COMPREHENSIVE MEDICAL ASSESSMENTS, FIRST DOSE ADMINISTRATION, AND PSYCHOTROPIC MEDICATION MANAGEMENT AT THE YOUTH SERVICES CENTER AND NEW BEGINNINGS YOUTH DEVELOPMENT CENTER

Report 2023 – 1

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OFFICE OF INDEPENDENT JUVENILE JUSTICE FACILITIES OVERSIGHT

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I. INTRODUCTION

This report of the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) is produced pursuant to Mayor's Order 2020-115, November 13, 2020. The Office was established to "regularly monitor and publicly report on….[t]he durability of the reforms the Department of Youth Rehabilitation Services ("DYRS") previously achieved under the Jerry M. Work Plan and Consent Decree; and DYRS's progress in achieving Jerry M. Work Plan Goals, including critical Work Plan indicators, that DYRS did not achieve prior to the Superior Court's termination of the Jerry M. lawsuit."[1]

This report focuses on medical intake assessments, timeliness of medication administration and medical monitoring of youth taking psychotropic medication at DYRS' two secure facilities, the Youth Services Center (YSC) and the New Beginnings Youth Development Center (New Beginnings). The OIJJFO relied on an assessment conducted by its medical expert, Michael D. Cohen, M.D.,[2] which is attached to and described in this report[3] as well as its review of the electronic health record (EHR) as it pertains to timeliness of medication administration and compliance with policies relating to use of psychotropic medication. A draft version of this report was provided to DYRS for review and comment on December 23, 2022. DYRS representatives submitted their comments on February 14, 2023, and a copy of those comments is attached to this report.[4]

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[1] Mayor's Order 2020-115, November 13, 2020, §§I.A.1.-2.

[2] Dr. Cohen served as the Medical Director for 20 years at the New York State Office of Children and Family Services, which operates the state's juvenile justice system. He is extremely knowledgeable about DYRS's dental services program, having served as an expert to the Office of the Special Arbiter from 2005 to 2020 and, most recently, evaluated aspects of DYRS's dental program in 2019.

[3] Attachment 1, Review of Intake Medical Assessments at the Youth Services Center and Continuity of Care at the Time of Transfer to New Beginnings Center for Youth, Michael D. Cohen MD, December 8, 2022.

[4] Attachment 2, February 14, 2023, Memorandum from Trey Stanback, DYRS Interim Director, and Dr. Khandra Tyler-Beynum, DYRS Medical Director, to Mark Jordan, Executive Director, OIJJFO.

II. BACKGROUND

This report assesses several distinct, but related, elements of the medical services program at the YSC and New Beginnings: (1) Comprehensive medical assessments administered to youth upon admission to a facility; (2) the development of problem lists and treatment plans to treat medical problems revealed by the comprehensive assessment; (3) timely administration of medications prescribed to youth after their admission to the YSC; and (4) monitoring of the health of youth who are prescribed psychotropic medications at the YSC and New Beginnings consistent with DYRS policies.

When youth are admitted to a secure facility, particularly when they are admitted directly from the community, it is critical to ensure that their medical needs are timely identified and treated as indicated, and that medical treatments youth are receiving in the community are continued without interruption. According to Dr. Cohen, "[y]outh admitted to juvenile detention often have had little health care prior to placement and are more likely to have acute illness or injury, chronic illness, infection, dental cavities, physical disability, mental illness and substance abuse than youth from the general population."[5]

The Jerry M. Work Plan included a goal outlining medical services requirements at the YSC and New Beginnings,[6] which included a requirement that within 24 hours of admission to a DYRS secure facility, a youth receive a comprehensive medical assessment.[7] For youth transferred between the facilities, the assessment was required to be reviewed and updated within 72 hours of the transfer.[8] The Work Plan further provided that the comprehensive health

[5] Attachment 1 at page 1.
[6] November 21, 2019 Revised Final Approved Amended Comprehensive Work Plan (Work Plan) at Goal VIII.
[7] Work Plan Goal VIII.A.1.b.ii.
[8] *Id.* The Work Plan indicates that overnighters are excluded from the requirement.

assessment result in a problem list entry that was updated as clinically indicated and a clinically appropriate plan of care for each health problem be implemented on a timely basis.[9]

In December 2019, the Special Arbiter filed a report regarding DYRS's progress on Goal VIII that was based on a 2019 assessment by Dr. Cohen.[10] With respect to the comprehensive medical assessment, the Special Arbiter noted that in March 2016 DYRS had met the required performance standard at New Beginnings, but not at the YSC, and therefore the 2019 report only assessed performance for the YSC. The report stated that while DYRS provided timely comprehensive medical assessments for all youth in the sample who were admitted to the YSC or transferred there, there were "significant deficiencies in the scope and content of the comprehensive admission assessments" that were performed at the YSC during the period of the report.[11] Specifically, Dr. Cohen found in his assessment that 43 percent of youth in the sample did not receive a complete medical assessment. He noted that "[d]eficiences in the admission comprehensive medical assessment can result in failure to diagnose and treat acute or chronic health problems, with resulting harm to incarcerated youth."[12]

The 2019 report also reported on the Work Plan requirement that the comprehensive medical assessment should result in a problem list entry and a clinically appropriate plan of care for each health problem, which should be implemented on a timely basis. Dr. Cohen found in his 2019 assessment that DYRS did not make progress at either the YSC or New Beginnings in identifying medical problems that were apparent during the admission process, developing and updating problem lists and treatment plans that were complete, or implementing treatment plans

[9] Work Plan Goal VIII.A.1.c.ii.
[10] The Special Arbiter's Report to the Court Regarding Defendants' Progress Toward Meeting Work Plan Requirements Related to Medical and Dental Services at the Youth Services Center and the New Beginnings Youth Development Center, filed December 20, 2019 (December 2019 Report) and Ex. 1.
[11] December 2019 Report at page 9.
[12] December 2019 Report, Ex. 1, at page 5.

in a timely fashion. At the YSC, he reported that 57 percent of the youth in the sample had at least one health problem, and in some instances multiple health problems, that were found in the health record but not on their problem list. Additionally, only 43 percent of the youth in the sample had a treatment plan for every health problem that was timely implemented. Similarly, at New Beginnings, 43 percent of the youth in the sample did not have all of their health problems listed on their problem list and 50 percent of youth in the sample had treatment plans which did not address all of the apparent health issues and were timely implemented. Dr. Cohen discussed in his 2019 assessment the clinical significance of some of the omitted problems that he found in his review, including youth with abnormal vision who did not have their issues addressed timely.

To ensure that youth in DYRS secure facilities received prescribed medications timely, the Work Plan required that newly prescribed medications be administered to youth within 24 hours of the issuance of the order at both the YSC and New Beginnings.[13] This requirement applied to all newly prescribed medications, including prescriptions for youth admitted from the community. For newly admitted youth, ongoing, timely access to prescription medications can be vital to managing youth health (*e.g.,* ensuring diabetic youth continue to receive prescribed insulin, as needed).

The Special Arbiter noted in the 2019 report that the YSC had met this particular performance standard in 2016 and thus the 2019 report only discussed findings for New Beginnings. Of the sample of new prescriptions that were reviewed for New Beginnings, 23 percent were not administered within 24 hours, but because some of the medications were ordered later in the day and the medicines were determined to be not urgent, the Special Arbiter found that 10 percent of newly prescribed medications were not administered timely. More

[13] Work Plan Goal VIII.A.2.b.ii.

importantly, Dr. Cohen concluded that of those not administered timely, some medications were for acute medical or psychiatric symptoms, thus should have been dispensed on an urgent basis. The report recommended that DYRS "review practices related to the administration of medicines prescribed to address acute needs in order to ensure prompt identification of the acute need and timely administration of the medicine on a consistent basis."[14] For this report, OIJJFO reviewed new prescription administration practices at the YSC only to assess specifically whether new prescriptions for newly admitted youth were administered timely.

Goal VIII of the Work Plan also required that youth prescribed psychotropic medications should have those medications administered and monitored according to standards that were developed by the Jerry M. parties as part of Work Plan requirements.[15] Dr. Cohen has previously written that "psychiatric medications are powerful drugs with a wide variety of side effects and complications." While "[s]ome side effects are minor and simply annoying, … others may become life threatening or disabling."[16] For this reason, clear standards for monitoring youth who are prescribed psychotropic medicines were required to be established and implemented at the YSC and New Beginnings.

The Special Arbiter's 2019 report also addressed the requirement related to psychotropic medication monitoring. Based on Dr. Cohen's assessment, the Special Arbiter noted that DYRS developed appropriate uniform standards for monitoring youth who were prescribed psychotropic medication, which were incorporated into various DYRS policies and remain in effect at this time, but found that DYRS needed to implement the standards more consistently at both facilities. Specifically, at the YSC Dr. Cohen determined that 45 percent of required

[14] December 2019 Report at page 19.
[15] Work Plan Goal VIII.A.2.d.iii.
[16] December 2019 Report, Ex. 1 at page 29.

baseline tests and assessments were not conducted as necessary for youth in the sample who were prescribed psychotropic medications. He also found that for youth in the sample who required follow-up testing, the follow-up testing or assessments were not conducted. In his assessment he raised "substantial concerns" regarding the monitoring of youth at the YSC who were prescribed psychiatric medications.[17] He stated that the "deficiencies at the YSC in medication monitoring practices placed youth 'at risk for medical complications that could result from unrecognized adverse drug reactions.'"[18] At New Beginnings Dr. Cohen determined that 72 percent of the required baseline tests and assessments were conducted for youth in the sample, but that only 50 percent of the required follow-up testing was conducted as necessary. While Dr. Cohen found that the psychiatrist at New Beginnings was "actively involved in clinical assessment and laboratory monitoring for adverse effects,"[19] he did note limitations at both facilities, including that youth with a history of taking psychiatric medicine should have baseline labs ordered by the medical staff at the time of admission, as well as perform periodic AIMS testing.

In light of the historical problems with and importance of the comprehensive medical assessment, problem list development and treatment plan implementation, the timely administration of newly prescribed medications, as well as the psychotropic medication monitoring, Dr. Cohen and OIJJFO have reassessed these fundamental elements of DYRS's medical service program at both the YSC and New Beginnings.

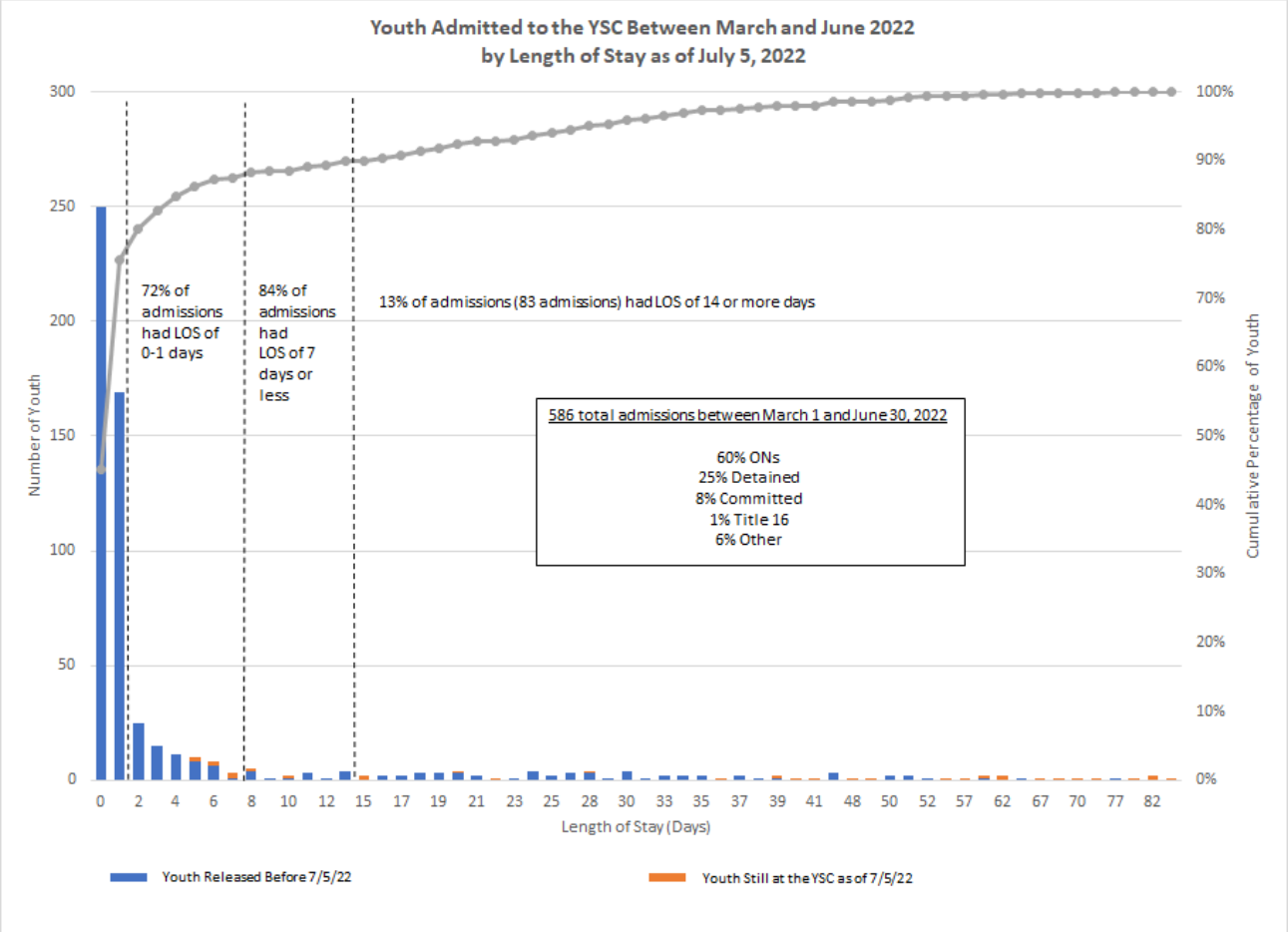
[17] December 2019 Report at page 31.
[18] *Id.*
[19] *Id.*, Ex. 1 at page 35.

