Training has begun for staff on the OH Close mental health and BTP units, and some staff at Chad and Ventura are being IBTM-trained as well. Ventura will be the next facility targeted for IBTM expansion.

***Assessment/Case Management Committee*:** The revised case conference schedule has been implemented, which increases multidisciplinary staff participation. Intake processing for youth transferring to the IBTM pilot units is now at 30 days. The integration of the CA-YASI with the WIN electronic system has not yet been finalized. Some minor edits were requested by education and mental health just before the IT staff member charged with this project retired. The IBTM team suggests that this should be finalized within the next quarter.

Treatment/Scheduling Committee: Now that core programming (CounterPoint and AIT) is being delivered on a routine basis on each of the initial IBTM units, CBT-based programming is being expanded. Skill of the Week groups are being conducted on Butte, Amador, Calavaras and Del Norte. These are brief, unit-based daily sessions that offer a mechanism for additional practice of social and coping skills. Coaching and support for effective delivery of these sessions is being provided by the IBTM. Furthermore the full schedule of AIT and CounterPoint groups are being conducted on Calavaras and Del Norte, in addition to the two initial IBTM units.

The curricula/lesson plans for Pre-treatment and Advanced Practice sessions were completed by IBTM staff, in conjunction with the UCCI consultant. These will provide front end and back end CBT-based programming to youth either awaiting core programming, or youth that have completed AIT or CounterPoint. Approximately 20 staff from the initial IBTM units, expansion units and intake unit were trained in Pre-treatment, with approximately the same number trained in advanced practice. IBTM staff attended the training/coaching sessions as well, and will be able to continue to train additional DJJ staff on these ancillary treatment groups.

The IBTM resource guide has been completed. This guide includes core skills that youth are learning, as well as cognitive behavioral and motivational interviewing skills that staff have been taught to assist youth in the change process. Each unit will receive the resource guide, which also assists staff in linking core criminogenic need areas with treatment or intervention strategies.

Feedback has been given by unit staff as to the utility of this guide, which led to some minor adaptations. Staff generally felt this was a useful tool for them in implementing the IBTM goals.

An IBTM overview has been developed and is being used to train staff on the expansion IBTM living units. This overview was also provided to DJJ middle managers in December, 2011.

At the last site visit, Interactive Journaling curricula were reviewed. Interactive Journaling (IJ) primarily targets criminogenic need areas, and incorporates cognitive strategies in doing so. The journals provide more limited opportunities for skills practice, but support the core programming being provided via AIT and CounterPoint. These sessions may be counted toward dosage aimed to decrease likelihood of recidivism. Facilitators, however, should try to augment skill practice where appropriate. While core programming should be prioritized, IJ should be incorporated into the program service day schedule on IBTM units, where it is not used or is currently used at more limited capacity.

Youth Assistants have been identified on Butte. These are Level A youth that have completed core programming and provide a supportive role to staff, currently limited to assisting with skill of the week sessions. A protocol has been designed by the IBTM and reviewed by UCCI on the selection, training, expectations and responsibilities of Youth Assistants. Other IBTM units should begin to incorporate this protocol and provide this leadership opportunity to youth on their respective units.

The Quality Assurance Committee: IBTM staff have increased unit coaching time, concentrating on training/coaching for skill of the week as well as observation and coaching for core programming. The coaching form developed by the IBTM and UCCI is being used to provide structured feedback to staff delivering core programming. The Quality Assurance team, along with DJJ's research team, has developed a proposal for formally studying the effectiveness of the IBTM programming.

The Behavior Management Committee: A draft Berhavior Management System (BMS) was developed by the IBTM, which was adapted from example BMS templates developed by UCCI. This system was intended to outline reinforcement and sanctioning strategies on general population units (with further adaptation needed for specialty units). Current policies related to existing contingency management strategies [i.e. Youth Incentive Program (YIP), DDMS and ABLE] were not modified in the development of the BMS, due in part to the wide scale policy and IT implications in doing so. Hence, new strategies were incorporated in the existing system, aimed primarily at augmenting the system with short-term reinforcers. Along with the behavior management description, both a staff and youth training were developed with a plan to roll this out in March 2012.

Mental health experts were asked to review the BMS system, and expressed several concerns resulting in the postponement of its implementation. A primary concern was the lack of integration of the BMS with existing DJJ strategies used to modify behavior (e.g., the DDMS, YIP, program credits, ABLE and Behavior Treatment Program). Other key concerns were that the strategies were

too complicated, did not focus enough on the appropriate target population (youth that behave most poorly), and targeted behaviors that were too subjective (e.g. moral development).

Mental health expert Bruce Gage, who most clearly outlined in a response letter concerns with the draft BMS, participated in both a conference call and subsequent on-site visit to provide further consultation on how the BMS might be adapted. UCCI participated in a portion of the site visit meeting via conference call. The meeting was helpful in narrowing the scope of the BMS to concentrate on the Positive Reinforcement System, outlining more concrete and simplified strategies for providing short-term reinforcers for positive/pro-social behaviors. Furthermore, a plan for describing how such strategies fit within the context of the larger BMS was discussed. Parties agreed to concentrate on this interim piece of contingency management (Positive Reinforcement System) to meet the immediate need for reinforcing daily pro-social behaviors and creating a more positive environment. Further work will be needed on adapting current policies to align more closely with sound behavioral strategies and in developing a more comprehensive description of all behavior management strategies (a full BMS).

The BMS subcommittee has also worked to modify a Core Correctional Practices training provided by UCCI to meet the needs of DJJ. This training focuses on areas such as effective social reinforcement, effective disapproval, effective use of authority and relationship skills. This training with a lesson plan was reviewed by mental health experts, and will be trained in combination with the Positive Reinforcement System. This training is aimed at improving interactions between youth and staff.

Areas of Need/Concern

There is pressure to move forward as quickly as possible with adapting and then implementing the BMS system according to the strategies outlined above. While there is support from the Special Master in "doing it right" rather than simply "getting it done", implementation time will still be closely monitored. UCCI has stressed that a short pilot period (1-3 months) on the pilot units will be important in testing the new strategies before training staff DJJ wide. Concentration on simplified short-term reinforcement strategies within the BMS should expedite this piloting process.

Observation on several units led to some concern about the amount of unstructured free time youth seem to have. While the Program Service Day (PSD) schedule describes this as "programming time", most youth are not participating in programming during their unstructured free time. Augmenting the core programming with orientation and Advanced Practice sessions, in addition to Skill of the Week and additional Interactive Journaling sessions will increase the overall dosage of treatment as well as add more structure to the daily schedule. However, effort should be made to develop additional structured leisure activities for youth to minimize unstructured socialization. These activities can provide youth with opportunity to use the skills they are learning in core programming, as well as decrease youth behavior issues. Youth Assistants could be given the task of generating possible activities for youth, which are then approved by staff.

Observation of units during the last site visit also raised an issue regarding overtime staff covering IBTM units. It was noted (and observed) that staff filling in on a unit that has been trained on an IBTM program (AIT, CP, Skill of the Week) do not always perceive it as his or her responsibility to conduct that program during the scheduled time (since he or she does not typically work on that unit). While untrained staff are not expected to conduct programming when working overtime, trained staff are. This should be made clear to staff and managers should supervise accordingly.

Two IBTM staff are assigned to Ventura, which will be the next facility where the IBTM is rolled out. Due to their proximity to Stockton, these IBTM staff have played a more limited role in development of the IBTM components. As such, the learning curve for these staff is higher, and additional support will be needed by IBTM headquarters staff and administration.

As IBTM is expanded to additional units and facilities, ongoing fidelity monitoring and coaching becomes increasingly difficult. It will be important for supervisors on the initial units to begin playing a more active role in this process. This will involve periodic group observation with supervision/coaching. This might also be an appropriate role for trained mental health facility staff, who until now have participated on a very limited basis in meeting the IBTM objectives.

Related to the above point, with the closure of DJJ substance abuse residential program units, programming in this area is seemingly non-existent for youth. Substance abuse is a common criminogenic need which should be addressed. DJJ will be reviewing substance abuse curricula to help meet this need, but before any training occurs, clear decisions need to be made about what staff will be conducting this treatment. It is recommended that mental health staff, who tend to be more highly credentialed and may be more likely to have clinical experience in this area be used to deliver a substance abuse curriculum. This would involve mental health staff in a more systematic way in the IBTM process, and help utilize their expertise in targeting a specialized need area.

Continued uncertainty related to potential layoffs and staff transfers has made keeping the momentum of the IBTM difficult. Staff being trained and coached by UCCI at the January site visit, however, still appeared open to learning new strategies in working with the youth.

Finally, meeting the IBTM deliverables and implementing evidence-based programming for youth at DJJ would not have been possible without the IBTM team. It is vital that DJJ administration invest the necessary resources into this team if continued progress is desired. While this is increasingly difficult during a time of continued budget cuts and uncertainly for DJJ, the IBTM team is absolutely necessary to expand evidence-based programming across DJJ. Furthermore, continued support of this team of highly trained, highly skilled staff is needed long term for sustainability of the IBTM.

Upcoming Tasks

Ten staff were trained as trainers in AIT the week of January 30th and the week of February 6th. This process also involved training a new group of 16-20 facilitators of AIT. This will assist DJJ in the expansion of IBTM programming.

Assessment/Case Planning: Ensure that electronic integration of the CA-YASI and WIN is complete.

Treatment/Scheduling: Incorporate orientation sessions for youth awaiting core programming and Advanced Practice groups for youth that complete core programming. Identify staff capacity for delivering the full spectrum of interventions.

Behavior Management System: Within the next quarter, the daily reinforcement system will be adapted and implemented on the initial IBTM units, including the adaptation of the training that was developed for this program component. The training plan for DJJ will then be adapted as well to expand application across DJJ.

Quality Assurance: Provide increased fidelity monitoring of new and core interventions via a coaching schedule.

Summary

The MIT and subcommittees, along with unit staff continue to work diligently to meet the IBTM deliverables. The IBTM has been fully expanded to 2 units, and training is underway for additional units. The next facility to be exposed fully to IBTM will be Ventura. Work in the final phase will turn to specialty units.

Farrell v. Cate
Fifth Report of Consent Decree
by the Medical Experts

Based on Site Visits Conducted

August 2011 to January 2012

FARRELL MEDICAL EXPERTS

Joe Goldenson, MD
Madie LaMarre, MN, FNP-BC

Contents

Introduction

From August 2011 to January 2012 the Farrell medical experts conducted site visits to each DJJ facility and to Health Care Services (HCS) headquarters to perform audits of compliance with the Health Care Services Remedial Plan (HCSRP).

This report contains the results of the Health Care Services headquarters review as well as the executive summary for each of the facility reviews. Mental health and dental expert reports are provided separately.

We would like to thank all DJJ staff for their cooperation and assistance during our site visits. Certain information in this report has been amended based upon comments and clarifications presented to the Medical Experts in letter sent to the experts on February 24, 2012.

Reference Documentation

Complete facility reports will be forwarded as addendums to this report. Please see the following documents for more information:

Ventura YCF Health Care Audit –August 15-17, 2011

Northern California Youth Correctional Complex (NCYCC) (NA Chaderjian and OH Close YCF) Health Care Audit – January 9-11, 2012

Executive Summary

Since our last report, DJJ has continued to undergo structural changes due to the declining youth population. Preston Youth Correctional Facility (PYCF) and the Southern Youth Correctional Reception Center and Clinic (SYCRCC) closed. DJJ transferred youth remaining at those facilities to Ventura Youth Correctional Facility (VYCF) and the Northern California Correctional Youth Complex (NCYCC).

Despite these challenges, DJJ has sustained improvements in health care services and at this time we find both Ventura and NCYCC to be in substantial compliance with the Health Care Services Remedial Plan. We also find DJJ Health Care Services to be in substantial compliance pending development and implementation of two structural elements of the remedial plan: standardized nursing procedures and a system for establishing fiscal accountability for the health care program. This progress has been made despite challenges such as staffing reductions in both headquarters and facilities, and turnover in headquarters health care leadership (e.g. nursing and medical directors).

Recognizing DJJ's achievements, as noted above there are areas that require continued attention. In the two most recent comprehensive medical reports we recommended to DJJ that decisions about staffing patterns be based on minimum staffing requirements and analysis of utilization of health care resources, including staff productivity. In addition to being a remedial plan requirement, doing so provides objective support for staffing decisions that comprise the business rules and protects DJJ against budget cuts detrimental to the health care program.

DJJ does collect health care utilization data but leadership concerns about standardization of the data have resulted in it not being used to make staffing and resource decisions. We also attribute turnover in health care leadership as a contributing factor to delays in developing both this system and the standardized nursing procedures.

The administrative duties of the Health Care Administrator position (which was vacant for an extended period of time and subsequently eliminated) have recently been assumed by the newly hired Special Services Manager I. However, during this most recent monitoring period prior to her arrival, we found that HCS tracking of statewide health services contracts lapsed, resulting in expiration of nursing registry contracts. It is important that DJJ headquarters continues to track and monitor statewide contracts through the process to ensure timely renewal. We understand that former Director Rachel Rios engaged in collaborative discussions with CDCR and the Receivers' office to reduce health care related expenses through contract consolidation, and we strongly support DJJ's efforts to reduce health care costs.

DJJ continues to function under budgetary pressures given its decreasing population and number of facilities to reduce costs. In August 2011 DJJ leadership consulted the Medical Experts regarding revisions of the staffing business rules. Following this meeting the Medical Experts were not provided a draft of the revised rules prior to their being finalized in September, and they were not shared with us until the Headquarters review in December 2011. We trust that this was simply an oversight, but note that reviewing the draft business rules and accompanying staffing patterns would have provided an opportunity for communication between DJJ and the Experts to ensure that the revised business rules and resulting staffing patterns were consistent with our verbal agreements. We have requested copies of staffing patterns that will be in effect following implementation of the business rules but have not been provided this information at the time of this report.

As noted in past reports, the Medical Experts are supportive of staffing reductions given decreases in population and facilities. However, given that the Experts recommendations and DJJ decisions were made in the absence of data, it will be important to reevaluate the impact of staffing reductions to ensure that access to care for youth continues to be provided in a timely manner.

DJJ has responded that it verbally agreed to the Experts recommendations with the exception that DJJ will change the Chief Physicians classification to Chief Medical Officer; and maintain some registered nurse staffing in mental health units. DJJ also indicated that the new staffing patterns have not been provided to us because they are in process of being presented to labor representatives of the involved classifications and will be forwarded to us when final agreement is reached. We request that DJJ forward staffing patterns to the Medical Experts upon receipt of this report.

Another area of progress since our last report is that DJJ has initiated a structured clinical auditing process. This is a critical element of the remedial plan to show that DJJ is capable of self-monitoring and correcting deficiencies once court monitoring is over. Our review of Health Care Services first internal audit at Ventura showed inconsistencies in scoring as compared to the Medical Experts, and we invited health care leadership to accompany us on future audits to promote consistency in interpretation of the audit instrument and clinical findings. Health Care Services second audit of NCYCC in July 2011 was hampered by absence of key clinical staff and travel restrictions and the OH Close portion of the audit was not completed until November 21, 2011. DJJ forwarded the OH Close report to us on December 14, 2011. We found the report to be well done and consistent with the Medical Experts findings with the exception of Nursing Sick call that scored significantly higher than our findings (91% versus 75%) suggesting that there may not be concurrence between the Experts and DJJ with respect to evaluation of this area.

Selected areas of clinical monitoring have been turned over to DJJ for internal monitoring; however we noted recurrent clinical findings at Ventura related to medical reception that suggest lapses in self-monitoring. We recommend that DJJ ensures that the quality management, clinical monitoring, and peer review processes focus on areas identified as requiring improvement during clinical monitoring.

In summary, we find DJJ facilities to be in substantial compliance with the health care services remedial plan. To maintain substantial compliance at the facilities, DJJ should demonstrate that both access and quality of health care services are sustained following staffing reductions.

We also find DJJ Health Care Services to be in compliance with the remedial plan pending implementation of the nursing standardized procedures; development and implementation of a system to evaluate health care resource utilization; and self-monitoring (e.g., clinical audits, peer review, quality improvement programs) that demonstrates sustained access and quality health care to youth during the next monitoring cycle. We request that both of these structural elements are developed and fully implemented by June 1, 2012.

We also recommend that DJJ continue to pursue collaborative measures with CDCR to obtain cost efficiencies; and to monitor renewal of statewide health care contracts.

With respect to the next monitoring cycle, we recommend that the Medical Experts no longer conduct formal health care audits at the facilities and headquarters. Rather, we propose that the experts conduct informal site visits at the facilities to ensure continued youth access to health care following staffing reductions; and to evaluate implementation of the remaining structural aspects of the health care program noted above. We also remain available to the parties to provide consultation and assistance as requested.

Glossary of Acronyms

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

Health Care Organization, Budget, Leadership, and Staffing

The medical experts visited DJJ Health Care Services on December 7-8, 2011, to conduct an assessment of HCS progress with respect to implementation of the HCSRP. At that visit, we evaluated the status of health care using the Health Care Audit Instrument audit tools, Health Care Organization, Budget, Leadership, and Staffing and Statewide Pharmacy Services.

We thank HCS staff for their assistance and cooperation during these visits. Overall, Health Care Services scored 85% (17 of 20 Questions). This represented the combined score of 77% (10 of 13 Questions) for Health Care Organization, Budget, Leadership and Staffing; and 100% (7 of 7 Questions) for Statewide Pharmacy Services. This score represents an improvement from the previous score of 50%.

Our findings and assessment of compliance with the questions in the audit tool are described below.

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

Assessment: Substantial Compliance

At our last review we found DJJ Health Care Services tables of organization at the headquarters and facility level to be internally inconsistent and unclear regarding organizational lines of authority and accountability.