III. METHODOLOGY

To assess the comprehensive medical intake assessment and associated problem list and treatment plan development, OIJJFO selected samples of youth admitted to the YSC and New Beginnings between March and June 2022.[20] Admissions data from both facilities was downloaded from FAMCare, DYRS's management information system, and OIJJFO analyzed the number of youth admissions to each facility over the four-month period, as well as each youth's length of stay as of July 5, 2022, at the YSC, and July 13, 2022 at New Beginnings.

The chart below reflects the total number of youth admitted to the YSC between March and June 2022 and the distribution of those youths' lengths of stay as of July 5, 2022.

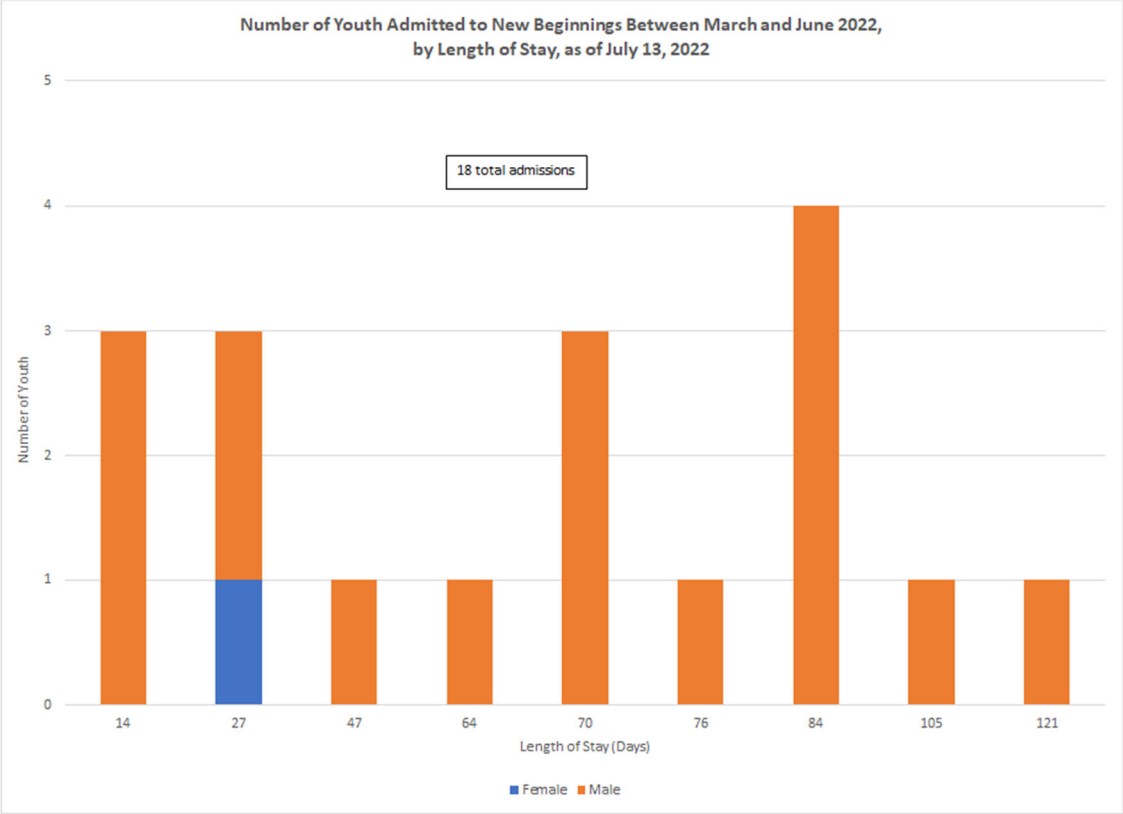
[20] Janet Maher assisted in the analysis of youth health records and production of this report. Ms. Maher is an attorney with extensive experience in institutional and health-care settings. She led the Office of Corporation Counsel's Mental Health Division from 1992 to 2000, operated as Deputy General Counsel and Chief of Staff for the District's Child and Family Services Agency from 2000 to 2007, served as a DOJ Compliance Officer at Saint Elizabeths Hospital from 2007 to 2014, as well as overseeing the Hospital's Performance Improvement Department from 2013 to 2016.



As the chart illustrates, of the 586 admissions over the four-month period, 60 percent of youth admitted to the YSC were overnighters, 25 percent were detained youth, eight percent were committed youth, one percent were Title 16 youth, and six percent had other legal statuses (*e.g.,* PINS youth, youth held under an interstate compact, or youth with multiple legal statuses).

Seventy-two percent of the admissions during the period were associated with a length of stay of less than two days and 84 percent of admissions resulted in a length of stay of one week or less. Thirteen percent of admissions, 83 admissions, had a length of stay of 14 days or more. OIJJFO selected 18 youth, 22 percent of admissions with lengths of stay of 14 days or more during the four-month period, to be in the YSC sample.

During the period reviewed, New Beginnings housed only committed youth.[21] Between March and June 2022, 18 youth were transferred to the facility from the YSC. Below is a chart that illustrates the 18 admissions and the cumulative distribution of youth lengths of stay among those youth as of July 13, 2022.



All 18 of the youth had lengths of stay of 14 days or more and thus all were included in the review.

For his assessment, Dr. Cohen developed review instruments specific to the YSC and New Beginnings, based on DYRS policies, and informed by his clinical training and experience. The instruments were used to guide consistent collection of data from youths' EHR for the youth in the two samples.

[21] In August 2022, DYRS transferred a cohort of Title 16 youth from the YSC to New Beginnings.

To assess whether DYRS is appropriately and consistently implementing the Psychotropic Medication Monitoring Parameter (PMMP)[22] and Medication Management Policy,[23] OIJJFO obtained data regarding all medications prescribed to youth housed at the YSC and New Beginnings between September 2021 and June 2022. Every prescription for psychotropic medications was identified and each medication was categorized according to its drug class, as defined in the PMMP.[24]

The prevalence of youth in custody who are prescribed psychotropic medications is high. Between October 1, 2021 and June 30, 2022[25] at the YSC, 17 percent of youth who were detained at the YSC were prescribed one or more psychotropic medications.[26] At New Beginnings, 66 percent of youth who were housed at the facility between October 1, 2021 and June 30, 2022 were prescribed one or more psychotropic medications.

There were 95 youth between September 2021 and June 2022 at the YSC who were prescribed psychotropic medications. Fifteen of these youth, 16 percent, were selected for the sample. These 15 youth were prescribed 16 medications during the review period, from eight different drug classes.[27] At New Beginnings there were 44 youth during the same period who were prescribed one or more psychotropic medications. A sample of 15 youth, 34 percent, was

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[22] Psychotropic Medication Monitoring Parameter, Department of Youth Rehabilitation Services, July 2018.
[23] Medication Management, policy no. V.d.2., eff. January 17, 2018 (Medical Management Policy).
[24] The analysis was reviewed by Dr. Cohen to confirm that medications were appropriately classified as psychotropic medications and placed in the appropriate PMMP classification, and that no psychiatric medications were omitted. Dr. Cohen noted that in a few cases, some medications could have been prescribed for either psychiatric or non-psychiatric, medical reasons. In conducting the review, there was one case in the original YSC sample for which the medication was prescribed for medical reasons. That case was eliminated from the sample, bringing the YSC sample reviewed here to 15.
[25] Daily population data for the facilities is not readily available until October 1, 2021.
[26] This percentage includes all youth who were admitted, including youth who would have ended up not staying long enough at the facility to have had medications ordered for them, such as overnighters.
[27] For the YSC sample, the drug classes for the medications reviewed included atypical anti-psychotics (three youth), typical anti-psychotics (one youth), other anti-depressants (three youth), anti-convulsants (three youth), selective serotonin reuptake inhibitors ("SSRI") (two youth), nonrepinephrine reuptake inhibitor ("NPRI") (one youth), mood stabilizer (one youth), and alpha agonist (one youth).

selected. The 15 youth were prescribed 17 medications from seven drug classes.[28] The sample selection was based upon length of stay[29] and was designed to have as many drug classes as possible represented in the sample, since each drug class has its own standards for use and monitoring.

The EHR of each youth in the sample was reviewed by OIJJFO to confirm the selected psychotropic medications were prescribed, the dosage that was prescribed (including any dose changes) and administered, and the period over which the medications were prescribed and administered. To determine if tests or assessments required by the PMMP were ordered and administered, OIJJFO reviewed the following sections of the EHR: medical intake file; overnight medical screening; 7-day medical follow up; annual physical; lab reports; observation flow sheets; initial and follow up psychiatric notes; sick call notes; and the AIMs and EKG records. A data collection template reflecting the policy and PMMP requirements for the baseline and ongoing monitoring for each drug class reviewed was used for each medication reviewed. For consistency and comparative purposes, the data templates were the same as were used to conduct the 2019 review of psychotropic medication monitoring.[30]

[28] For the New Beginnings sample, the drug classes for the medications reviewed included anti-convulsants (two youth), other anti-depressants (three youth), NPRI (one youth), stimulants (four youth), alpha agonist (two youth), SSRI (two youth) and atypical anti-psychotics (three youth).
[29] Because New Beginnings houses youth with longer lengths of stay and the analysis included a review of follow-up data, the minimum length of stay for the sample was three months.
[30] The PMMP and DYRS Medication Management policies were not updated since that review, so it was not necessary to modify the data templates.

IV. FINDINGS

A. Comprehensive Medical Assessments, Problem List and Treatment Plan Development and Implementation, and First Dose Administration For New Prescriptions After Admission

Goal VIII.A.1.b.ii. of the Work Plan required that, "95 percent of youth admitted.…shall receive a comprehensive medical assessment consistent with the criteria set forth in Attachment Two within 24 hours of admission, and if a youth is transferred from the YSC to [New Beginnings], or transferred from [New Beginnings] to the YSC, the comprehensive assessment shall be reviewed and updated, as indicated, within 72 hours of the transfer."[31] Current DYRS Policy requires that youth receive a comprehensive health assessment "as soon as possible," but no later than 24 hours after a youth is admitted to their facility.[32] Furthermore for youth transferred between DYRS facilities, DYRS policy requires that a qualified health care professional review the youth's health record and complete a screening within 12 hours of the youth's arrival at the receiving facility.[33]

Once newly admitted youth are clinically assessed, all evident medical problems should be documented on the youth's problem list in the youth's EHR and a treatment plan should be developed for each problem and recorded in the EHR. Work Plan Goal VIII.A.1.c.ii. required "95 percent of youth at [New Beginnings] and 95 percent of youth at the YSC shall have a problem list that is updated as indicated, and 90 percent of youth at [New Beginnings] and 90 percent of youth at the YSC shall have a clinically appropriate plan of care for each health

[31] Work Plan Goal VIII.A.1.b.ii.
[32] Health Assessment, policy no. V.e.10., eff. August 16, 2016, at II.
[33] Transfer Screening, policy no. V.e.3., eff. September 14, 2018, at VI.b.-c.

problem revealed by the comprehensive assessment, that is implemented on a timely basis, as clinically indicated."[34]

The comprehensive assessment, problem list development, and treatment plan development and implementation are foundational to the delivery of appropriate medical services to youth in DYRS's secure facilities. Consequently, OIJJFO reengaged Dr. Cohen to conduct this assessment of these functions based on a representative sample of youth at each facility.

1. Youth Services Center

Among its several functions,[35] the YSC is the intake processing facility for youth who are ordered to be securely confined in DYRS custody. The overwhelming majority of youth admitted to the facility arrive directly from the community and their medical conditions and needs are not immediately known to staff. A timely medical assessment enables medical staff to determine whether there are any acute or urgent medical needs that must be addressed, whether youth have any chronic medical conditions that require ongoing medical treatment (*e.g.,* diabetes or asthma), whether youth are taking any prescription medications for medical conditions that should be continued upon admission, and whether youth have any infectious diseases that must be addressed for their own health and to prevent spread within the facility (*e.g.,* COVID, influenza, or tuberculosis).

In addition to its primary function of providing necessary health services to youth while they are incarcerated and unable to seek care elsewhere, as a secure intake facility, the medical program at the YSC serves a vital public health function. By providing medical services to large

[34] Work Plan Goal VIII.A.1.c.ii.

[35] When the facility opened in December 2004, the intent was to house mainly detained youth and overnighters. Over time the population of youth at the YSC has changed: In addition to detained and overnighter youth, youth with various other legal statuses are currently held at the facility for various lengths of time, including committed youth, youth awaiting placement at a different facility, and Title 16 youth (*i.e.,* individuals between 16 and 18 years old who are charged pursuant to D.C. Code §16-2301(3)(A)).

numbers of at-risk youth from the community, medical staff are in a position to: (1) provide medical services to youth who might not otherwise receive them in the community; (2) in some cases, diagnose medical conditions in youth who might not know they are ill; (3) provide medical treatment, both in the facility and in clinical settings outside of the facility, that youth might not seek in the community; and (4) provide general health education and education specific to their health needs that they may not seek or obtain in the community.

a. Comprehensive Medical Assessments

To evaluate comprehensive medical assessments at the YSC, Dr. Cohen reviewed a sample of 18 youth admitted to the facility between March and June 2022. As noted in the methodology section, above, there were a total of 586 youth admissions over that four-month period and of that total only 83 youth admissions, 13 percent, resulted in lengths of stay of 14 days or more. In consultation with Dr. Cohen, OIJJFO selected a sample of 18 youth from the 83 youth admissions with lengths of stay of 14 days or more, 22 percent of the cohort. Limiting the sample to youth with lengths of stay of at least 14 days ensured that Dr. Cohen reviewed records of youth who were at the YSC for a long enough period for medical staff to have sufficient time not only to conduct an initial comprehensive medical assessment and develop a problem list, but also to begin to implement medical treatment plans.