We reviewed DJJ's Headquarters and Statewide Administrators Organization Chart dated October 2, 2011. This chart shows a Health Care Administrator CEA position as the chief health authority, however this position has not yet been established and the Statewide Medical Director (i.e., Chief Medical Officer) is currently the chief health authority. DJJ subsequently provided us a HCS headquarters organizational chart dated 12/21/11 showing the current organizational structure. We find this TO clear and internally consistent.

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

Assessment: Substantial Compliance

DJJ has established a centralized model for health care delivery, supervision and oversight. According to the Remedial Plan, headquarters clinical staff, (e.g. Medical Director, Chief Psychiatrist, Supervising Dentist, and Director of Nurses, etc.) provides clinical supervision of their respective counterparts in the field.

The DJJ Medical and Mental Health Clinical Supervision and Clinical Oversight Organizational Chart approved October 2, 2011 showed clear lines of clinical supervision for all health disciplines and was internally consistent. It also showed the DJJ Director, Deputy Directors and Facility Superintendent as providing communication and collaboration regarding clinical supervision with mental health services. While we understand and commend the intent of DJJ including correctional administrators on the organization chart, it was confusing that communication and collaboration was limited to mental health services. Moreover, we believe that it is unnecessary to include correctional administrative staff on clinical supervision organizational charts. DJJ amended the chart during our visit and we find this area to be in substantial compliance.

The DJJ Health Care Services Facility Administration Supervision TO approved October 2, 2011 shows the Correctional Health Services Administrator (CHSA) II as providing administrative supervision to all health disciplines. It is internally consistent and provides clear lines of administrative authority and accountability at the facility level.

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

Assessment: Substantial Compliance

Since our last review there has been turnover in key HCS leadership positions. The status of each position is as follows:

The Statewide Medical Director (Chief Medical Officer) position is currently not a budgeted position. However DJJ has appointed an acting Chief Medical Officer who is carrying out the responsibilities of this position. From a budgetary perspective this position is assigned to NCYCC.

The Director of Nurses (Nurse Consultant Program Review) position was vacant for approximately 4 months and recently filled. The DON was in orientation at the time of *our review*.

The Chief Psychiatrist position is filled.

The Pharmacy Services Manager position is filled.

The Standards and Compliance Coordinator position is filled.

The Health Care Administrator position has never been budgeted at the headquarters level. DJJ has established a Staff Services Manager I position at headquarters to assume these administrative duties and this position was recently filled.

The Clinical Record Administrator position has been eliminated. Given DJJ's decrease facilities and population, it is our opinion that a full time position is no longer needed or justified. We recommend that DJJ obtain consultation in managing health records from CDCR.

We find this provision in substantial compliance but note that continued turnover in key positions (Chief Medical Officer, Director of Nurses, and Health Care Administrator) slowed the development and implementation of Health Care Services Remedial Plan requirements such as collection and analysis of health care utilization data, development of nursing protocols and tracking of state contracts.

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

Assessment: Partial Compliance

In August 2011, Evalyn Horowitz MD, Statewide Medical Director transferred from DJJ to CDCR adult system. In September 2011, DJJ appointed Ronald Wisdom MD as acting Statewide Medical Director. He divides his time between NCYCC (2/3) and headquarters (1/3). Dr. Wisdom has clinical autonomy for the health care program.

As noted earlier in this report, turnover in this position has delayed implementation of the few remaining structural aspects of the remedial plan. This includes the requirement that the Chief Medical Officer establish a system to evaluate staff productivity and fiscal accountability that has not yet been accomplished. Therefore staffing reductions have occurred without the benefit of objective data to support staffing decisions. With the possibility of future budget cuts, it is important that DJJ establish criteria to justify and protect positions from future budget cuts and ensure that DJJ has sufficient staffing to provide adequate services to youth under its care.

DJJ responded that the CMO has been actively involved in measures to improve health care resource utilization and fiscal accountability, including collaboration with CDCR and the Receiver's office to incorporate DJJ into the Health Net system; implementation of the new business rules; and monitoring staff overtime, registry and sick leave usage to decrease costs. We acknowledge these positive steps to contain costs. We point out that in the Medical Experts Third and Fourth Comprehensive reports we emphasized that this area would be found in substantial compliance with successful implementation of a clinical auditing process and system for evaluating health care utilization, staff productivity and fiscal accountability.

Peer review has been turned over to DJJ for internal monitoring. However repeated clinical findings at Ventura from previous audits highlight the need for more vigorous peer review with attention to clinical issues identified during clinical audits and sentinel events, as well as routine peer review.

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

Assessment: Partial Compliance

Since our last site visit, Louise Allen RN resigned as the Statewide Director of Nursing. There have been four different Director of Nurses' since monitoring began and turnover in this position has hampered development of the nursing program.

Ms. Terri van Aalst RN has recently been appointed to this position and was in orientation at the time of our headquarters visit. Ms. van Aalst has previous experience in DJJ at Preston and in CDCR adult system.

The HCSRP requires the development and implementation of standardized nursing procedures to provide clinical guidance to nurses in patient evaluation however, this has not yet occurred. We discussed this with Ms. van Aalst who intends to make this a priority. We are available to provide consultation and assistance.

We note that the classification of the Statewide Director of Nurses position has been changed from a Nursing Consultant III (Supervisor) to a Nursing Consultant, Program Review. Although this position does not provide administrative supervision to nursing supervisors and other nursing personnel, it is our understanding that this position has the responsibility and authority to provide clinical supervision and enforce nursing clinical practice standards.

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

Assessment: Partial Compliance

DJJ has replaced the Health Care Administrator position with a Staff Services Manager I position that was recently filled by Ms. Marie Del Real. A requirement of the Health Care Services Remedial plan is that health care administrative leadership develops a tracking system for each budget line item (e.g., pharmacy, hospitalizations, personnel, etc) and on a monthly basis monitors, analyzes and reports on expenditures for each facility to ensure that DJJ health care expenditures remain within budget. At this visit, the Medical Experts became aware that Health Care Services contemporaneously tracks only headquarters health care expenditures, and not facility health care expenditures.

In addition, we were advised that HCS does not currently track the renewal of DJJ statewide health care contracts. At one time this was occurring, but apparently has lapsed. At our site visit to the Northern California Youth Correctional Complex, staff reported that two state nursing registry contracts expired in September 2011.

DJJ responded that the Staff Services Manager does not fill all of the roles that the HCA performs and that many of the responsibilities are carried out by the CMO at this time, including the tracking of facility monthly budget plans.

However, we note that the HCA position was vacant for 2 monitoring cycles and the SSM I position has recently been established and filled. In the interim period, statewide contracts were not monitored at the Headquarters level and some permitted to lapse (e.g., statewide nursing registry contracts).

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

Assessment: Substantial Compliance

For the most recent completed fiscal year (FY 2010/2011), the initial allotment for the DJJ health care budget was $53,294,806 and final expenditures were $45,619,371. Based upon an average population of 1264 on 7/1/2011 this averages $36,090 per youth for all health care services (e.g., medical, dental and mental health). For the fiscal year 2011/2012, in January 2012 the projected expenditures were $31,462,120. Based upon an average current population of 1137 from July-March 1, 2012 that averages $27,768 per youth for all health care services.

Review of facility budgets show that personnel costs account for >80% of health care expenditures. Faced with state's budgetary pressures, DJJ is currently undergoing staffing reductions. In addition, former Director Rachel Rios explored potential cost savings opportunities related to health care contracting through collaboration with CDCR. Areas of potential savings included:

- Reduction in medical contract rates
- Provider networks for physician and hospital services
- Increasing purchasing power by incorporating DJJ into the CDCR medical contracts
- Centralizing medical contracts > $25,000 per year and >$75,000 for up to 3 years.
- Combine DJJ and CPHCS pharmaceutical purchases.
- Utilization Management
- Telemedicine
- Third party administrator invoice processing[1]

As CDCR is the parent organization of DJJ, presumably statutory authority exists for DJJ to be included in CDCR health care contracts.

The Medical Experts believe that the sustainability of DJJ is directly related to its ability to provide services in a cost-effective manner and we commend DJJ and CDCR leadership for exploring and achieving cost savings through collaboration in medical contracting and fiscal oversight.

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

Assessment: Substantial Compliance

This area remains in substantial compliance. We requested and were provided a job description and duty statement for each central office position.

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

Assessment: Substantial Compliance

This area remains in substantial compliance. HCS staff has developed a structured, written orientation program for headquarters staff. The plan is for supervisors to provide specific training to new employees based on their specific assignment. The orientation is to be documented via a checklist that is maintained in the supervisory file. We reviewed the current orientation manual and found it to be useful.

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

Assessment: Substantial Compliance

This area remains in substantial compliance. Health Care Services continues to update policies and procedures on an ongoing basis. However, do note that some policies have not been reviewed and updated since 2009 and we would anticipate that by the end of 2012 that all policies would have been reviewed and updated.

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

Assessment: Substantial Compliance

This area remains in substantial compliance. HCS has developed chronic care policies and procedures. Clinical guidelines from the NCCHC have been distributed to the medical staff and appropriate training has been provided.

There have been no new physicians hired that require chronic disease training.

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

Assessment: Substantial Compliance

HCS has developed a Quality Management Plan. The plan establishes an HCS Quality Management Team (QMT), which coordinates and facilitates the performance of quality improvement activities at each facility.[2] The Standards and Compliance Coordinator (SCC) leads the HCS QMT.

Since our last report Health Care Services has implemented structured health care audits. According to the Standards and Compliance Coordinator, the current plan is for health care audits to be conducted in collaboration with OACC approximately 6 months before the Medical Experts audit so that areas requiring improvement can be identified and corrective strategies implemented prior to the Medical Experts site visit. We strongly support this plan.

The first audit was performed the week of February 17, 2011 at Ventura YCF. This review involved the previous DJJ Medical and Nursing Directors, Standards and Compliance Coordinator. The Medical Experts were provided a copy of the audit report and noted inconsistencies in how the scoring was conducted as compared to the Medical Experts. We invited HCS staff to join us on the next audit to discuss interpretation of the audit instrument and scoring which took place in August 2011 at VYCF. We believe this was a productive experience, however since then, both the Medical and Nursing Directors left DJJ. We invite the DJJ's current Medical and Nursing Directors to join the experts on future site visits.

In July 2011 HCS leadership performed a structured audit in collaboration with the Office of Audits and Court Compliance (OACC) at NCYCC. The intent was to complete a review of both NA Chaderjian and OH Close, however the Director of Nurses was on leave and due to limited staff resources and travel restrictions the OH Close portion of the review was not completed until November 2011. At the time of our visit to Headquarters in December 2011, the OH Close report had not yet been published.

DJJ responded that the OH Close audit report was completed and a final copy reported to the Medical Experts on December 14, 2011 after our headquarters visit. Although we appreciate that the OH Close report was provided to the Medical Experts prior to the Comprehensive Report, our primary concern is that DJJ develop a clinical auditing process in which the audits and reports completed and distributed to key stakeholders in a timely manner. The OH Close report was not completed and made accessible to DJJ staff for approximately six months after the audit was scheduled to be performed.

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

Assessment: Substantial Compliance

The Clinical Records Administrator position has been eliminated however review of compliance with health record policies and procedures is being performed under the auspices of the clinical monitoring process. In our opinion, this effectively meets the requirement of the HCSRP.

Health Care Organization, Leadership, Budget, and Staffing

Interview HCS staff. Review the DJJ Table of Organization, Staffing and Budget Reports. Review orientation and training materials. **Key:** SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated		SC	PC	NC	NA
Question # 1	The Health Care Services (HCS) Table of Organization is consistent with the Health Care Services Remedial Plan (HCSRP) (pages 9 and 10).	1			
Question # 2	The DJJ organizational structure has established a centralized model for health care delivery, supervision, and oversight. Health Care Services has authority over facility personnel decisions including decisions to hire, promote, and discipline staff.	1			
Question # 3	Key HCS leadership positions (pages 9-12) are budgeted, filled, or being effectively recruited. Pay parity exists with CDCR.	1			
Question # 4	The Statewide Medical Director position is filled or being effectively recruited and provides competent oversight and leadership of DJJ Health Services in compliance with HCSRP requirements (page 10). The Medical Director has medical autonomy for the health care program.		1		
Question #5	The Statewide Director of Nurses (DON) position is filled or being effectively recruited and provides competent leadership and oversight of nursing services in compliance with the HCSRP (page 11). The DON has clinical authority for nursing services.		1		
Question # 6	The Health Services Administrator (HSA) position is filled or being effectively recruited and provides competent administrative leadership. The HSA has developed a comprehensive health care budget that includes monthly tracking and reporting for each line item (e.g., pharmacy, hospitalizations, equipment, and supplies, etc.) per facility. The HSA provides administrative support to clinical staff to ensure that operational systems are functioning smoothly.		1		
Question # 7	The health care budget is adequate to meet all the requirements of the Health Care Services Remedial Plan. The integrity of the health care budget is maintained (funds are not diverted to other programs except when approved by the Chief Deputy Secretary).	1			
Question # 8	There are job descriptions for each budgeted position in Health Care Services (HCS).	1			
Question # 9	HCS has developed and implemented a structured, written orientation program for headquarters and facility staff. All new headquarters staff is oriented within 30 days of hire. Personnel orientation is documented and maintained in personnel files.	1			
Question # 10	HCS has developed and implemented initial policies and procedures and health record forms in collaboration with the Medical Experts. These policies are reviewed annually and updated as necessary.	1			
Question # 11	Health Care Services has developed chronic care policies and procedures, and clinical guidelines that are consistent with nationally accepted standards of care (e.g., Joint National Committee reports (as applicable), NCCHC, American Diabetes Association, etc.). DJJ has provided appropriate policy and guideline training for the clinicians.	1			
Question # 12	HCS has developed and implemented a structured auditing process in compliance with the HCSRP.	1			
Question # 13	The Clinical Record Administrator monitors health record management at each facility a minimum of annually to ensure compliance with health record policies and procedures.	1			
	Totals:	10	13		

Compliance = 77% (10 of 13 Questions)

Statewide Pharmacy Services

Steve Laverone is the Statewide Pharmacy Manager. He reported that he is based at the Northern California Youth Correctional Complex and comes to DJJ headquarters as necessary.

Question 1. The Statewide Pharmacy Manager (SPM) in collaboration with key staff (nursing, medical) has developed and implemented comprehensive pharmacy policies. Pharmacy policies are reviewed annually and updated as necessary.

Assessment: Substantial Compliance

This remains in substantial compliance. Pharmacy policies and procedures are comprehensive and current.

Question 2. The Statewide Pharmacy Manager, in collaboration with the Statewide Medical Director has developed and implemented standardized and cost-effective pharmacy practices. This includes standardization of dispensing practices, and consideration of alternate pharmacy models such as regionalizing and/or outsourcing of pharmacy services.

Assessment: Substantial Compliance

DJJ has been exploring potential collaboration with CDCR adult system to provide more cost effective pharmacy services.[3]

Question 3. The Statewide Pharmacy Manager monitors staff productivity levels and recommends adjustments in staffing levels as appropriate.

Assessment: Substantial Compliance

This remains in substantial compliance. DJJ has made reductions in pharmacy staffing appropriate to the demand for services.

Question 4. The Statewide Pharmacy Manager has constituted and chairs the Statewide Pharmacy and Therapeutics (P & T) Committee that meets Quarterly. The Pharmacy Manager produces and distributes minutes of the meetings to committee members.

Assessment: Substantial Compliance

The Statewide Pharmacist provided copies of Statewide Pharmacy and Therapeutics (P & T) Committee meeting minutes

Our review of the minutes showed that they reflected trends in pharmacy prescribing practices and could be clinically useful in finding opportunities for improving clinician prescribing practices and for peer review purposes. We encourage health care leadership to examine prescribing practices that not only improve clinical outcomes, but are cost effective as well.

Question 5. The Statewide Pharmacy Manager attends facility P & T Meetings on alternate months in person or via teleconference.

Assessment: Substantial Compliance.

This area remains in substantial compliance. Our review of facility P & T Meeting minutes showed that the SPM attended committee meetings via teleconference.

Question 6. The Statewide Pharmacy and Therapeutics (P & T) Committee has developed or adopted a statewide drug formulary that is appropriate to the needs of youth and includes a non-formulary request process. The Statewide Pharmacy Manager monitors compliance with the statewide formulary.

Assessment: Substantial Compliance

This area remains in substantial compliance. As noted in our last comprehensive report, DJJ has adopted the California Drug Formulary as its own. Because this formulary is not youth-specific, we recommend that the Statewide P & T Committee review expenditures to determine whether any drugs should be made non-formulary.

Question 7. The Statewide Pharmacy Manager develops a per youth/per month cost. The Statewide Pharmacy Manager and Health Care Administrator monitor trends in aggregate and per facility costs and present data at Statewide P & T Committee Meetings.

Assessment: Substantial Compliance

This area remains in substantial compliance. Review of institutional and statewide P & T committee meeting minutes shows that the SPM tracks a variety of pharmaceutical costs.