For each youth in the sample, Dr. Cohen assessed 17 elements of the comprehensive medical assessment based on DYRS policies.[36] "YSC Table 1," attached to Dr. Cohen's report, summarizes his findings for each of the youth in sample.[37] In total, per Dr. Cohen there were

[36] For the three females in the sample, Dr. Cohen also assessed whether a pregnancy test was administered, for a total of 18 elements for these three youth.
[37] Attachment 1, YSC Table 1.

297 elements assessed among the 18 youth.[38] On an aggregated basis, YSC medical staff performed 289 of the 297 elements among the youth in the sample, 97 percent of the elements. Using youth as the unit of analysis, 12 youth in the sample had all applicable elements performed during their comprehensive assessment, whereas six youth had one or more applicable element missing from their assessment.[39]

Below is a summary of Dr. Cohen's findings regarding key elements of the comprehensive assessment that he reviewed in the sample of youth:

- Continuity of Medications Upon Admission – Five of six youth in the sample who were taking medications upon admission had medications confirmed and continued.[40] The one youth whose medication was not confirmed and continued was taking a psychotropic medication and according to policy the youth should have continued to receive his medication.

- Medical History – All 18 youth in the sample had a medical history taken and 12 of 18 youth "had important positive findings…an indicator for effective history taking skills [among staff]."[41] However, for youth with positive findings, additional inquiry was needed to inform the development of problem lists and treatment plans. Needed additional history often was not obtained or was not documented in the records.

- Physical Examination – All 18 youth in the sample had a physical examination. Neither pelvic examinations nor cervical cytology were offered to the girls in the sample,[42] an issue that is discussed in more detail below.

- Allergies – All 18 youth in the sample had an allergy history obtained and allergy management was appropriate for most youth.[43]

- Immunizations – All 18 youth had current immunization records obtained. Twelve youth, 67 percent of the sample, needed immunizations to meet public

[38] This total excludes pregnancy tests for male youth and an assessment of whether medications were continued upon admission for youth who did not take medications in the community.
[39] Attachment 1, YSC Table 1. Four youth had one element missing and two youth had two elements missing.
[40] Attachment 1 at pages 3-4.
[41] *Id.* at page 4.
[42] *Id*. at page 5.
[43] *Id*. Allergies were prevalent among youth in the sample: Half of the youth had a history of a drug, food, or seasonal allergies.

health recommendations and in all but one case medical staff contacted parents to request consent to administer needed vaccinations.[44] Among the 11 parents contacted for consent, eight parents, 73 percent, did not provide consent to administer vaccinations. This is a public health issue that DYRS should consider how best to address, perhaps in partnership with other District public health agencies.

- Sexually Transmitted Disease (STD) Tests – All 18 youth in the sample had urine tests upon admission for chlamydia, gonorrhea, and trichomonas and all 18 had current HIV tests. Seventeen of 18 youth had current syphilis tests.[45] STDs are prevalent among youth admitted to the YSC.[46]

- Complete Blood Count (CBC) – All 18 youth in the sample had current CBCs. One youth had abnormal results, which medical staff responded to appropriately.[47]

- Urine Dipstick – All 18 youth in the sample had a urine dipstick screening. Although ten of the screenings, over half of the sample, initially returned abnormal results, all returned normal results after they were readministered after youth hydrated.[48] Dr. Cohen recommends a change in practice to reduce false positive results and simultaneously to conserve valuable nursing resources.[49]

- Pregnancy Test – Two of the three female youth in the sample had a pregnancy test upon admission and one did not.[50] Pregnancy would have a significant impact on a youth's treatment plan and a pregnancy test should always be offered to female youth upon admission as required by DYRS policy.

- Tuberculosis (TB) Skin Test – Seventeen of 18 youth in the sample had current TB tests. The one youth without a test had a test administered within the prior year at the YSC, but the result was never read, and the test was not readministered.[51] Dr. Cohen also observed one youth with a history of latent TB was managed well by YSC medical staff, but in another case a TB test result was read significantly after the 48 to 72 hour window for reading test results.[52]

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[44] *Id.*
[45] *Id.* at page 6.
[46] Five youth in the sample tested positive for chlamydia, three tested positive for gonorrhea, and one tested positive for trichomonas. All were treated and later tested negative. No youth tested positive for HIV or syphilis. *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.* at page 7.
[50] *Id.*
[51] *Id.*
[52] *Id.*

Dr. Cohen notes that TB skin tests are prone to injection errors, which can result in false negative test results. He recommends readministering skin tests in certain circumstances. He also recommends that DYRS consider the costs and benefits of switching to an FDA-approved TB *blood* test, which could be appropriate for an environment like the YSC where many youth are released before TB skin test results can be read.[53]

- Vision Screening – All 18 youth in the sample had current vision screenings and eight youth, 44 percent, had abnormal vision. Two youth with abnormal vision were not referred to the optometrist and, notably, none of the eight youth had seen the optometrist at the time of Dr. Cohen's review.[54] Access to optometry services is a long-standing systemic issue discussed in more detail below.

- Hearing Screening – Fifteen of 18 youth in the sample had a current hearing screening upon admission.[55] The three youth without current screenings at intake did not subsequently receive a hearing screening while at the YSC.

- 7-Day Follow Up – The 7-Day follow up is a quality assurance procedure whereby a practitioner reviews each youth's health record seven days after admission to identify and perform any missing diagnostics and/or perform any indicated follow up. A 7-Day follow up review was conducted for 17 of the 18 youth in sample; however, Dr. Cohen found that for four youth whose records were reviewed during the 7-Day follow up, 24 percent, missing elements were not identified or abnormal results were not followed up on as expected.[56] This suggests that the 7-Day follow up is not adequately meeting its intended quality assurance function.

Overall, the evidence shows that with limited exceptions YSC medical staff are performing the requisite elements of the comprehensive medical assessment. There are certain recommended procedural changes to improve the efficacy and/or efficiency of comprehensive assessments, including changing the procedure by which urine samples are taken, readministering in certain cases or considering alternative methods of testing for TB, and

[53] *Id.* at page 8.
[54] *Id*. Dr. Cohen observed that one youth with 20/60 vision had been waiting more than four months to see an optometrist at the time of his review.
[55] *Id.* at page 9.
[56] *Id.* Missing elements included hearing screenings and one TB skin test.

ensuring that practitioners write orders for any required procedure not completed during the intake comprehensive assessment.[57] Furthermore, the established internal quality assurance process for the comprehensive assessment – the 7-day follow up – is not adequately detecting deficiencies in comprehensive assessments.

Dr. Cohen makes a significant policy recommendation with respect to the health program for female youth, beginning during the comprehensive assessment. He states that, "[s]exually active, detained female youth represent a population at high risk of sexually transmitted infections and unplanned pregnancies. My opinion is that contraception, pelvic exams, and cervical cytology screening should be offered routinely to all sexually active detained female youth."[58] As an example of the high-risk nature of this population, one female youth in the sample had been admitted to the YSC five times in the prior 18 months and at every admission was diagnosed with one or more STDs, placing her at "extraordinarily high risk for repeated HPV infection, cervical dysplasia and subsequent cervical cancer at a young age."[59]

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[57] *Id.*

[58] *Id.* at page 5. Dr. Cohen also states the following:

> [T]he current consensus professional recommendation is not to provide cervical cytology screening for the general population of women under 21. However, youth in detention are not the general population and some are at particularly high risk for sexually transmitted diseases including HPV that causes cervical cancer. When I monitored results of cervical cytology in about 200 New York state delinquents I found that 18% had abnormal or atypical results, an extraordinarily high number of positive findings.
>
> Because the prevalence of abnormal cervical cytology was so high, we continued cervical cytology screening even though it was no longer recommended for the general population. The goal was to educate patients with positive findings about their risk and encourage routine follow-up. No surgical procedures were contemplated unless the cytology showed a High-Grade lesion.
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> *Id*. at page 27, note 31.

[59] *Id.* at page 24.

b. Problem List Development and Treatment Plan Implementation

The comprehensive health assessment represents the first pillar of the process by which health care is delivered to youth in DYRS custody. The resulting problem list and treatment plan based upon the findings of the health assessment are the other two pillars. The Work Plan required that youth have a problem list that is updated as indicated by the results of the comprehensive assessment and that a clinically appropriate plan of care (*i.e.,* a treatment plan) be developed for "each health problem revealed by the comprehensive assessment."[60]

For each of the 18 youth in the YSC sample, Dr. Cohen reviewed the problem list and treatment plan that was developed, and determined whether the treatment plan had been appropriately initiated within the first two weeks of the youth's detention. Importantly, Dr. Cohen assessed whether all "evident" medical problems – all problems "revealed" by the comprehensive assessment – were included on the problem list and treatment plan.

Overall, Dr. Cohen found that among the 18 youth in the sample, 13 youth, 72 percent, had problem lists reflecting all evident health problems. Youth with incomplete problem lists were the following:

- Two female youth who stated that they were sexually active without contraception did not have "no contraception" included on their problem lists.[61] One of these two youth additionally had abnormal vision, but the problem was not listed on the problem list and no referral was made to optometry.

- One youth had been hospitalized with coma and pancreatitis in the recent past, but this was not included on the problem list.[62]

[60] Work Plan Goal VIII.A.1.c.ii.
[61] Attachment 1 at page 10.
[62] *Id.*

- One youth diagnosed with obesity was also prediabetic. While obesity was listed on the problem list, prediabetes, for which there are additional treatment options, was not listed.[63]

- One additional youth had abnormal vision of 20/30, but it was not included on the problem list.[64]

- One youth did not have his lactose intolerance include on his problem list.[65]

It is consequential for youth when medical problems are excluded from the problem list, as it is quite likely that undocumented problems will not be treated. For example, the youth with abnormal vision was not referred to optometry for further assessment and corrective eyewear. The prediabetic youth was not specifically assessed for his need for medications that could have helped normalize his blood sugar and promote weight loss.[66] The lactose intolerant youth was not provided with treatment options such as enzymes that could enable him to consume dairy without negative symptoms rather than simply to avoid dairy products.[67]

In addition, Dr. Cohen assessed the treatment plans for all 18 youth in the YSC sample. He observed that, *for problems that made it onto youths' problem lists*, treatment plans were largely developed. He found that for 17 of 18 youth in the sample all problems that were documented on the problem list had a treatment plan. However, as previously discussed, five youth in the sample did not have all medical problems listed on their problem lists and thus did not have complete treatment plans, plus one additional youth who had been shot multiple times prior to admission to the YSC did not have a treatment plan to address the ongoing consequences

[63] *Id.* at pages 10-11.
[64] *Id.* at page 11.
[65] *Id.*
[66] *Id.* at pages 10-11.
[67] *Id.* at page 11.

of this major trauma.[68] Thus, in total 12 of 18 youth in the sample, 67 percent, had complete problem lists and treatment plans.

Finally, to assess whether youth were receiving services for all evident medical problems, Dr. Cohen reviewed whether Treatments Plans were, in fact, initiated. He found that treatment plans had been initiated for all evident problems for nine of the 18 youth in the sample, 50 percent. Among the nine youth who did not receive treatment for one or more problems were the six aforementioned youth lacking a treatment plan for one or more evident problem. In addition, one youth had a specific enzyme deficiency, but was not counselled about how to avoid foods that, because of the condition, could trigger a dangerous medical event.[69] A second youth required certain immunizations upon admission and parental consent was obtained, but the immunizations were not administered until over three months after the youth's admission.[70] Finally, a third youth required immunizations upon admission and after a parent could not initially be reached, no additional attempts were made to obtain consent to administer the needed vaccinations.[71]

c. First Dose Administration Within 24 Hours

The Work Plan required that newly prescribed medications be administered to youth within 24 hours of issuance of a medication order.[72] At the YSC, where youth are admitted from the community and may be taking prescribed medications at home, identifying, confirming, and continuing medications is critical to ensuring continuity of health care.

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[68] *Id*. Dr. Cohen notes that the youth "may have needed for orthopedics, orthotics, physical therapy (PT), occupational therapy (OT), speech therapy, or chronic disability resulting from these injuries."
[69] *Id.* at page 12. In individuals with the enzyme deficiency – G6PD – certain foods, drugs, and environmental conditions can trigger "hemolytic episodes," during which red blood cells are broken down faster than the body produces them.
[70] *Id.*
[71] *Id.*
[72] Work Plan Goal VIII.A.2.b.ii.

Dr. Cohen identified six youth in his sample who were taking medications that should have been continued upon admission to the YSC. OIJJFO reviewed the health records of the six youth to determine whether ordered medications were administered within 24 hours of the order. The review focused on continuity of medication administration upon admission and thus was limited to medications that were ordered upon admission and not medications ordered later during the youths' period of detention at the YSC.

Collectively, 22 medications were ordered for the six youth; however, seven of the 22 medications were ordered to be taken only as needed rather than on a prescribed schedule (*i.e.,* "PRN"), and were excluded from the analysis. Among the 15 non-PRN medications in the sample, 12 were administered within 24 hours of the order, 80 percent, and three were not.[73] Among the three not administered within 24 hours, one was administered 24 hours and 47 minutes after the order, and one was administered approximately 36 hours after the order. The third medication was previously discussed in this report: a youth taking a psychotropic medication at home did not have the medication continued until approximately three weeks after admission to the YSC because it could not be confirmed with a parent upon admission.

d. Systemic Issues With the Medical Program at the YSC

Based on his record review, Dr. Cohen made several observations and recommendations regarding clinical practices. First, he found that there is no women's primary care program for female youth in DYRS custody.[74] Female youth are not offered and do not receive pelvic exams upon admission and cervical cytology screening is not conducted, notwithstanding the high-risk the population of female youth represents. Furthermore, female youth are not offered

[73] The three medications were taken by three different youth.
[74] Attachment 1 at page 13.

contraception, specifically hormonal contraception, routinely. DYRS policy requires that hormonal therapy should be made available upon request and that medical staff should educate female youth about contraception.

Second, youth access to optometry services is grossly inadequate. Abnormal vision can have significant negative impacts on youth well-being, including impeding youth's access to the educational program at the YSC. Dr. Cohen documents that eight of 18 youth in the sample, 44 percent, had abnormal vision, a high percentage. Only six of these eight youth were referred to optometry for assessment and, most significantly, *none* of the eight youth were seen by an optometrist by the end of Dr. Cohen's review period. Notably, one youth with significantly abnormal vision did not see an optometrist during his three-month detention and was released without ever having been seen by the optometrist.[75]

Finally, Dr. Cohen observed that three youth in the sample, 17 percent, had a history of significant medical trauma, including gunshot wounds and a youth who had been in coma with organ failure. He states that, "significant past [traumatic] health problems can have residual chronic effects including physical disability, pain, and PTSD" and should be managed as a chronic condition.[76] Additional history should be gathered regarding any past traumatic medical conditions and services and medical care should be provided, as indicated.

Dr. Cohen concluded that although the medical intake process at the YSC is well organized and complete, "the gaps [he] observed tend[ed] to be aspects of health care that are related to chronic health needs."[77] As examples, he cited inadequate services related to vision problems, contraception services for female youth, and youth with histories of past trauma and

[75] *Id.* at pages 13-14
[76] *Id.* at page 14.
[77] *Id.*

serious medical issues. The chronic care needs of youth who remain housed at the YSC for prolonged periods must have these needs attended to just as their acute health needs are addressed.

2. New Beginnings

New Beginnings serves a different function than the YSC, and the functions of the medical program are different. Youth who are admitted to New Beginnings are transferred from the YSC, instead of arriving directly from the community, as occurs at the YSC. Furthermore, the flow of youth into New Beginnings is a fraction of that at the YSC. Whereas the YSC receives numerous youth every day, New Beginnings admitted on average three youth per month between September 2021 and June 2022, and youth admitted to New Beginnings have longer lengths of stay than most detained youth housed at the YSC.

When youth arrive at New Beginnings, their medical needs should already be known to DYRS medical staff and documented in each youth's EHR. Thus, the focus of the New Beginnings *intake* health program is essentially one of quality assurance to ensure that there is continuity of existing care and identifying and correcting any gaps in care. In practice, this means ensuring that care is uninterrupted, including continuation of medication and care for any chronic conditions, reviewing existing lab results to identify any undetected abnormalities, and identifying and administering any missing or overdue tests or screenings.

The Jerry M. Work Plan included a requirement related to medical services at the time of transfer. The requirement stated that for youth who are transferred between the YSC and New Beginnings, the medical assessment should be reviewed and updated within 72 hours of the

transfer.[78] DYRS policy also states that at the time of transfer medical staff should identify any missed initial assessments and schedule any required assessments.[79]

a. Review of Medical Assessment

When youth are transferred from the YSC to New Beginnings, medical staff at the YSC complete a Transfer Sending form titled "TSEND," which includes certain health information including active health problems and allergies, medications youth are taking, open medical orders, and current vital signs.[80] Once the youth is received at New Beginnings, the New Beginnings medical staff complete a Transfer Receiving form titled, "TREC," which includes relevant information such as current vital signs, observations of the youth, plan/disposition for the youth, and open orders.[81] The goal is for medical staff to review all elements of the youth's health record and to ensure that any missing, due, or overdue elements are identified and addressed.

To assess DYRS's review of the medical assessment upon transfer to New Beginnings, Dr. Cohen reviewed the EHRs of all 18 youth who were transferred to the facility between March and June 2022. He found that the 18 youth who were transferred to New Beginning had the required TSEND and TREC forms completed. He did question the accuracy of some documented responses.[82]

Dr. Cohen reviewed the medical records of the 18 youth to assess if the required admission immunization records, labs, and screening tests were up to date, due or overdue at the

[78] Work Plan Goal VIII.A.1.b.ii.
[79] DYRS Transfer Screening Policy at VI.d.
[80] Attachment 3, sample Transfer Sending form.
[81] Attachment 4, sample Transfer Receiving form.
[82] For example, he noted that in the section "Youth Concerns" the response was always "None," but he found that in one case there was a general note on the same day as the form indicating that the youth stated that he was having severe dental pain. Attachment 1 at page 19.

time of transfer. "NB Table 1," attached to Dr. Cohen's report, documents 126 different elements reviewed among the 18 youth.[83] On an aggregate basis, New Beginnings medical staff verified that an element had been completed or themselves completed 102 of the 126 elements among the youth, 81 percent. Using youth as the unit of analysis, nine youth had all applicable elements performed during transfer, and the remaining nine youth had one or more applicable elements missing from their assessments.[84]

Below is a summary of Dr. Cohen's findings regarding key elements of his review of missing, due, or overdue immunizations records, labs, and/or screening tests.

- Up to Date on Required Tests – Nine of the 18 youth were up to date on all required tests at the time of transfer to New Beginnings. Several youth were brought up to date at the YSC prior to their transfer.[85]

- Immunizations – One of the 18 youth's immunization record was overdue (more than one year old).[86]

- Due or Overdue Lab and/or Screening Test – Nine of the 18 youth had one or more overdue lab and/or screening test.[87] Of these nine youth, who collectively had 24 due or overdue labs and/or screening tests, only one youth was brought up to date on all missing elements.[88] For the remaining eight youth, not all of the missing, due, or overdue elements were identified and ordered at the time of transfer to New Beginnings. Six of these youth continued to have elements due or overdue 30 days after their transfer.

Dr. Cohen notes in his report that "[t]he RN/NP chart review at TREC is failing to identify and remedy more than half of the due/overdue required tests."[89] He observes that

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[83] Attachment 1, NB Table 1.
[84] *Id*. Three youth had one element missing, four youth had two elements missing, one youth had six elements missing, and one youth had all seven elements missing.
[85] Attachment 1 at page 20.
[86] *Id*.
[87] Of the overdue labs and/or screening tests, five youth were missing syphilis, five youth were missing HIV, four youth were missing TB, three youth were missing vision, three youth were missing hearing, and one youth was missing his immunization records.
[88] *Id*. For this youth, a TB screening was identified and ordered at the time of his transfer to New Beginnings.
[89] *Id*.

whereas he found very few missing tests in the YSC sample that he reviewed, in his New Beginnings sample he found some tests had been overdue since the youth's admission to the YSC. Ideally, these missing or overdue tests should have been found during the intake 7-day follow-up visit at the YSC, but certainly should have been identified and rectified when the youth were transferred to New Beginnings. He continues that "[b]oth the Medical Intake 7-day follow-up review at the YSC and the TREC review at NB are failing to identify needed labs and tests. The [TREC] review appears generally to be done pro forma, without the attention to detail that a true record review requires."[90] He posits that part of why some of the issues are missed is because the "documentation is scattered and must be sought out in the EHR."[91]

b. Review of Labs, Screenings, and Problems at Transfer

As discussed above, after the comprehensive medical assessment is completed, the problem list and treatment plan should be produced based on the results of the assessment. When youth are transferred to New Beginnings, their medical records already include the problem list and treatment plan that was developed at the YSC. The goal for the medical team upon transfer is to review the medical assessments and lab and screening results, confirm that all appropriate issues are included on the problem list and that youth have an appropriate and complete treatment plan in place, include all missing problems, and initiate treatment for any that were missing.

As part of his assessment, Dr. Cohen reviewed each youth's EHR for the response to abnormal labs and screening tests that were in the record when the youth were transferred to New Beginnings. "NB Table 2," attached to his report, documents his findings for each youth.

[90] *Id*. at pages 20-21.
[91] *Id*. at page 21. The EHR is discussed in greater detail below. See pages 32 to 33.

He found that five of the 18 youth who had been admitted during the period had no abnormal labs or screening tests. Three of the youth had abnormal labs or tests already listed on the problem list and had treatment plans already developed and initiated, thus no further action was needed when they were transferred to New Beginnings. An additional three youth had abnormal labs or tests which were identified at New Beginnings and received the needed action when they were transferred. Lastly, seven of the 18 youth, 39 percent, had abnormal labs or tests that required action at the time of transfer but the necessary steps to address the issues were not taken at that time.[92]

Below is a summary of Dr. Cohen's findings regarding key elements of his review of the response at transfer to abnormal labs and screening tests without adequate treatment plans:

- Abnormal Vision – Five of the 18 youth had abnormal vision screenings while they were at the YSC. Four of the five had abnormal vision included on their problem list when they were transferred. The fifth youth's abnormal vision screening result from the YSC was identified when he was transferred to New Beginnings, a new vision screening was conducted and also returned abnormal, and the youth was referred to optometry. For this youth, at the time of Dr. Cohen's review, it had been five months since the referral and the youth had not yet been seen by an optometrist.

  Of the remaining four youth who already had abnormal vision on their problem list when they were transferred to the YSC, one youth had replacement glasses ordered while at the YSC and they were delivered to him at New Beginnings. However, the other three youth had been waiting between three and nine months from for their optometry appointments at the time of Dr. Cohen's review.[93]

- Abnormal CBC – Five youth had abnormal CBC results in their records when they were transferred to New Beginnings, but only one of the abnormal results was identified at New Beginnings.[94] A sixth youth had an abnormal CBC test result *after* he was transferred to New Beginnings. Four of the six youth with abnormal CBC tests had low neutrophil counts. Two of the six youth had

[92] *Id*.
[93] *Id*. at pages 21-22.
[94] For this youth, a repeat CBC was ordered but never done. *Id*. at page 22.

increased red cell count, decreased red cell size, and/or decreased red cell hemoglobin, without anemia. These abnormal results may be attributable to a benign condition; alternatively, they may also indicate a health problem with consequences and diagnosis of the cause is important.[95]

- Abnormal Liver Tests – One youth had persistently abnormal liver tests, which was already on the problem list when he was transferred to New Beginnings. Dr. Cohen did not find an adequate treatment plan was developed when the youth was admitted to New Beginnings.[96]

- Pre-Diabetes – Two youth who were admitted to New Beginnings during the period were pre-diabetic. Both youth had pre-diabetes on their problem list when they were transferred to New Beginnings, and one youth was referred to the chronic care clinic when he was transferred. The other youth had no treatment plan other than to repeat the A1C test (one of the tests to identify pre-diabetes).

- Abnormal Lipids – One youth had persistently elevated blood lipids with high Total and LDL cholesterol. Elevated lipids were on his problem list when he was transferred to New Beginnings, but he had not yet received diet education for his condition and no referral was made to the dietitian when he was transferred.[97]

c. Evident Problems Not Listed on the Problem List

During his review, Dr. Cohen found that some youth had evident problems in their health record which were not on the problem list when they were transferred to New Beginnings nor during the first month after their transfer. His findings are included in "NB Table 3," which is included at the end of his report. Nine of the 18 youth who were admitted between March and June 2022 had no evident but unlisted problems when they were transferred to New Beginnings. The remaining nine youth had the following problems that were not recognized and/or not documented on the problem list: five youth had abnormal CBCs; one youth had abnormal

[95] *Id.* at page 25.
[96] *Id*. at page 23. The only apparent plan was to repeat the labs.
[97] The youth was referred to the dietitian six months after he was transferred to New Beginnings. *Id*.

vision; one youth had seasonal allergies; one youth had lactose intolerance; and one youth had gynecological problems.

Below is a summary of Dr. Cohen's findings regarding key elements of his review regarding evident problems that were not on problem lists:

- Abnormal CBC – As discussed above, five youth were identified who did not have their abnormal CBCs included on the problem list, nor was there a treatment plan initiated. Four of the youth were transferred from the YSC with abnormal CBCs evident in their record and the fifth youth's abnormal results were returned after transfer to New Beginnings.[98]

- Seasonal Allergies – One youth had seasonal allergies and was receiving medication for it, but it was not on his problem list at the YSC and was not added once he was transferred to New Beginnings.[99]

- Lactose Intolerance – One youth had lactose intolerance, which was identified when he was transferred to New Beginnings and "no milk" was added to his allergy list. However, the problem was never added to his problem list, no related history was collected, and no treatment other than avoidance was considered, such as use of Lactaid tablets.[100]

- Women's Health – Contraception and High Risk for Cervical Dysplasia – There was one female youth admitted to New Beginnings during the review period. She was sexually active, but had no hormonal or other contraception plan and "no contraception" was not listed on her problem list, nor was there a treatment plan. Additionally, this youth had been admitted to the YSC five times in the prior 18 months, and at every admission she was diagnosed with chlamydia, trichomonas, or both. Dr. Cohen reports that because of this history of STDs, the youth was at extraordinarily high risk for repeated HPV infection, cervical dysplasia, and cervical cancer at a young age.[101] While the youth had received two doses of the HPV vaccine, the vaccine protects against only the most common cancer-causing strains of HPV. Dr. Cohen stresses the importance of pelvic examinations and cervical cytology testing for high-risk youth.[102] Dr. Cohen's recommendations

[98] *Id*. at page 24.
[99] *Id*.
[100] *Id*.
[101] *Id*.
[102] *Id*. at pages 24 and 26-27.

regarding the medical program for female youth are discussed in greater detail, below.[103]

d. Systemic Issues with the Medical Intake Program at New Beginnings

Based on his review, Dr. Cohen found that there were areas that were working well in terms of continuity of care for youth transferred to New Beginnings. All 18 youth who were transferred between the facilities between March and June 2022 had received a medical review at both their release from the YSC (a TSEND note) and also once they were admitted to New Beginnings (a TREC note). For youth who were on medications, their medicines were continued without missing a dose. Also, youth who were participating in chronic care clinics continued their appointments as necessary.