Statewide Pharmacy Services

SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated		SC	PC	NC	NA
Question # 1	The Statewide Pharmacy Manager in collaboration with key staff (nursing, medical) has developed and implemented comprehensive pharmacy policies. Policies are reviewed annually and updated as necessary.	1			
Question # 2	The Statewide Pharmacy Manager, in collaboration with the Statewide Medical Director, has developed and implemented standardized and cost-effective pharmacy practices. This includes standardization of dispensing practices, and consideration of alternate pharmacy models such as regionalizing and/or outsourcing of pharmacy services.	1			
Question # 3	The Statewide Pharmacy Manager monitors staff productivity levels and recommends adjustments in staffing levels as appropriate.	1			
Question # 4	The Statewide Pharmacy Manager has constituted and chairs the Statewide Pharmacy and Therapeutics (P & T) Committee that meets Quarterly. The Pharmacy Manager produces and distributes minutes of the meetings to committee members.	1			
Question # 5	The Statewide Pharmacy Manager attends facility P & T Committee Meetings on alternate months in person or via teleconference.	1			
Question # 6	The Statewide P & T Committee has developed or adopted a statewide drug formulary that is appropriate to the needs of youth and includes a non-formulary request process. The Statewide Pharmacy Manager monitors compliance with the statewide formulary.	1			
Question # 7	The Statewide Pharmacy Manager develops a per youth/per month cost. The Statewide Pharmacy Manager and Health Care Administrator monitor trends in aggregate and per facility costs, and present data at the Statewide P & T Committee Meetings.	1			
	Totals:	7			

Compliance = 100% (7 of 7 Questions)

Facility Findings

Ventura Youth Correctional Facility

The Farrell Medical Experts visited Ventura Youth Correctional Facility (VCYF) on August 15-17, 2011. We thank Mark Hynum MD, CMO, Debbie Gerhart SRN II, Superintendent Eugenia Ortega and their staff for their assistance and cooperation during the audit.

Overall, the facility scored 85% (566 of 662 applicable screens and questions). This review did not include pharmacy services, credentialing, peer review and quality management that have been turned over to DJJ for internal monitoring. A companion excel spread sheet contains the data that support the findings in this report. Certain information in this report has been amended based upon comments and clarifications presented to the Medical Experts in letter sent to the experts on November 16, 2011.

Earlier this year DJJ conducted an internal review of Ventura YCF, however the audit methodology and scoring was not consistent with that of the Medical Experts. Therefore, we invited DJJ health care leadership to jointly conduct this review to promote consistency in interpreting the audit tool and clinical findings. We were joined by Evalyn Horowitz MD, Acting DJJ Chief Medical Officer and Debbie Gerhart SRN II from Ventura. We hope that staff found the joint review process to be helpful. In conducting the review, if we could not locate information in the health record we requested that our DJJ counterpart locate the information, and if it could still not be located we assumed it was not present.

The facility population at the time of our visit was 322 youth, a decrease of 53 youth since March 2010. This included 33 females and 211 males in the main facility and 78 males in the fire camp. Staff reported that beginning in September 2011 SYCRCC will begin transferring youth to Ventura in anticipation of the closure of SYCRCC by January 1, 2012. The transfer of youth is anticipated to be completed by November 1, 2011. In addition, Ventura will perform medical reception and mental health residential units will be increased. The Ventura population is ultimately expected to be approximately 400 youth.

Last year DJJ planned to create a Correctional Treatment Center (CTC) to manage youth with acute mental health conditions, however DJJ now plans to contract with Sierra Vista Hospital to provide acute mental health care services.

This review showed that the facility made progress in some areas of health care delivery (e.g., medical care, intrasystem transfer) for which staff is to be commended. However, we also note that performance in other areas was not sustained. One area of concern was medical reception for which the score dropped from 95% to 80%. This was primarily due to providers not elaborating on positive responses to symptoms for the purposes of establishing a medical diagnosis (e.g. chest pain, headache, etc); and not consistently evaluating and treating women with vaginal discharge. This latter issue was a finding last year which remained unchanged.

Note: DJJ responded regarding the finding that the medical provider does not adequately evaluate and treat women with vaginal discharge, by noting that small to moderate amounts of vaginal discharge without symptoms (e.g., odor, itching, etc) is normal and does not require clinical evaluation. We agree that scant or minimal vaginal discharge without symptoms is normal and does not require microscopic examination. We also note that Bacterial Vaginosis (BV) is a sexually transmitted infection with an estimated prevalence of 29% of women aged 14 to 49 years old in the general population and 50% among African-American women. Approximately 50-75% of women with BV are asymptomatic; and those with symptoms present with an odorous, off-white, thin and homogenous discharge.[4] We anticipate that clinical judgment will always be a factor in the decision to evaluate vaginal discharge, however given that DJJ youth are at high risk for sexually transmitted infections, our concern is that we found no evidence that the medical provider ever used microscopy to diagnose women with vaginal discharge. According to one literature source, for patients presenting with symptoms of vaginitis, laboratory documentation is mandatory before initiating therapy, and empiric treatment is discouraged.[5]

In addition, an18 year-old woman had an abnormal pap smear showing a high-grade squamous intraepithelial lesion (HSIL) but was not referred for evaluation and treatment. Instead she was counseled and scheduled for a repeat pap smear in six months. HSIL lesions are associated with persistent HPV infection and a higher risk of progression to cervical cancer. When initially evaluated, 50% of patients have a finding of moderate cervical intraepithelial neoplasia (CIN 2) or greater and 2 percent have invasive cancer. The American College of Obstetricians and Gynecologists (ACOG) recommends that women with HSIL be referred for colposcopy and biopsy. We discussed this finding with Dr. Hynum at the exit debriefing who agreed with our concern that the patient should have been immediately referred for evaluation and planned to coordinate the appointment following the audit. We request that DJJ advise the Experts whether this referral took place.

We also note that DJJ requested credit for 2 items that were noncompliant at the time of our review were corrected after the audit. While we appreciate that staff followed up with each patient, credit cannot retrospectively be given for these items.

Audit scores also dropped slightly in medication administration records, consultation and preventive services. The nursing sick call score remained unchanged, most likely related to the lack of standardized nursing procedures to provide nurse guidance regarding their practice.

As noted in our last report the various populations, (e.g., girls, boys, BTP and fire camp) has resulted in an operationally complex facility. In addition to the need to keep populations separated (e.g. females and males); there continue to be frequent youth disturbances in housing units that interferes with youth access to scheduled appointments. Health care leadership has established satellite medical clinics to promote access to care, including the Behavioral Treatment Program (BTP). Given the current climate, this is a reasonable approach until reductions in youth violence have been achieved.

Staff reported that 65% of youth are in school. The program service day limits access to routine health care to before 8 am to after 4 pm. Implementation of the program service day, while positively increasing youth access to education, has resulted in prolonged periods during the day

when health care staff does not do not have access to youth. Since DJJ youth are as a whole a medically healthy population, this is not in and of itself a significant problem. However it does require matching health care resources to the demand for services and scheduling provider staffing when youth are most readily available.

Currently, there are 2.5 clinical FTEs scheduled during normal business hours when youth are not available. Although there are some administrative duties that can be carried out during these periods, these duties appear to be insufficient to justify the current provider staffing. As just one example, a provider was posted at the female satellite clinic from 11 am for the remainder of the afternoon with no patients scheduled. This is not a cost effective use of resources.

We also recommend that DJJ evaluate staff schedules and consider staggering provider hours and other services to be available when youth are out of school. For example, nurse sick call might be scheduled at a set time each day, preferably before school. If competing functions in the morning (e.g., breakfast, medication administration, school, etc.), present challenges to completion of sick call in the morning, DJJ may want to consider adjusting the school day to begin 30-60 minutes later than normally scheduled or scheduling sick call after school.

Another issue related to staff efficiency involves documentation regarding use of force incidents. Staff reported that each use of force requires that multiple staff document in WIN, however currently only one staff member can log into WIN at the same time even though staff document on different screens. Consequently staff is sometimes asked to stay overtime, increasing personnel costs. We recommend that modifications are made to WIN that permit more than one staff member to document at a time.

We noted health care practices that are not in policy and that increase the cost of health care without a commensurate benefit. For example, upon arrival all youth are tested for hepatitis and varicella (i.e., chicken pox) antibodies even if there is documentation of previous immunization. If youth are not immune, they are revaccinated. We recommend that DJJ leadership evaluate the cost-benefit of this practice.

In summary, Ventura YCF is in process of mission and population change as well as anticipated changes in medical leadership that present ongoing challenges to the facility. Given the score of 85% and our overall findings, we find the facility to be in substantial compliance pending improvements in the medical reception process.

We wish to acknowledge the service and dedication of Mark Hynum MD who will retire in the near future. During this period of transition in mission and leadership, Ventura would benefit from the support and oversight of DJJ health care leadership.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 89%

With respect to facility leadership, Dr. Hynum is currently the Chief Physician & Surgeon, however he reported that he plans to retire in the near future. The previous SRN II retired and Debbie Gerhart SRN II provides nursing leadership.

Clinical staffing consists of 2.5 FTEs. In addition to the Chief P & S, there is a part-time physician who is a permanent intermittent employee (PIE) who averages 20 hours a week; and a full time nurse practitioner (NP). The facility also regularly utilizes a retired annuitant (RA) physician to conduct specialty clinics such as tattoo removal and minor surgical procedures. The RA physician also is called in when the nurse practitioner or a physician is on leave. The medical experts understanding of DJJ's business rules model was that with increased clinical involvement of the Chief P & S, as well as a full time NP and a half-time physician, the utilization of RA's would not be necessary.

There is now a second custody officer post in the medical section which has increased the efficiency of health care operations.