However, Dr. Cohen identified several systemic and operational issues with the New Beginnings medical admissions process. As discussed above, when youth are preparing for transfer from the YSC to New Beginnings, medical staff complete a TSEND form which should include all relevant information. Dr. Cohen found that some of the TSEND notes were prepared days or weeks before the youth was transferred, not on the day of transfer. When information is prepared in advance, the information sent may not include current vital signs, and may not include new medications, and new active problems. Additionally, the computer algorithm that lists current medications on the TSEND note excludes the medications that are ordered to be given "as needed," or PRN. These medications should not be excluded from the medication list, as they are often necessary medications (like asthma inhalers given as needed). All current medicines should be listed on the TSEND note.

[103] See pages 56-58.

When youth are admitted to New Beginnings, a TREC note is completed by the medical staff. Dr. Cohen found that the medicine and physical documents that are received by the New Beginnings staff at transfer are not consistently listed on that TREC note. He recommends that all medications and documents that are received with the youth at transfer should be routinely included, and if none are received that should also be recorded so that there is no ambiguity.

Most significantly, Dr. Cohen found that for 50 percent of the youth who were admitted during the review period there were due or overdue labs and/or screening tests that were not identified as due or overdue. Sixteen percent of youth had abnormal labs or screening tests that were not identified as abnormal. For 33 percent of the youth admitted during the period, there were evident problems for which there were not treatment plans developed or implemented.

B. Electronic Health Record

During his record review, Dr. Cohen made several observations regarding the EHR and its impact on the delivery of health services to youth at the YSC and New Beginnings. First, he found evidence that in some cases certain chronic health problems with no clear end date did not appear on youth problem lists. For example, one youth who was diagnosed and continuously treated for asthma did not have the condition included on his active problem list; however, asthma was listed, multiple times, on the youth's inactive problem list. It appeared that each time the problem was entered, an end date was included, and therefore the problem had to be reentered as an active problem after the end date.[104] Dr. Cohen posited that the EHR may automatically enter an end date of one year from the date of entry for problems that are not otherwise recorded as resolved by medical staff. Whether caused by user or system error, he

[104] Attachment 1 at page 28.

notes that unresolved chronic health problems should not be removed from a youth's problem list.

Dr. Cohen also observed that for some youth requiring specialty medical services (*e.g.,* optometry services), medical staff had ordered a referral, but youth had not been seen by a specialist. In one of those cases, notwithstanding evidence that a referral had been made, there was no pending order for the referral in the youth's health record, causing Dr. Cohen to question whether open orders for referrals automatically close after a certain period.[105]

Finally, while the EHR captures significant volumes of health data, Dr. Cohen noted that the organization of the EHR requires practitioners to search multiple data sources to identify test results and completion dates to conduct even routine reviews. Because these reviews are intended to improve the quality and completeness of healthcare services at the YSC and New Beginnings (*e.g.,* the 7-day review), it is critical that they are conducted thoroughly. Dr. Cohen suggests that, at a minimum, a written guideline or protocol to guide users conducting reviews in the EHR could help ensure a more complete process, but preferably, leveraging the EHR database technology to produce a customized report that would extract all relevant health data into a single report could enhance the quality and conserve staff resources.[106]

C. Psychotropic Medications

As noted above, the prevalence of psychotropic medications is high at the YSC and New Beginnings: 17 percent of youth housed at the YSC and 66 percent housed at New Beginnings between October 1, 2021 and June 30, 2022 were prescribed one or more psychotropic medications.

[105] *Id.*
[106] *Id.* at pages 28-29.

A broad range of psychotropic medications are prescribed to youth in DYRS facilities. Below is a table summarizing all prescriptions for psychotropic medications for youth at the YSC during the ten-month period between September 1, 2021 and June 30, 2022:

Table 1: Prescriptions at the YSC, by Psychotropic Drug Class
September 1, 2021 - June 30, 2022

Prescription by Psychotropic Drug Class	Number of Prescriptions	Percentage of Psychotropic Prescriptions
Sleep	288	25.49%
Stimulants	211	18.67%
Alpha Agonist	153	13.54%
Other Antidepressant	149	13.19%
Atypical Antipsychotic	137	12.12%
SSRI	92	8.14%
Anticonvulsant	57	5.04%
Norepinephrine Reuptake Inhibitor	30	2.65%
Mood Stabilizer	6	0.53%
Tricyclic Antidepressant	3	0.27%
Anxiolytics	2	0.18%
Typical Antipsychotic	2	0.18%
Grand Total	**1130**	**100.00%**

Similarly, the table below presents all prescriptions for psychotropic medications for youth housed at New Beginnings over the same ten-month period:

Table 2: Prescriptions at New Beginnings, by Psychotropic Drug Class
September 1, 2021 - June 30, 2022

Prescription by Psychotropic Drug Class	Number of Prescriptions	Percentage of Psychotropic Prescriptions
Stimulants	222	50.36%
Sleep	192	15.14%
Other Antidepressant	189	14.86%
SSRI	83	6.53%
Atypical Antipsychotic	72	5.69%
Alpha Agonist	71	5.59%
Anticonvulsant	15	1.19%
Norepinephrine Reuptake Inhibitor	8	0.64%
Grand Total	**852**	**100.00%**

1. Standards for Use of Psychotropic Medication

DYRS has adopted a Medication Management Policy,[107] which includes specific provisions regarding the use of psychotropic medications at DYRS. The policy states that psychotropic medication "shall be used solely for the purposes of providing effective treatment and protecting the safety of the youth and shall not be used as punishment or for the convenience of staff."[108] The policy also specifies that prior to initiating psychotropic medication, youth shall have a medical assessment that includes a "Complete Blood Count ('CBC') with differential, platelets, hepatic, thyroid studies, chemistry panels, lipids, and a pregnancy test. Exceptions may be made by the prescribing advanced level provider if it is decided that, based on their documented clinical judgment, the youth should receive the medication concurrent with medical or other laboratory tests."[109] Continuing, the policy also requires that the prescribing practitioner "must order requisite testing and lab work to monitor for serious side effects that may occur with psychotropic drugs."[110] The potential side effects that the policy specifies the practitioner to monitor and document include:

- Allergic reaction;
- Change in level of alertness;
- Eating problems;
- Change in heartbeat;
- Change in blood pressure;
- Fainting or dizziness;
- Abnormal posture, body or muscle movements or gait;
- Yellowing of eyes or skin; or
- Unusual bruising or bleeding.[111]

[107] Medication Management Policy.
[108] *Id.* at Section II.
[109] *Id.* at Section VI.G.1.
[110] *Id.* at Section VI.G.2.
[111] *Id.*

The policy mandates that medical and direct care staff document any observations of possible side effects to psychotropic medications and report such to the prescribing practitioner, and the administering qualified health care professional (QHCP) is required to observe for and inquire of the youth about side effects on a daily basis. The policy also requires monitoring for tardive dyskinesia twice yearly, including an AIMS test.

In addition, in July 2018, the DYRS published its Psychiatric Medication Monitoring Parameter (PMMP)[112] which sets forth clinical standards, by drug classification, for use of psychotropic medications for youth, as well as requirements for a medical work-up before psychotropic medications are prescribed and for medical follow-up once they are prescribed.[113] The PMMP tailors the specific information to each of 18 drug classifications and provides clear guidance to prescribing health care practitioners regarding their use, risk, and monitoring of health effects. While there are differences within the standards among the 18 classifications, each classification requires some type of medical work-up before psychotropic medication is prescribed and some type of medical follow-up to monitor the health of youth who are taking such medications. The policy and PMMP complement each other and provide a comprehensive approach to ordering and monitoring the use of psychotropic medication at the DYRS facilities.

In a December 2019 report, informed by an assessment conducted by Dr. Cohen, as well as by the Special Arbiter's independent review, the Special Arbiter found that DYRS had not yet

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[112] In the December 2019 Report, the Special Arbiter noted that although DYRS did not develop uniform monitoring standards for monitoring youth who have been prescribed psychiatric medications in consultation with the plaintiffs, as required by the Work Plan, the Special Arbiter and her medical experts as required by the Jerry M. Settlement Agreement, and the defendants did develop appropriate uniform standards for monitoring youth who have been prescribed psychotropic medication. December 2019 Report at page 27.

[113] PMMP July 2018 at page 1. It does not appear that it has been updated since its adoption in July 2018. The PMMP is organized by drug classification, and each drug classification includes classification-specific information relating to indications for use, dose and appropriate frequency for dose changes, possible interactions with other medications or effects of medication use, complications and side effects, cautions and contraindications as well as medical work-up and follow-up requirements.

implemented appropriate monitoring of youth prescribed psychotropic medications.[114] For example, Dr. Cohen found that at the YSC, just over 50 percent of youth had all the required baseline labs and assessments.[115] With respect to the required medical follow-up at the YSC, Dr. Cohen found that of the nine youth that required medical follow-up, none had the fully panoply of required tests or clinical assessments.[116] At New Beginnings, 72 percent of youth prescribed psychotropic medication after the effective date of the PMMP had the required baseline testing and assessments and 50 percent had the required follow-up testing and assessments.[117] The findings reflected that DYRS had not yet fully implemented its adopted standards for use and monitoring of psychotropic medication at its facilities. Therefore, under the terms of the Order dismissing the Jerry M. case, management of youth prescribed psychotropic medications became subject to further monitoring by OIJJFO.

2. Findings

a. YSC

OIJJFO reviewed the records relating to the prescriptions of 11 different medications from nine unique drug classes prescribed to 15 youth during the period of September 2021 through June 2022 to determine if the requirements of the Medication Management Policy and PMMP related to medical work-up and medical monitoring of youth on psychotropic

[114] December 2019 Report at pages 27-32.
[115] *Id.*, Ex. 1 at page 32. Dr. Cohen reported that 12 of 22 youth at the YSC had the required baseline labs and assessments, with five of ten having the required AIMS test, four of ten with missing labs and one case with both missing labs and AIMS test.
[116] *Id.* Of the 22 youth in the YSA sample, 13 did not require medical follow-up either because it was not required by the PMMP or policy for the medication the youth was taking or because the youth's stay at the YSA was too short to require follow-up. Of the five youth that were on medications that required medical follow-up, whose stay was long enough to require follow up and whose testing was due after the PMMP was effective, none received the required testing or assessment.
[117] *Id.*, Ex. 1 at page 34. At New Beginnings, 13 of 18 had baseline testing and assessments consistent with the PMMP and policy, and four of eight had the required follow-up testing and assessments.

medications were implemented.[118] In conducting this review, OIJJFO utilized the same criteria that was utilized by the Office of the Special Arbiter in the 2019 review concerning the timeliness of tests and examinations; a test completed within twelve months prior to starting psychotropic medication was considered to be current for purposes of the initial medical work-up. For follow-up tests due at six month or annual intervals, tests completed within two months before or after the follow-up labs were due were considered timely and for tests required at two-month intervals, tests within one month of the due date were considered timely. Labs or tests due monthly were considered timely if they were administered within one week of the due date.[119]

Of the 15 youth in the YSC sample, seven youth, 47 percent, received all baseline labs and assessments specified in the Medication Management Policy and the PMMP for their prescribed medication prior to the initiation of the medication, and eight, 53 percent, did not received all required assessments and labs. This is comparable to the finding from the 2019 assessment, in which 12 of 22 youth, 54 percent, had all required baseline tests and assessments administered.

Of the eight youth who did not receive all the required labs and assessments, six youth were missing one lab or assessment, one youth was missing two of the required labs or tests and one youth was missing four of the required labs or assessments, including the liver function test, chemistry, thyroid and lipid panels. Additionally, of the youth in the sample, four were

[118] Melatonin, a hormone that is sometimes prescribed by psychiatrists to youth in DYRS facilities for sleep, was excluded from the sampling selection.

[119] In the 2019 review, Dr. Cohen noted that the AIMS test referenced in the Medication Management Policy and the PMMP is a structured assessment for involuntary movements, and that references to the absence of side effects in clinical notes were not substitutes for AIMS testing at the intervals specified in the policy or the PMMP for those medications for which the policy or PMMP specifically mandate AIMS testing. December 2019 Report, Ex. 1 at page 33.

prescribed medications for which AIMS testing was required by the PMMP;[120] three of the four youth did not have a baseline AIMS test completed at the time the medication was prescribed.[121] All but one of the youth in the sample had a current physical examination at the time the psychotropic medication was ordered, and the one youth for which the record identified positive cardiac risk factors (by family history) received an EKG.[122] Table 3 below sets forth the specific lab work or assessment required and the number of cases in which the lab work or assessment was administered consistent with the policy or PMMP.

[120] The Medication Management Policy requires AIMS testing for all psychotropic medications; however, the PMMP, which is more specifically tailored to individual psychotropic drug classes, requires AIMS testing for certain classes of drugs. See note 133, below. For this analysis, OIJJFO relied up on the PMMP requirements.
[121] In 2019, five of 10 youth did not have a baseline AIMS test.
[122] The PMMP for some drug classes requires an EKG if there is a family history of cardiac problems or if the youth is positive for cardiac risk factors. In most records, the medical intake note would simply state negative (or include similar language) in the family history section; however, some records had no recorded cardiac history. For the purpose of this review, in these cases it was assumed there was no family history. In none of the cases in which the doctor ordered one of the designated drug classes requiring an EKG in certain instances did the psychiatric note explicitly address either the presence or absence or risk factors that would require an EKG.

Table 3: Summary of Findings of Baseline Tests and Labs for Prescribing Psychotropic Medications at the YSC[123]			
Lab or Assessment	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable/ Not Required**
CBC with diff and platelets[124]	13	2	0
LFTs[125]	14	1	0
Chem panel (including glucose, BUN and creatine) [126]	14	1	0
Thyroid[127]	13	2	0
Lipids[128]	13	2	0
Urinalysis[129]	14	1	0
Pregnancy	2	1	12
Vital signs[130]	15	0	0
Height, weight, BMI	14	1	0
Special - EKG[131]	1	0	14
Physical Exam[132]	14	1	0
Special - Abnormal movements/AIMs test[133]	1	3	11
Special - order establishing BP and/or pulse parameters	0	2	13
Special ADHD/behavior - rating scale (Connors, Vanderbilt, etc.)	0	1	14
Special - serum levels[134]	0	0	15
Special - med interaction alerts in each PMMP classification	0	0	15

[123] Cases reflected in Tables 3 to 6 are considered meeting the requirement if the monitoring occurred at the intervals and frequency specified in the PMMP and policy. A requirement is considered to be not applicable or not required if the policy or PMMP did not require it for the particular medication reviewed or if the youth was no longer in custody or on the medication at the time a particular lab or assessment was due.