With respect to the health care budget, the facility does not yet have the FY 2011-2012 initial budget allotment. The 2010-2011 allotment was $9,044,395, down from $13,929, 358 for the previous fiscal year. Of this amount $7,384,477 (82%) was allocated to personnel costs.

Medical Reception scored 80%

This is a significant decrease from the previous score of 95%. The provider who performs the intake physical examinations did not consistently elaborate on positive responses to the review of systems (e.g., chest pain, headache, etc). In addition, the provider did not adequately diagnose and treat women with vaginal discharge. As noted at our last visit, the provider did not utilize a microscope to aid in diagnosis of vaginal discharge and in some cases, did not evaluate and treat the patient's vaginal discharge at all. Although DJJ screens women for chlamydia and gonorrhea, trichomonas and bacterial vaginosis (BV), are also common causes of vaginal discharge in women of childbearing age. At our last visit, staff indicated that this finding would be addressed as soon as possible and it was disconcerting to return to the facility to find that there had been virtually no change in clinical practice. We expect this issue to be reviewed using the peer review and quality management systems. We will review the results of these findings at our next visit.

Intrasystem Transfer scored 96%

This is an improvement from the previous score of 87%. Congratulations.

Nursing Sick Call scored 75%

This score is unchanged from our last visit. As noted in our last review, we found that nurses generally collect and triage health services requests (HSRs) in a timely manner. The quality of nursing assessments is still in need of improvement which would be expected to occur after development and implementation of standardized nursing procedures. In 2 of 6 records nurse to provider referrals did not occur in a timely manner.

Note: DJJ requested credit for one item in which the youth was not seen for an appointment due to a refusal. However the youth stated that she did not refuse her appointment and requested to be seen. Credit not given for this item.

Medical Care scored 92%

Even though the facility scored above 85%, an area that would benefit from improvement is follow-up on the treatment plan.

Chronic Disease Management scored 94%

Congratulations.

Infection Control scored 100%

Congratulations.

Pharmacy Services scored 100%

In October 2011 the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB), in conjunction with the Division of Juvenile Justice Subject Matter Experts conducted a review of pharmacy services as required by the Health Care Services Remedial Plan (HCSRP). This report was provided to the Farrell Medical Experts for our review and we note that pharmacy services were found to be 100% compliant, which is consistent with our previous findings.

Medication Administration Process scored 92%

While the facility met the goal of 85%, an area that could be improved is ensuring that two nurses document counting narcotics at every shift.

Medication Administration Health Record Review scored 82%

This is a decrease from a score of 86% at our last visit. Areas requiring attention include documentation of a progress note to support the clinical rationale for each medication order. In this review 3 records did not contain a psychiatric progress note to support the medication order.

In addition, nurses did not document administration status for each dose. These omissions should be treated as medication errors and studied under the auspices of the quality improvement program.

Urgent/Emergent Care scored 80%

This is a decrease from the previous score of 82%. Areas that could be improved are documentation in the urgent-emergent log; and the performance and critique of emergency drills on every shift over the course of the year. Summaries of emergency drills should be shared with staff not in attendance at the drill.

Outpatient Housing Unit

This area was not monitored due to its infrequent use.

Health Records scored 100%

Congratulations!

Preventive Services scored 84%

This is a decrease from the previous score of 89%. An area that is in need of improvement is the identification and care of obese youth. DJJ noted that body fat measurements had been obtained and revealed acceptable percentages of body fat. However, these measurements had not been repeated in over one year. Even though the youths' weight had been stable, the percentage of body fat could have changed. This was discussed with Dr. Wisdom who agreed that if body fat measurements are used, they should be obtained on an annual basis.

Consultations scored 85%

This is a decrease from the previous score of 89%. While the facility met the goal of 85%, areas in need of improvement include use of the consultation log and implementation and monitoring of the consultant's recommendations.

Peer Review scored 100%

In October 2011 the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB), in conjunction with the Division of Juvenile Justice Subject Matter Experts conducted a review of peer review as required by the Health Care Services Remedial Plan (HCSRP) requirements. This report was provided to the Farrell Medical Experts for our review and we note that peer review was found to be 100% compliant, which is consistent with our previous findings.

Credentialing scored 100%

In October 2011 the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB), in conjunction with the Division of Juvenile Justice Subject Matter Experts conducted a review of credentialing in light of Health Care Services Remedial Plan (HCSRP) requirements. This report was provided to the Farrell Medical Experts for our review and we note that peer review was found to be 100%, which is consistent with our previous findings.

Quality Management scored 80%

In October 2011 the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB), in conjunction with the Division of Juvenile Justice Subject Matter Experts conducted a review quality management in light of Health Care Services Remedial Plan (HCSRP) requirements. This report was provided to the Farrell Medical Experts for our review and we note that quality management was found to be 80% compliant, which is a decrease from 100% compliance found at our most recent audit. Two areas found to be noncompliant included lack of physician reviews of nursing sick call and Outpatient Housing Unit patient records for 2 of the past 4 quality management review periods. Given that the quality of nursing assessments in DJJ is an area requiring significant improvement, it should receive a high level of priority with respect to quality management activities.

Northern California Youth Correctional Complex

The Farrell Medical Experts conducted a site visit at the Northern California Youth Correctional Complex (NCYCC) on January 9-11, 2012. NCYCC consists of NA Chaderjian (Chad) and OH Close Youth Correctional Facilities.

Since our last visit in May 2010 NCYCC has been impacted by the closure of both Preston and Southern Youth Correctional Facilities resulting in changes in population and medical and mental health missions of each facility. The medical reception mission was transferred from Preston to Chad. At the time of our visit, the population of Chad was 375 and OH Close was 239 totaling 614 youth. This is an increase of 150 youth or 30% since our last visit.

NCYCC scored 88% (1245 of 1419 applicable screens/questions). OH Close scored 92% and NA Chaderjian scored 85%. We find NCYCC to be in substantial compliance,

We thank Superintendent Erin Brock and Rose Bustillos, Correctional Health Administrator II, and staff for the cooperation and assistance in completing the health care audit.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 100%

DJJ leadership has amended the organizational structure so that the Correctional Health Services Administrator (CHSA) II is administratively in charge of health care services. The Medical Experts strongly support this organizational structure as a means to both support and hold staff accountable for administrative performance. DJJ has also amended the organizational structure with regards to clinical supervision and oversight that we find to be clear and consistent.

With respect to health care staffing, DJJ has amended the business rules for medical staffing. The Medical Experts have previously recommended that health care staffing should be based upon minimum staffing requirements to meet the requirements of the Health Care Services Remedial Plan (HCSRP) combined with collection and analysis of health care utilization data to determine the most appropriate types of staffing.

However our understanding is that the current business rules were not based upon analysis of health care utilization, population, and mission changes. Therefore, while overall reductions in staffing may be appropriate, refinement may be needed in the types and numbers of staff to provide adequate services. Therefore, we continue to recommend that DJJ collect and analyze data and make staffing adjustments as necessary.

In addition, some staffing positions have been eliminated altogether (e.g., infection control, nurse instructor), and their duties will need to be assumed by other staff. We recommend that facility and DJJ health care leadership collaborate in the process of reassigning duties and functions to ensure continued compliance with DJJ policies and procedures, and requirements of the Health Care Services Remedial Plan.

We also recommend that DJJ review policies and procedures as well as practices at the facilities for inefficiencies in staff productivity. For example, DJJ's mental health policy requires that a registered nurse sees all youth submitting mental health requests within 24 hours. At OH Close, a registered nurse triages mental health requests, makes a copy of each one and places it in the box of the psychiatrist. Then she performs an assessment of each youth who submitted a request, makes a copy of her progress note and places it in the psychiatrist's box, then files her note in the health record. The nurse indicated that this is what the psychiatrist wanted her to do, but this practice is an inefficient use of registered nurse time and warrants reevaluation.

We found that clinical staffing is 3.5 FTEs. This includes a 1.0 FTE physician and surgeon, 2 FTE nurse practitioners. The DJJ Chief Medical Officer (CMO) position is attached to the NCYCC budget as a 1.0 FTE but divides his time between headquarters (0.5) and NCYCC (0.5). There is also a 0.7 FTE physician relief factor. This clinical staffing pattern is a clinician to youth ratio of 1:198 and is more than adequate clinical staffing.

DJJ responded that DJJ policy requires the availability of a physician for emergency coverage, thus necessitating the physician relief factor. We encourage DJJ to consider other options for providing coverage including having physicians at VYCF and NCYCC share on-call coverage. We do not believe it is necessary or should be required that the on-call provider be located in the immediate geographical area. Consideration should also be given to changing DJJ policy to permit nurse practitioners to take call responsibilities.

With respect to nursing staff, the business rules call for significant reductions. The SRN III position has been eliminated and SRN II positions reduced from 3 to 2 FTEs. Mental health and behavioral treatment units no longer have a registered nurse assigned to the units. Psychiatric technician positions will be reduced.

Chad and OH Close medical clinics each have an RN and an LVN assigned to the day and evening shifts 7 days per week. In addition, an RN is assigned to the OHU 24 hours, 7 days per week. Infection control and nurse instructor positions have been eliminated.

The new business rules call for 2.0 FTE custodians for the OHU. It is our understanding that the second position is to provide a relief factor. Currently custodian services are utilized in the satellite clinics on only a quarterly basis. We recommend that health care leadership consider increasing the frequency with which custodial services are provided in the clinics or reconsider the need for the second position.

Pharmacist staffing has been reduced from 2.0 to 1.0 FTEs and 1.0 pharmacy technicians. Radiology services are provided on an on-call basis.

With respect to custody staffing, an officer continues to be posted in the Chad medical unit from 7 am to 3 pm. This position is necessary to direct youth movement. However there is no officer in the medical clinic after 3 pm and no officer in the control room after 5 pm. Given that the program service day limits youth access during school hours, we recommend that leadership consider staffing the control room 16 hours a day, instead of 8 hours to facilitate youth being seen in the evening hours.

With respect to budget, this fiscal year DJJ received its allotment in a much timelier manner than in previous years. We reviewed NCYCC November 2011 budget information and noted that the FY 2011-12 final allotment for the complex was $9,402,88 with a projected annual expenditure of $12,547,927 and projected deficit of $2,977,118. Of the total budget allotment $7,626,215 (81%) is attributed to personnel costs and $1, 217,927 (13%) to professional medical services. Thus, 94% of all medical costs are due to personnel and professional medical services.

Health care leadership reported a reemergence of issues related to renewal of medical contracts with service providers. For example, two of three nurse registry contracts expired in September 2011 and leadership reported difficulty obtaining registry LVNs and RNs. With business rules reductions in nursing positions, this may have a more significant impact in the future. Staff also reported that in some cases they continue to use service providers even when the contracts have expired.

Medical Reception scored 85%

This score is a significant improvement from the previous score of 76%. The volume of youth admitted to the facility as a result of parole revocation and/or medical reception has increased.

The facility has implemented standardized physician orders for medical reception that are in compliance with DJJ's policies and procedures, and which provide a mechanism for accountability with respect to implementation of the medical reception process. The use of standardized physician orders has likely played a role in improving compliance and should be considered for other facilities.

While the facility met the required threshold of 85%, there are a few areas that would benefit from continued attention. Clinicians do not consistently document the pertinent negatives such as the absence of TB symptoms (e.g., "patient denies cough, fever, night sweats and weight loss). Although the medical screening form may contain this information, it is important for the provider performing the physical examination to perform an independent assessment of the patient's condition. The design of the medical reception form does not require the documentation of pertinent negatives and we recommend that at the next policy review that consideration be given to amending the form to require this.

Another area that would benefit from attention is ensuring that the treatment plan is fully implemented following the medical reception process. For example, clinicians wrote orders for monthly weights x 6 months that were not completed. In another case the physician order that the youth be enrolled into the chronic disease clinic, but this did not take place.

Intrasystem Transfer scored 96%

Congratulations. This is an improvement from the previous score of 89%. We reviewed 18 records of youth who transferred into the facility from October 2010 to December 2011. NA Chaderjian scored 93% and OH Close 98%.

Nursing Sick Call scored 73%

This score is an improvement from the previous score of 67% however this area still requires significant improvement. At NCYCC, nurses collect and triage health service requests and perform limited assessments. Health record documentation shows that since the last visit, nurses more fully utilize their clinical assessment skills; however the quality of the assessments, still needs significant improvement. The nurses use a documentation format called SAMPLEPAIN that often results in documentation of information that is not pertinent to the complaint. Nurses also attempt to document all nursing assessments on the Health Service Request (HSR) form that provides inadequate space to document a complete assessment.

One finding of concern is that nurses are treating patients independently without the use of nursing protocols. As noted above, the nurses are making a greater effort to utilize nursing assessment skills, but without written protocols often do not adequately assess patients.

Following patient evaluations, nurses forward the health record to a medical provider for chart review. We found that providers review and sign off on nursing assessments that have are not appropriate and do not personally evaluate the patient.

For example, one patient complained of a shoulder dislocation and was evaluated by a nurse who did not perform an appropriate examination of his shoulder. The nurse ordered prescription strength Motrin and an orthopedic referral. This was signed off by the nurse practitioner without examining the patient. In another case a nurse evaluated a patient who complained of chest pain but did not examine the patient. The nurse referred the record to a provider who ordered Motrin and a chest x-ray but did not evaluate the patient. In two other cases, nurses referred the health record for provider review but this did not take place.

We encourage DJJ to develop nursing assessment and treatment protocols for nurses to use in the evaluation of minor health conditions (e.g., acne, dry skin, athlete's foot). However nurses should not independently evaluate youth with more complex symptoms such as chest pain and orthopedic problems. These patients should be referred to a provider for clinical evaluation.

Medical Care scored 96%

This score is an improvement from the previous score of 92%. Chad scored 93% and OHC scored 100%. While the facility met the overall goal of 85%, areas that could be improved included follow-up of the treatment plan.

Chronic Disease Management scored 95%

Congratulations. This score is a slight decrease from the previous score of 97%. We reviewed 20 (23%) records of 85 youth identified has having a chronic disease. While the facility scored above 85%, an area requiring attention is follow-up of abnormal laboratory tests.

Infection Control scored 100%

We evaluated the infection control program by reviewing policies and procedures; reportable disease reports and tracking logs; infection control meeting minutes; and toured clinic areas to

evaluate the presence of personal protective equipment and engineering controls designed to minimize staff and youth exposure to communicable diseases. The infection control nurse has developed an excellent infection control program. Infection control minutes show collection of data, evaluation for trends and meaningful content. It is our understanding that the revised business rules eliminate the infection control nurse position. At the time of our visit, a decision had not been made regarding reassignment of these duties but should be done as soon as feasible to maintain performance in this area.

Sanitation in the Chad and OHC medical clinics has improved since our last visit.

Pharmacy Services

Pharmacy services were not evaluated during this review as it has been transferred to DJJ for internal monitoring. The Medical Experts will review the results of DJJ Health Care Services pharmacy services monitoring prior to our next report.

Medication Administration Process scored 100%

We evaluated the medication administration process by inspecting medication storage areas and observing the medication process. Congratulations. This is an improvement from the previous score of 88%.

Medication Administration Health Record Review scored 89%

We reviewed 20 records of patients with medication orders to evaluate the accuracy and timeliness of medication administration and completeness of documentation in the health record. Chad scored 87% and OHC scored 91%. This is a significant improvement from the previous combined score of 74%. While the facility exceeded the goal of 85%, areas that could benefit from focused attention include the accuracy of physician order transcription by nurses or the pharmacy. In one case the pharmacy label did not contain the dose of the medication. We also note that the month and year of the MAR is often obliterated because of where the MAR has a hole-punch for filing. Therefore, it is frequently not possible to determine which month the MAR represents. This has been pointed out in previous site visits and should be corrected.

Urgent/Emergent Care scored 86%

This is an improvement from the previous score of 73%. While the facility exceeded the goal of 85%, at OHC areas that could benefit from improvement include use of the SOAP format and emergency log. At Chad areas that could benefit from improvement include use of the emergency log and nursing assessments and plans. In addition, we were not provided copies of quarterly emergency drills. Emergency drills should be performed on a quarterly basis and involve every shift over the course of the year. Ideally they should vary in the types of drills conducted, and the results of drills should be shared with all shifts. Documentation that all staff not involved in the drill has reviewed the results should be maintained.

Outpatient Housing Unit scored 88%.

Congratulations. This is an improvement from the previous score of 81%. Areas requiring improvement include the initial nursing assessment (primarily orientation to the OHU) and physician orders (especially noting clinical criteria for which they want to be notified), and a nursing discharge note.

Health Records scored 100%

This is an improvement from the previous score of 75%. While the facility exceeded the threshold of 85%, on a consultative note, we noted two issues related to filing documents in the health record.

The chronic care encounter forms were not filed in a consistent area of the health record (or even the same chart). Some were filed chronologically with the progress notes and some were filed in a separate chronic care section of the record.

If the Problem List is more than one page, the second page is placed on top of the first page. Since the second page is not full, it is not evident there are two pages. The chronic problems that are usually documented on the first page may be missed. We recommend that the Problem List is recopied so that all active medical problems, including chronic diseases are visible when the record is opened.

Preventive Services scored 94%

This is an improvement from the previous score of 89%. Chad scored 91% and OHC scored 97%. While the facility met the goal of 85%, an area that could benefit from attention is the care of youth who are overweight.

Consultations scored 95%

Congratulations. OHC scored 93% and Chad scored 95%. While the facility exceeded the threshold of 85%, areas that would benefit from attention are timely review of the consultants' report (OHC) and timely follow-up by the primary care provider (Chad).

Peer Review

Peer review was not evaluated during this review as it has been transferred to DJJ for internal monitoring. The Medical Experts will review the results of DJJ Health Care Services peer review process prior to our next report.

Credentialing

The credentialing process was not evaluated as it has been transferred to DJJ for internal monitoring. The Medical Experts will review the results of DJJ Health Care Services credentialing process prior to our next report.