[124] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: First generation antipsychotics, second generation anti-psychotics, mood stabilizer – lithium, and mood stabilizer- anticonvulsants.

[125] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: First generation antipsychotics, second generation anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), tricyclic antidepressants, and mood stabilizer – lithium.

[126] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: First generation antipsychotics, second generation anti-psychotics, mood stabilizer – lithium, and mood stabilizer- anticonvulsants.

[127] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: Mood stabilizer Lithium.

[128] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: First generation antipsychotics, second generation anti-psychotics.

[129] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classifications: First generation antipsychotics, tricyclic antidepressants, mood stabilizer – lithium, mood stabilizer- anticonvulsants.

[130] This is required by the Medication Management Policy. In addition, the PMMP requires this lab for the drug classification: other anti-depressants (venlafaxine).

[131] This is applicable to the following drug classifications: Second generation anti-psychotics (for Geodon), psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), (if positive cardiac risk factors),

With respect to the ongoing monitoring of psychotropic medication prescribed to YSC youth, nine of 15 youth, 60 percent, received all of the labs and assessments required by the PMMP and policy for their specific medication at the specified intervals, and six youth, 40 percent, were missing one or more of the follow-up labs or assessments. This is an improvement from 2019, when none of the youth had the full panoply of required follow-up testing.

Of the six youth in the 2022 sample who did not receive all of the follow-up assessments, three youth were missing two or more of the monitoring labs or tests. As was the case with the baseline assessments, thyroid tests were omitted to a significant degree. Table 4 below sets forth the specific required monitoring interventions and the status of compliance.

alpha-adrenergic agonists (if positive cardiac risk factors), tricyclic antidepressants, mood stabilizer – Lithium if multiple medications, relevant history and medical conditions, mood stabilizer (Tegretol).

[132] This is applicable to all drug classification in the PMMP except for anti-Parkinson/anticholinergics and other anti-depressants.

[133] This is required by the Medication Management Policy. In addition, the PMMP requires AIMS testing for the following drug classifications: First and Second-generation antipsychotics and long-acting anti-psychotic injectables.

[134] This is applicable to the following drug classifications: Mood stabilizer-Lithium, and Mood stabilizer-anticonvulsants.

Table 4: Summary of Findings Medical Follow Up for Prescribing Psychotropic Medications at the YSC			
Lab or Assessment[135]	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable/ Not Required**
CBC with diff and platelets[136]	4	1	10
LFTs[137]	4	1	10
Chem panel (including glucose, BUN and creatine) [138]	3	1	11
Thyroid[139]	0	2	13
Lipids[140]	2	0	13
Urinalysis[141]	1	2	12
Pregnancy			15
Vital signs[142]	3		12
Height, weight, BMI[143]	6	1	8
EKG[144]			15
Physical Exam[145]	2	0	13
Abnormal movements/AIMs test[146]	1	2	13
Special - BP and/or pulse parameters	0	2	13
Special ADHD/behavior rating scale (Connors, Vanderbilt, etc.)	0	0	15
Special - serum levels[147]	2	0	13
Special - med interaction alerts[148]			15

[135] The Medication Management Policy provides that the prescribing practitioner "must order requisite testing and lab work to monitor for serious side effects that may occur with psychotropic drugs" but does not specify particular lab work or testing. Medication Management Policy, Section G. 2. Among the issues for which the practitioner must monitor include allergic reaction, change in level of alertness, eating problems including weight loss or weight gain, changes in heartbeat, change in blood pressure, fainting or dizziness, abnormal posture, body or muscle movements or gait, yellowing of eyes or skin or unusual bruising or bleeding.

[136] The PMMP requires CBC diff/platelets at specific intervals based upon the drug classification for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, serotonergic anti-depressants, and mood stabilizer anti-convulsants.

[137] The PMMP requires LFTs at specific intervals based upon the drug classification for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), mood stabilizers-anti-convulsants, and serotonergic anti-depressants.

[138] The PMMP requires a chemical panel at specific intervals based upon the drug classification for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, and serotonergic anti-depressants.

[139] The PMMP requires liver functioning related tests at specific intervals for the following class of drugs: mood stabilizer-lithium.

[140] The PMMP requires lipid related tests at specific intervals for the following classes of drugs: second-generation anti-psychotics and long-acting anti-psychotic injections, psychostimulants and selective norepinephrine reuptake inhibitors.

[141] The PMMP requires urinalyses at specific intervals for the following classes of drugs: first- and second-generation antipsychotics, long acting injectable anti-psychotics, serotonergic anti-depressants, and mood stabilizer-lithium.

[142] The PMMP requires some or all vital signs at specific intervals based upon the drug classification for the following drug classes: first-generation, second-generation and long-acting injectable anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), alpha-adrenergic agonists, tricyclic antidepressants, serotonergic anti-depressants, and other anti-depressants.

Of particular note was the failure to address side effects experienced by some YSC youth taking atypical anti-psychotics. While weight and BMI were monitored, there was no evidence that weight gain in two youth prescribed atypical antipsychotics was meaningfully addressed. In the YSC sample, two youth were prescribed Seroquel, a second-generation, atypical anti-psychotic with a well-recognized potential for weight gain, increase in lipid levels and glucose and development of diabetes; thus, under the PMMP, weights are to be monitored closely, at least every two months.[149] In one of the cases reviewed, a youth prescribed Seroquel experienced a nearly 50-pound weight gain in one year. Within just two months, the youth had gained almost 20 pounds and complained of being hungry at night.[150] He was referred to a dietician at that time who concluded that he was not overweight and approved his request for additional snacks. His weight continued to increase over the next 10 months until a second referral to the dietician was finally made almost one year later. By that time, he had gained

[143] The PMMP requires the taking of height, weight and/BMI at specific intervals for the following classes of drugs: first and second generation antipsychotics, long acting injectable anti-psychotics, psychostimulants, selective norepinephrine reuptake inhibitors, serotonergic anti-depressants, mood stabilizer-lithium, and mood stabilizer-anti-convulsants.

[144] The PMMP requires an EKG at specific intervals and under specific conditions for the following classes of drugs: first and second-generation antipsychotics, alpha-adrenergic agonists, tricyclic antidepressants, and mood stabilizer – lithium.

[145] The PMMP requires a physical exam after the start of psychotropic medication at specific intervals for the following classes of drugs: first and second-generation anti-psychotics, long-acting psychotic injections, psychostimulants, selective norepinephrine reuptake inhibitors, alpha-adrenergic agonists, tricyclic anti-depressants, serotonergic anti-depressants and mood stabilizers-lithium.

[146] For youth on first or second-generation antipsychotics or long-acting injectables, the PMMP requires monitoring for abnormal movements each month and AIMS testing every six months.

[147] The PMMP requires periodic serum levels at defined intervals for specific medications within the following classes of medications: first generation antipsychotics, long acting anti-psychotic injectables, mood stabilizer-lithium, mood stabilizer -anti-convulsants. For youth prescribed psychotropic medication, the Medication Management Policy requires at least bi-annual screening for TD by the QHCP on either the AIMS form or a process/format of the practitioner's choice.

[148] The PMMP provides medication interaction alerts for each class of medication.

[149] PMMP at pages 4-5.

[150] There is some question about the recording of weights in this youth's record, as the baseline and first monthly weights were identical to the tenth of a pound, but, by the third month, the recorded weight reflected an 18.2 pounds increase in just one month.

almost 50 pounds, was deemed to be severely overweight, and was experiencing elevated lipid and liver levels. The psychiatrist did not address the weight gain in any meaningful way in the psychiatric notes during much of this twelve-month period. Similarly, a second youth taking Seroquel likewise experienced a significant increase in weight that was not addressed in psychiatric notes as a possible side effect of the medication. A third youth prescribed an anti-convulsant was not weighed as often as required by the PMMP despite obesity identified as a potential side effect of the medication in the PMMP, although he did not experience an excessive weight gain while at the YSC.

Additionally, as was the case in 2019,[151] AIMS tests required by the PMMP were not completed as specified in the PMMP; of the two youth in the sample prescribed medication for which an AIMS test is required, neither had AIMS tests completed each six months. While the psychiatric notes typically include a notation that the youth reported no side effects or that none were observed, under the PMMP that does not suffice for an AIMS test.

b. New Beginnings

OIJJFO reviewed the records of 15 youth prescribed medications at New Beginnings during the period of September 2021 to June 2022 to determine if the requirements of the Medication Management Policy and PMMP related to medical workup and medical monitoring of youth on psychotropic medications were implemented. The sample included a review of 11 different medications from seven unique drug classes.[152] While several youth were prescribed more than one psychotropic medication, OIJJFO reviewed two medications for two of the youth

[151] December 2019 Report, Ex. 1 at pages 32-33.

[152] The medications reviewed included Trileptal, Remeron, Strattera, Methylphenidate, Clonidine, Trazodone, Prozac, Abilify, Amphetamine, Intuniv and Depakote. The drug classes included anticonvulsants, other anti-depressants, norepinephrine reuptake inhibitors, stimulants, alpha agonist, SSRI, and atypical antipsychotics.

prescribed more than one psychotropic medication. Thus, among the 15 youth in the sample, a total of 17 prescriptions for psychotropic medications were reviewed.[153] The same standards for timeliness described above were utilized to review this sample, and the same data collection templates were also used.

Of the 15 youth in the New Beginnings sample, six youth, 40 percent, received all baseline tests and labs specified in the Medication Management Policy and the PMMP for their prescribed medication prior to the initiation of the medication, and nine youth, 60 percent, did not received all the required assessments or labs.[154] Of the two youth in the sample prescribed multiple medications, each received all of the baseline tests and assessments relevant to one of the medications, but were missing one test relating to the second medication. Of the nine youth who did not receive all the required labs or tests, six youth were missing one lab or test, one youth was missing two of the required labs or tests and one youth was missing four of the required labs or tests, including the liver function, chemistry, thyroid and lipid panels. Additionally, three youth in the sample were prescribed medications for which AIMS testing to establish a baseline was required; all three youth had a baseline AIMS test completed at the time the medication was prescribed.[155] All youth in the sample also had a current physical examination at the time the psychotropic medication was ordered, two youth for which the record identified positive cardiac risk factors (by family history) received an EKG and two others did not, although the records were silent as to whether there were positive cardiac risk factors.[156]

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[153] Where applicable, the results of the review use the 17 medications as the unit of analysis (*i.e.,* not the 15 youth), as there are some differences between the baseline and follow-up monitoring for the specific medications.
[154] In 2019, 13 of 18 youth, or 72 percent, had all the required baseline tests and assessments.
[155] This finding is consistent with the findings in 2019.
[156] In ordering the medication, there was no mention of the presence or absence of cardiac risk factors and thus it is unclear if the ordering psychiatrist considered whether to order an EKG.

Table 5 below sets forth the specific lab work or assessment required and the number of cases in which the lab work or assessment was administered consistent with the policy or PMMP.

Table 5: Summary of Findings Baseline Workup for Prescribing Psychotropic Medications at New Beginnings[157]			
Lab or Assessment	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable / Not Required**
CBC with diff and platelets	17	0	0
LFTs	16	1	0
Chem panel (including glucose, BUN and creatine)	16	1	0
Thyroid	12	5	0
Lipids	15	2	0
Urinalysis	17	0	0
Pregnancy	1	1	15
Vital signs	17	0	0
Height, weight, BMI	17	0	0
EKG	2	2	13
Physical Exam	16	1	0
Abnormal movements/AIMs test	3	0	14
Special - BP and/or pulse parameters	0	0	17
Special ADHD/behavior rating scale (Connors, Vanderbilt, etc.)	0	1	16
Special - serum levels	1	0	16
Special - med interaction alerts	0	0	17

With respect to the ongoing monitoring of youth on psychotropic medication at New Beginnings, four individuals (taking six medications) did not receive all the required follow up monitoring in accordance with the PMMP or policy. Comprehensive metabolic panel (including liver function tests), thyroid testing, and lipid labs were not completed for two individuals and a third individual was missing a thyroid test. One individual was missing a urinalysis and another youth was missing one AIMS test. All youth had vital signs taken as required by the PMMP or policy,[158] but in the case of three youth prescribed four medications, weight was not monitored

[157] See note 123.

[158] In one case, however, the plan noted in the record was for daily blood pressure checks. While there were regular blood pressure checks, they did not occur daily.

as provided in the PMMP.[159] See Table 6 below for a summary of monitoring at New Beginnings.

Table 6: Summary of Findings Medical Follow Up for Prescribing Psychotropic Medications at New Beginnings			
Labs/Assessments	**Number Meeting Requirement[160]**	**Number Not Meeting Requirement**	**Number Not Applicable / Not Required**
CBC with diff and platelets	5	0	12
LFTs	1	2	14
Chem panel (including glucose, BUN and creatine)	1	2	14
Thyroid	0	3	14
Lipids	1	2	14
Urinalysis	2	1	14
Pregnancy	0	1	16
Vital signs	8	0	9
Height, weight, BMI	7	4	6
EKG	0	0	17
Physical Exam			17
Abnormal movements/AIMs test	1	1	15
Special - BP and/or pulse parameters	0	0	17
Special ADHD/behavior rating scale (Connors, Vanderbilt, etc.)			17
Special - serum levels			17
Special - med interaction alerts			17

There were two youth who were prescribed a medication known to cause weight gain and hyperlipidemia for whom the record establishes excellent follow up. One youth's weight was monitored consistently, weight gain and elevated A1C and triglycerides were noted by the psychiatrist, and a referral to the dietician was made promptly. The youth was seen by the dietician monthly for several months, additional labs were ordered and a diagnosis relating to

[159] Weight was monitored consistent with standards for seven youth and the remaining youth weight monitoring was not applicable.