Quality Management

Quality management process was not evaluated during this review as it has been transferred to DJJ for internal monitoring. The Medical Experts will review the results of DJJ Health Care Services Quality Management process prior to our next report.

Recommendations

Central Office

1. Develop and implement standardized nursing protocols and related training program.[6]

2. Conduct a productivity study and staffing analysis to determine the appropriateness of health care staffing at each facility.[7]

3. Continue to develop and refine the clinical monitoring and quality management programs.

Facility

4. Improve the quality of nursing clinical assessments and documentation.

5. Conduct quality improvement studies for problems identified by the staff or medical experts.

6. Develop a statewide program to address the problem of obesity in the DJJ population.

Endnotes

[1] See CDCR Evaluation of the Division of Juvenile Justice Health Care Service Contracts for Enhanced Access to Care, Cost Containment Opportunities and Possible Realignment.

[2] DJJ Health Care Services Quality Management Plan, page 1.

[3] See CDCR Evaluation of the Division of Juvenile Justice Health Care Service Contracts for Enhanced Access to Care, Cost Containment Opportunities and Possible Realignment.

[4] See UpToDate. Bacterial Vaginosis.

[5] See UpToDate. Bacterial Vaginosis.

[6] See Question #5 of Health Care Organization, Leadership, Budget and Staffing Audit Tool and pages 10 and 12 of the Health Care Remedial Plan.

[7] See Questions #4 and #5 of Facility Organization, Leadership, Budget, Staffing, Orientation and Training; and Health Care Remedial Plan: Statewide Leadership Page 10 and Number and Types of Staffing page 13.

ID	Task_Name	Duration	Start Date	Finish Date	Percent Complete	Resource_Names
1	USE OF FORCE	475 days	8/15/11	7/5/13	43%	
2	A Define and Convey Management Expectations	225 days	8/15/11	7/6/12	47%	
3	1 Revise Crisis Prevention and Management Policy	96 days	8/15/11	1/3/12	98%	
4	a Issue Policy in Draft Form	46 days	8/15/11	10/18/11	100%	
5	b Draft Response Due	10 days	10/19/11	11/1/11	100%	
6	c Finalize Policy	40 days	11/2/11	1/3/12	95%	
7	2 Provide Training on New Policy to Staff	129 days	1/3/12	7/6/12	14%	
8	a Develop and Issue Training curriculum in draft form	6 days	1/3/12	1/11/12	75%	
9	b Draft Response Due	5 days	1/11/12	1/18/12	75%	
10	c Finalize Training Curriculum	3 days	1/18/12	1/24/12	75%	
11	d Identify and Train Trainers	18 days	1/3/12	1/30/12	50%	
12	e Deliver Training through block training	111 days	1/30/12	7/6/12	0%	
13	e1 100% of staff trained	111 days	1/30/12	7/6/12	0%	
14	B Promote and Enhance Staff Proficiency	475 days	8/15/11	7/5/13	53%	
15	1 Core Correctional Practices Training (endorsed by UCCI)	221 days	8/15/11	6/29/12	35%	
16	a Identify Work Group to modify curriculum to include more of a mental health emphasis	23 days	8/15/11	9/15/11	100%	
17	b Modify curriculum	96 days	8/15/11	1/3/12	100%	
18	c Deliver training through block training	221 days	8/15/11	6/29/12	0%	
19	2 LETRA Training	475 days	8/15/11	7/5/13	14%	
20	a Adopt Curriculum	56 days	8/15/11	11/1/11	100%	
21	b Train the Trainers	95 days	8/15/11	12/30/11	50%	
22	c Deliver training to high priority living units (mental health units, BTPs, and high core units)	130 days	12/30/11	7/6/12	0%	
23	d Deliver training to remaining living unit staff	475 days	8/15/11	7/5/13	0%	
24	3 Psychotropic Medication Training	150 days	8/15/11	3/21/12	97%	
25	a Identify and create OJT model	105 days	8/15/11	1/16/12	100%	
26	b Identify target audience (direct care staff)	105 days	8/15/11	1/16/12	100%	
27	c Deliver training	45 days	1/16/12	3/21/12	85%	
28	4 Crisis support plan	55 days	8/15/11	10/31/11	100%	
29	a Modify and update the crisis support plan form	2 days	8/15/11	8/16/11	100%	
30	b Complete a crisis support plan for every youth and document in WIN	55 days	8/15/11	10/31/11	100%	
31	c Create a binder of the most current crisis support plan for each youth in every living unit	55 days	8/15/11	10/31/11	100%	

32	5 Weekly Team Meetings	220 days	8/15/11	6/28/12	100%	
33	a Issue memo requiring weekly team meetings in every living unit	2 days	8/15/11	8/16/11	100%	
34	b Develop format, structure, and topic to be discussed (youth crisis support plan) during weekly meetings and apply cognitive behavior skills to address youth treatment needs	53 days	8/15/11	10/27/11	100%	
35	c Develop a monitoring protocol by facility management and by DJJ headquarters	53 days	10/28/11	1/17/12	100%	
36	d Conduct weekly meetings	167 days	10/28/11	6/28/12	100%	
37	6 Mentoring and Coaching	220 days	8/15/11	6/28/12	80%	
38	a Identify mentors and coaches on different topics and subject areas in each living unit	84 days	8/15/11	12/13/11	40%	
39	b Use the weekly meeting as a forum for mentoring coaching activities	167 days	10/28/11	6/28/12	100%	
40	C Increased Application of Positive Incentives	286 days	8/15/11	10/2/12	39%	
41	1 Youth Programs	179 days	8/15/11	5/1/12	54%	
42	a Utilize the Behavior Management Tool (being developed by the IBTM workgroup) for immediate reinforcement for reductions of Use of Force Incidents	55 days	8/15/11	10/31/11	100%	
43	b Develop a plan to implement the Behavior Management System	56 days	8/15/11	11/1/11	75%	
44	c Use youth incentive funds to fund activities	64 days	8/15/11	11/11/11	100%	
45	d Provide training to all direct care staff on behavior management tool	123 days	11/2/11	5/1/12	0%	
46	2 Pilot Projects	286 days	8/15/11	10/2/12	32%	
47	a Identify two pilot project sites, one North and one South, with high levels of force application	14 days	8/15/11	9/1/11	100%	
48	b Develop a strategy and protocol for implementation of pilot projects	82 days	8/15/11	12/9/11	100%	
49	c Train staff on protocol	102 days	12/12/11	5/8/12	50%	
50	d Implement pilot projects	102 days	5/8/12	10/2/12	75%	
51	e Monthly reports on the progress of the pilot projects	200 days	8/15/11	5/31/12	0%	
52	f Headquarters to propare report on pilot project results and recommendations	200 days	8/15/11	5/31/12	0%	
53	D Continuous Improvement	311 days	8/15/11	11/6/12	32%	
54	1 Improve the effectiveness of force review process	221 days	8/15/11	6/29/12	39%	

55	a Obtain services of a force expert through contract	35 days	8/15/11	10/3/11	100%	
56	b Prepare an outline delineating conceptual changes to the current force review model to reflect a truly multi-disciplinary approach that places primary emphasis on treatment and prevention	54 days	8/15/11	10/28/11	100%	
57	c Draft Response Due on the force review model	64 days	8/15/11	11/11/11	100%	
58	d Finalize the force review model with appropriate instructions on protocol and procedures, appoint staff to force review committees	82 days	8/15/11	12/9/11	100%	
59	e Inform staff and provide training to individuals on the force review committees	136 days	8/15/11	3/1/12	50%	
60	f Implement the force review model	137 days	8/15/11	3/2/12	50%	
61	f1 implement force review	137 days	8/15/11	3/2/12	50%	
62	g Monthly Report by each facility on outcome of cases reviewed and lessons learned	221 days	8/15/11	6/29/12	0%	
63	g1 Headquarters review of the report to provide feedback and to ensure the review results reflect views of multi-disciplinary experts	221 days	8/15/11	6/29/12	0%	
64	h Headquarters produces a report summarizing the results of the new force review model, identify best practices, and identify possible changes to improve the system	221 days	8/15/11	6/29/12	0%	
65	2 More Meaningful Analysis of Available Data Throughout the Organization	311 days	8/15/11	11/6/12	22%	
66	a1 Review data that are currently available and determine how such data could be useful at the living unit level, at the facility level, and at the divisional level.	76 days	8/15/11	12/1/11	50%	
67	a2 Develop statewide database	55 days	8/15/11	10/31/11	100%	
68	b Develop standardized user friendly reports for staff at all levels	75 days	8/15/11	11/30/11	25%	
69	c Generate and dessiminate reports for use by staff at all levels	87 days	8/15/11	12/16/11	25%	
70	d Obtain feedback on a quarterly basis from facility and living units on the usefulness of data provided	221 days	8/15/11	6/29/12	0%	
71	e Reassess the usefulness of data provided and make appropriate changes	90 days	6/29/12	11/6/12	0%	