[160] Cases are considered compliant it the monitoring occurred at the intervals and frequency specified in the PMMP and policy. If the monitoring was missed or late, it is considered to be non-compliant. Additionally, a test or assessment is considered not applicable or not required if the youth was not in custody or on the medication at the time designated in the PMMP or policy, or if the PMMP did not require the particular test or assessment.

high triglycerides was added.[161] In another case the youth experienced weight gain and an elevated A1C while on an atypical anti-psychotic, and the psychiatrist discontinued the medication. They youth was discharged shortly thereafter.

In another case the psychiatrist promptly discontinued a stimulant for a youth who complained of chest pains, although the youth had been taking the medication without incident for several months. When the youth asked to restart the medication, the psychiatrist first ordered an EKG. Similarly, serum levels in the one sampled case involving Depakote were monitored before any change in dose was made.

However, and as with the YSC, psychiatric notes often referenced the absence of side effects, but did not detail for what side effects the youth was assessed. Notes for those on anti-psychotics did not specifically address the presence or absence of involuntary movements except in one case in which tremors were observed, the medication was adjusted, but no AIMS test was performed to fully assess the presence of involuntary movements.

c. Conclusion Regarding Psychotropic Medication Monitoring

Overall, there has been improvement in implementing the policy and PMMP at both YSC and New Beginnings, however, there remain gaps in implementing these standards which may reflect the cumbersomeness of the PMMP.

V. RECOMMENDATIONS

OIJJFO adopts the recommendations listed below, many of which were made by Dr. Cohen in his report. The recommendations should be understood in the context of the full report

[161] The medication ultimately was discontinued after a few months due to the youth's noncompliance with taking the medication.

and the findings related to medical practice at the YSC and New Beginnings specifically and are not intended to be interpreted or understood separately.

A. Comprehensive Intake Assessment Recommendations

<u>Recommendation 1</u>: To promote more complete comprehensive intake health assessments, nursing staff should write orders for all due or overdue tests, labs, screening, and other procedures that are not completed during the initial comprehensive exam.

Generally, medical staff completed required tests, screenings, and labs required during the comprehensive intake assessment; however, Dr. Cohen did identify a small number, including hearing screenings, an STD test, and a pregnancy test, that were not completed upon admission and were not subsequently identified and completed at the 7-day follow-up visit. Based on his review, Dr. Cohen observed that when medical orders are written, they are consistently executed by nursing staff. He therefore recommends that to ensure any procedures that are not completed upon intake are not overlooked, the NP performing the intake medical assessment should order it so that the procedure is subsequently completed.

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[162]

B. Systemic Issues Recommendations

<u>Recommendation 2</u>: Improve access to vision services at both facilities.

Lack of timely access to optometry services remains an issue. Between his sample of 35 youth at the YSC and New Beginnings, Dr. Cohen identified 12 youth with abnormal vision who did not see an optometrist during the period he reviewed. In some cases, youth had been waiting months. At least one youth was released without having his abnormal vision treated. Abnormal

[162] Attachment 2 at page 1.

vision can have a significant impact on youth well-being, including negatively impacting youths' ability to participate in the education and/or recreation program.

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[163]

Recommendation 3: Offer contraceptive health services to female youth.

DYRS policy provides that emergency contraception be made available to female youth when they are admitted to a DYRS facility, that they are provided an opportunity to continue any contraception method that they had been using prior to their admission, and that hormonal contraception be available to female youth upon request. Additionally, pamphlets with information about contraception methods and community resources should be available throughout DYRS facilities, as well as counseling and social services regarding sexuality for all male and female youth.[164] Dr. Cohen found no evidence that contraception was provided or offered to female youth in the samples he reviewed. He states that "[a]ll sexually active female youth need to make an informed choice about contraception. They should be educated about contraception, offered the varieties of hormonal and other forms of contraception, and provided with whatever method of birth control they choose."[165]

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[166]

[163] *Id.*
[164] Contraception and Family Planning Services, policy no. V.g.2., eff. June 8, 2016, at VI.
[165] Attachment 1 at page 26.
[166] Attachment 2 at page 1.

<u>Recommendation 4</u>: Enhance the quality of 7-day follow up and New Beginning intake quality assurance functions.

The 7-day follow up review conducted after a youth's admission to the YSC is intended to serve as a quality assurance process to identify and complete due or overdue medical procedures that were not provided at the intake medical visit. It is also an opportunity for medical staff to review each youth's health record to determine whether any medical follow-up is indicated based on test results. Dr. Cohen found that the 7-day follow up was not sufficiently meeting its intended goal, as over a quarter of the youth in the YSC sample either had one or more missing elements which were not rectified at the 7-day follow-up visit or did not receive the 7-day follow-up visit at all.

To improve the completeness and quality of the 7-day follow up, Dr. Cohen suggests that the EHR could be leveraged to include a custom report that would automate the standardized data collection required to perform the 7-day follow up, which currently requires searching multiple data sources in the EHR. Additionally, because the results of some medical procedures are recorded inconsistently in different locations in the EHR (*e.g.,* sometimes in notes rather than in designated database folders), medical staff should receive ongoing training regarding consistent, effective data entry of the screening tests in the EHR. Finally, medical staff should review the results of 7-day follow up visits on a routine basis as part of their continuous quality improvement program, which should provide staff feedback regarding strengths and weaknesses of the reviews and improve their quality over time.

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[167]

[167] *Id.*

<u>Recommendation 5</u>: Provide additional guidelines and training to nurse practitioner staff in interpretation of the CBC results.

Dr. Cohen identified four abnormal CBC results that were not identified by medical staff as abnormal or needing additional follow-up. Some abnormal CBC results may have benign causes; however, it is not possible to determine whether the cause is benign absent additional diagnostic assessment. Nurse practitioner staff should be provided with additional training regarding interpretations of the CBC results and perhaps guidelines detailing how they should respond to commonly encountered CBC abnormalities.

DYRS did not address this recommendation in its comments on the draft version of this report.

<u>Recommendation 6</u>: Identify ways to improve the consent process for immunizations to reduce parental refusal of consent.

DYRS staff consistently review youth immunization records upon intake to ensure they are up-to-date with current public health recommendations. This serves a significant public health function. Sixty-seven percent of youth in Dr. Cohen's YSC sample needed immunizations to be brought up-to-date to current public health recommendations. Significantly, however, Dr. Cohen found that 73 percent of parents of youth who were not up-to-date with public health recommendations did not consent to having needed vaccines administered, which he indicated is an "unusually large portion" of parents to refuse.[168] Medical staff, perhaps in consultation with DC Health, should review the methods that are used to request consent from parents, determine the reasons why parents are refusing, and attempt to find ways to improve the process so more parents consent to the administration of recommended immunizations.

[168] Attachment 1 at page 5.

DYRS did not address this recommendation in its comments on the draft version of this report.

<u>Recommendation 7</u>: Treat trauma and significant past health problems as a chronic care issue.

Many youth in DYRS custody have a history of significant medical trauma or past serious medical illness. During his review, Dr. Cohen found records of youth with gunshot wounds, past history of coma with organ failure, and serious hand trauma. While their health issues were recognized in their records, little or no history was collected regarding their chronic pain management, any continuing disabilities, or the need for ongoing specialty services in these cases. Dr. Cohen notes in his report that serious health issues can have residual chronic effects, which could include PTSD, pain, or physical disabilities. These major health events should be included on the youth's problem list and additional history regarding the past follow-up plans and current needs should be collected to produce a meaningful treatment plan that includes any additional services that may be necessary.

DYRS did not address this recommendation in its comments on the draft version of this report.

C. Psychotropic Medication Recommendations

<u>Recommendation 8</u>: Review the PMMP and Medication Management Policy to update as new information concerning the medications has been published.

DYRS's PMMP was last revised in 2018. The PMMP and Medication Management Policy should be reviewed and revised on a periodic basis to incorporate any recommended changes in clinical practice. The PMMP should be incorporated by reference into the Medication Management Policy and made fully consistent with the policy.

The updated PMMP should include explicit parameters for monitoring blood pressure for youth on sympathomimetics, standards for monitoring behavior for youth to treated for ADHD, and parameters for monitoring weight gain and establishing criteria for when action should be taken.

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[169]

Recommendation 9: Consider developing comprehensive groups of orders for baseline and follow-up psychotropic medication management, by drug class, to ensure that one or more required tests are not overlooked.

Managing psychotropic medications is complicated by the fact that there are numerous drug classes that have varying baseline and follow-up testing requirements and intervals. This requires a high degree of detailed knowledge about psychotropic medication management and an ability to track and implement those requirements for multiple youth at any given time. To facilitate this complex process for practitioners, DYRS should consider developing standardized groups of orders for psychotropic medications, by drug class. If an automated system of reminders could be incorporated into DYRS's EHR system triggered by prescriptions for psychotropic medications, it might ensure an even greater degree of consistency in the application of the PMMP.

DYRS did not address this recommendation in its comments on the draft version of this report.

[169] Attachment 2 at page 1.

<u>Recommendation 10</u>: When ordering psychiatric medications, doctors' notes should reflect that they completed or reviewed current labs and assessments and reviewed the periodic assessments required by the PMMP. Similarly, doctors' notes should reflect the monitoring expectations for the ordered medications.

Having prescribers affirmatively document that they completed or reviewed all labs and assessments required by the PMMP will help ensure that the protocols are followed consistently. Furthermore, prescribers should communicate to other providers what the follow-up monitoring expectations, including monitoring for possible side effects of the medication. In several cases in the sample reviewed, youth prescribed psychiatric medication experienced substantial weight gain, a known side effect of the prescribed medication, that was not addressed timely or effectively.

For six different classes of psychotropic medications, an EKG is required before prescribing if there are cardiac risk factors present. For these medications, the prescribing psychiatrist should specifically address the presence or absence of cardiac risk factors in a note when the medications are ordered. In cases reviewed by OIJJFO, the youths' health records were silent about cardiac risk factors, and it was not possible to determine whether the prescriber considered this issue.

In its response to the draft report, DYRS stated that "[t]he Agency agrees [with the recommendation] to the extent that clinical notes should reflect a review of labs and include a pertinent plan for medication monitoring."[170] The response focuses specifically on a review of labs and does not address the necessity of documenting a review of *all* applicable requirements of the PMMP and the different requirements related to the 18 different drug classes included in the PMMP. Different classes of psychiatric medications pose different health risks that must be

[170] *Id.* at page 2.

screened for and/or monitored consistent with defined standards. It is important that doctors' notes affirmatively document that *all* required labs *and* assessments required by the PMMP are reviewed when monitoring psychotropic medications. Recommendation 9 is intended to simplify the complexity associated with monitoring of 18 different drug classes.

<u>Recommendation 11</u>: Implementation of the PMMP should be reviewed periodically as part of DYRS's internal continuous quality improvement program.

To promote ongoing improvement in consistent implementation of the PMMP, DYRS's medical CQI program should include periodic case record reviews of youth prescribed psychotropic medications.

In its comments on the draft version of this report, DYRS indicated that it agrees with and will implement this recommendation.[171]

D. Clinical Practice Recommendations

Dr. Cohen identified several clinical practices that he recommended be modified to improve either efficiency or efficacy of the health program. These recommendations are for DYRS medical staff's consideration.

<u>Recommendation 12</u>: Pelvic exams and cytology screenings should be offered to all female youth.

Dr. Cohen documents that whereas pelvic exams and cytology screenings are not routinely recommended for adolescent females in the general population, sexually active adolescent female youth in detention are at high-risk for repeated HPV infections, cervical dysplasia, and cervical cancer at a young age. His review of a sample of female youth admitted to the YSC and New Beginnings confirmed that this population is at high-risk. This population would benefit from a health program that includes offering a pelvic exam and screening and

[171] Attachment 2 at page 1.

educating youth about the reasons why an exam should be considered. Youth with abnormal results should receive clinical follow-up and high-grade cervical legions may need treatment.

More broadly, Dr. Cohen urges DYRS to adopt a more comprehensive approach to women's primary care that would include more complete reproductive health history, attention to contraception, offering pelvic exams and cytology screenings, and attention to menstrual issues.

In its response to the draft version of this report, DYRS states that it disagrees with this recommendation "as this is not the standard of care under the current guidelines supported by the United States Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics (AAP)."[172] The response continues, stating the following:

> Consideration of the natural course for most HPV infections in immunocompetent hosts (transient), paired with the observations that it normally takes several years to progress from infection to cancer, do not support this recommended approach. There is no clear benefit to cancer risk reduction or outcomes by performing screenings before 21 years of age. Furthermore, one must consider the risks of patient harm caused by over-screening, especially since HPV infections are quite common among those who are sexually active.[173]

DYRS's practice is consistent with the standard of care; however, the response does not account for the fact that, as the evidence from Dr. Cohen's assessment reveals, the population of females served by the DYRS medical program is not the general adolescent population, but rather a high-risk population. In his report, Dr. Cohen recognizes the prevalence of HPV infections and thus recommends only periodic clinical follow up (*e.g.,* every six to 12 months) for youth found to have minor cervical lesions and treatment for youth with high-grade lesions. DYRS's response does not address Dr. Cohen's broader recommendation that the agency adopt a

[172] *Id.* at page 2.
[173] *Id.*

more comprehensive approach to women's primary care, including reproductive health history and attention to contraception and menstrual issues.

<u>Recommendation 13</u>: Readminister any TB skin test that results in an induration less than 10 mm. Alternatively, consider using an FDA-approved TB blood test.

Dr. Cohen notes that errors in administering TB skin tests may result in false negative test results. Consequently, in a secure care setting where communicable diseases such as TB can spread rapidly, he recommends readministering TB test results that could be the result of a skin test placement error. Dr. Cohen also observes that TB blood tests are available which, while more expensive, do not require a follow up reading by a medical practitioner 48 to 72 hours after administration as TB skin tests do. In an environment like the YSC, where over 70 percent of admitted youth have a length of stay of one day or less and do not return to have TB skin test results read, DYRS would obtain much more comprehensive TB results from the blood test and released youth with positive blood tests and DC Health could follow up with these youth in the community.

In its response to the draft version of this report DYRS disagrees with this recommendation noting, "[t]he Agency's current practices related to the screening and testing of tuberculosis align with the Centers for Disease Control (CDC) recommendations in correctional settings. DYRS's two secure facilities are currently considered minimal TB risk facilities. The current TB screening and testing program is also successful. In the past, blood tests were cost-prohibitive to administer. As fiscal resources permit, the Agency will revisit our practices related to the TB testing modality utilized."[174]

[174] *Id.*

While this recommendation is intended to prevent false negative test results associated with inherent problems with the TB skin test, given the low prevalence of TB among youth admitted to DYRS facilities, the agency's practice is reasonable. It may be worth exploring whether the Tuberculosis and Chest Clinic operated by DC Health could be a low-cost partner to analyze TB blood tests administered to DYRS youth, particularly youth admitted to the YSC.

<u>Recommendation 14</u>: Reduce false positive urine test results by having youth void their bladders twice when obtaining urine specimens for initial dipstick screenings.

At the YSC, Dr. Cohen found that over half of the youth in his sample initially had abnormal urine dipstick screening results; however, all of the same youth had normal results after the youth hydrated and the urine test was readministered. He recommends that in order to reduce the high number of false positives, youth should be asked to void their bladders, provided an opportunity to hydrate, and shortly thereafter the urine specimen should be obtained. Not only will false positives be reduced, but nursing and other secure care staff will save valuable resources by not having to return youth to the clinic to perform a second urine test.

In its comments on the draft version of this report DYRS disagreed with this recommendation stating the following:

> In addition to the urine point of care (POC) urinalysis, urine specimens collected from youth are used to detect common sexually transmitted infections (STIs). For STI testing, it is best to collect the first catch urine in a patient who has not recently voided. The recommended approach of encouraging youth to dilute their urine before collection (in an effort to decrease the likelihood of abnormal urinalysis results) may negatively impact the sensitivity of STI test results. As an alternative, the Agency will consider discontinuing routine urinalysis and instead reserve the use of POC urinalysis on a prn basis as clinically indicated. This practice better aligns with the current standards of care endorsed by the American Academy of Pediatrics.[175]

[175] *Id.* at page 3.

This recommendation was made in an effort to use staff time more efficiently. DYRS points out that because first catch urine is recommended for the purposes of STI testing, they will continue to obtain samples for that purpose using their existing practice, which is reasonable. Rather than considering discontinuing routine urinalysis, Dr. Cohen suggests collecting two urine specimens, one first catch specimen to be used for STI testing and a second specimen collected after a youth voids his/her bladder which could be used for dipstick screening. While this would not reduce the volume of work medical staff perform, it could reduce the volume of false positives obtained from dipstick screenings relative to the current baseline.

Attachment 1

Review of Intake Medical Assessments at the Youth Services Center and Continuity of Care at the Time of Transfer to New Beginnings Center for Youth

Michael D. Cohen MD
12/8/22

Introduction

This review of Intake Medical Assessments at the Youth Service Center (YSC) and Continuity of Care at the time of transfer to New Beginnings (NB) was undertaken at the request of the District of Columbia Office of Independent Juvenile Justice Facilities Oversight (OIJJFO).

Intake Medical Assessment at the Youth Service Center

Youth admitted to juvenile detention often have had little health care prior to placement and are more likely to have acute illness or injury, chronic illness, infection, dental cavities, physical disability, mental illness and substance abuse than youth from the general population.

The intake medical assessment conducted at the time of admission is the basis for each youth's individual treatment plan. It should include a review of past medical history, a physical examination, and screening tests appropriate to the age, gender and background of the youth. All significant positive findings revealed by the assessment should be recorded on a Problem List, and a Treatment Plan should be developed for each problem. An accurate and complete Problem List and Treatment Plan are the essential products that should result from the intake medical assessment.

Standards

I identified the required elements of the intake medical assessment in the DYRS health policies that specify what to do and how often they are to be done. This is an objective measure, as each required element is either present or absent.

The Problem List is a tool for keeping track of the active and chronic health problems. Everything of importance to the youth's ongoing health program should be listed.
To assess the "completeness" of the Problem List requires an assessment of the initial history, physical exam, labs, and screening tests based on training and experience. Of necessity, this assessment may involve some subjective judgment about the importance of a particular abnormality to a youth's health, how to name a problem or when to separate or combine related problems.

For example:

- Should a vision screening result of 20/30 be a problem and the youth referred for examination by an optometrist?
- Should a patient's pre-diabetic condition be listed as a separate problem or subsumed under Obesity?
- How important is it to know more about the ongoing physical and emotional consequences of past serious traumatic injury or serious acute medical illness?
- Is lactose intolerance a problem to be listed or is it sufficient to simply add it to the food allergy list?

These and other issues are discussed below. There is always room for dialogue about how to list and address health problems. The Problem List should be a dynamic element of the health record that changes with time as the patient's experience and needs change. The ultimate measure of success is the ongoing health of youth in care.

I used my clinical experience and training to assess the adequacy of Treatment Plans and their implementation.

Methods

Relevant DYRS policies were reviewed, including the following: Intake Screening,[1] Health Assessment,[2] Medication Management,[3] Contraception and Family Planning,[4] Transfer Screening,[5] and Continuity and Coordination of Care.[6]

Using information from the policies as well as my clinical training and experience I developed record review checklists and forms to document observations of the content and completeness of the intake medical assessments, Problem Lists, Treatment Plans, and initial implementation of the Plans.

In general, I reviewed all entries in the electronic health record (EHR) at the time of admission and up to one month after admission to determine how issues were initially handled. In the EHR, the Medical Intake or Overnighter Medical Screening for the designated admission is the principal source of information. Specific records such as lab results, TB tests, vision and hearing tests, etc., were located in the EHR to confirm what was done and review the results. The electronic medicine administration records (eMAR) were reviewed to confirm what medicines were ordered at the time of admission. Timeliness of the first dose of medicine was ascertained by OIJJFO staff.

The sample for this review was selected from admissions during March, April, May and June 2022. The sample includes youth with length of stay of at least two weeks. Youth

[1] Intake Screening, policy no. V.e.2. (YSC), eff. April 19, 2016.
[2] Health Assessment, policy no. V.e.10., eff. August 16, 2016.
[3] Medication Management, policy no. V.d.2., eff. January 17, 2018.
[4] Contraception and Family Planning Services, policy no. V.g.2., eff. June 8, 2016.
[5] Transfer Screening, policy no. V.e.2., eff. September 14, 2018.
[6] Continuity and Coordination of Care, policy no. V.e.7., eff. July 19, 2016.

were selected from the various types of admissions to YSC: detained, committed, and Title 16 youth being held for trial on adult charges. A sample size was selected that we think is sufficient to support an assessment of how well the program is doing overall and identify program areas that may need improvement. The YSC sample included 18 youth.

Using the information gathered via the EHR review for each youth in the sample I developed three YSC Tables to present my observations.

- **YSC Table 1** lists observations for each youth in the sample regarding the completeness of the required elements of the assessments. This is the raw data.

- **YSC Table 2** is a summary of the completeness of the assessments for each of the required elements.

- **YSC Table 3** includes observations of the completeness of the Problem Lists, Treatment Plans and initial Plan implementation.

Observations of Completeness of the Medical Intake Assessment at YSC

YSC Table 1 is a summary of the completeness of the Medical Intake Assessment. Each sample youth is listed with the required elements of their assessments indicated by 1 if present (completed) and 0 if absent (not completed). **YSC Table 2** summarizes this data for each of the required elements.

Overall, the initial assessments are very well completed. 6/18 youth were missing one or two of 18 elements. Only 8/324 (2.5%) total required elements for all 18 sampled youth were not completed. The most frequently omitted element was a hearing screening for 3 youth.

Most of my comments in this section are based on findings in one to three youth records. It is not necessary to demonstrate that an issue is widespread to learn from experience and improve care. I believe that important lessons can be learned from careful review of even a single event and recommendations are provided here with this in mind.

Continuity of Medicines

In general, admitting nurse practitioners (NPs) take care to identify current medicines with the youth and then confirm the medicines with a parent. Confirmed medicines are generally ordered to continue at the time of admission. In this sample 6/18 youth were taking medicine regularly at home and 5/6 had their medicines confirmed and continued on admission.

For one youth the medicine was not continued on admission. This youth (MP) stated he was taking a psychiatric medicine (atomoxetine; Strattera) regularly at home. His medicine could not be confirmed with a parent at the time of admission (likely because the youth's mother had recently been murdered) and it was not continued.

A youth stable on psychiatric medicine at home should not have his medicine discontinued on admission due solely to an inability to confirm the medication. The Medication Management policy provides explicit guidance on how to handle this situation in the best interests of the youth in section VI.B.4, as follows:

> 4. If existing medication orders cannot be verified by the QHCP, the advanced level provider shall assess the youth as soon as necessary to avoid a missed dose and determine his/her medication needs and a clinically appropriate treatment plan.

Issue: Contrary to existing policy, necessary medicine was not continued when the admitting NP was unable to reach a parent to confirm the medicine.

Recommendation: Health staff who perform the medical intake function should be well-informed about how to continue necessary medicines when a parent cannot be reached to confirm. Orders for follow-up to confirm the medicine (and obtain consents that may be needed) should also be written.

History

18/18 sample youth had a medical history taken on admission. 12/18 had important positive findings by history, an indicator for effective history taking skills.

Additional history was needed for one youth regarding prior hospitalization with coma. Another youth had a history of multiple gunshot wounds to limbs. For 8 sample youth with abnormal vision screening, only one had a note with additional history regarding vision and glasses. The youth with 20/40 and 20/60 vision needed more history and clinical follow-up for glasses more urgently, as their vision was most compromised.

Issue: Additional history was needed for youth with positive findings at intake.

Recommendation: Health staff who perform the medical intake function should be mindful of the need to obtain and document additional history when positive findings are identified by history, physical exam, lab, or screening tests.

Physical Examination

18/18 youth in the sample had a physical examination on admission. While a genital exam was appropriately offered routinely for males, no pelvic examination or cervical cytology screening was offered to the three young women in the sample.

Issue: Routine primary care services for women are not offered or provided at intake.

Recommendation: Sexually active, detained female youth represent a population at high risk of sexually transmitted infections and unplanned pregnancies. My opinion is that contraception, pelvic exams, and cervical cytology screening should be offered routinely to all sexually active detained female youth. The need for routine primary care for women is discussed further in the **YSC Conclusions** section below.

Allergies

Allergy history was obtained for 18/18 youth in the sample. 9/18 had a history of drug, food, or seasonal allergies. Management of allergy history was appropriate for most youth: alerts were sent to medical and/or food services; as needed medicine was ordered for those with seasonal allergies; epi-pen was ordered for one youth with significant risk for a life-threatening anaphylactic reaction.

Immunizations

Current immunization records were obtained from the DC registry on admission for 18/18 youth. 12/18 youth needed immunizations to be brought up-to-date with current public health recommendations. The admitting NP generally called a parent to request consent for needed immunizations.

For one youth who needed immunizations, no consent was requested on the day of admission as there was no phone number available. No further efforts were made to obtain consent for needed immunizations thereafter and his need for immunization was never followed-up. (TG)

Issue: Efforts to request consent for immunizations were not continued after intake.

Recommendation: When consent cannot be requested on the day of admission, the admitting NP should write an order for consent to be requested by health staff later.

When parents were called to request consent for immunization, I observed that 8/11 parents refused. I think this is an unusually large portion of the parents to be refusing needed immunizations. If at all possible, the opportunity to provide needed immunizations while placed at the YSC should not be missed.

Issue: High rate of parents refusing consent for needed immunizations.

Recommendation: The health program should review the current methods for requesting consent for immunizations to determine reasons for refusal and identify ways to improve the consent process.

STD Tests

For 18/18 youth in the sample routine urine tests for chlamydia, gonorrhea, and trichomonas were obtained at intake. 18 sampled youth had current HIV tests within 6 months and 17 youth had current syphilis tests.

Youth KK had a prior syphilis test more than 6 months before intake. A new test was ordered on admission but was not obtained with the rest of the ordered blood tests. The absence of syphilis results was observed at the 7-day admission follow-up visit, but the practitioner simply recommended calling the lab for the results while in fact it was never drawn.

Some STDs are common among admitted youth: 5/18 had chlamydia; 3/18 had gonorrhea and 1/18 had trichomonas. No youth in the sample were positive for HIV or syphilis.

Complete Blood Count (CBC)

For 18/18 youth in the sample CBC tests were current within one year. For one youth a current CBC report was included among the documents submitted from the hospital where he was treated for a hand fracture immediately prior to admission.

One youth had an abnormal CBC with low white blood cell count and low neutrophil count. The abnormal results were recognized, low white count was added to the Problem List, and a Treatment Plan was developed for further evaluation. However, the youth was discharged before his repeat tests and hematology referral could occur.

Urine dipstick:

18/18 youth in the sample had on-site urine dipstick screening for chemical abnormalities. 10/18 had abnormal urine screening tests on admission, but normal results were obtained when the test was repeated later after hydration. These false positives require additional nursing time and youth movement to obtain and analyze repeat tests.

In my experience false positive urine screening on admission commonly results when the urine specimen is obtained from youth who have not been drinking much and have not voided recently.

Issue: Highly concentrated urine that has been sitting in the bladder for hours will often give false positive screening results.

Recommendation: To avoid false positive urine dipstick results, youth in the intake unit should be provided with water or other drinks to keep them well hydrated. In addition, it may be useful to obtain "double voided" urines to remove concentrated, aging urine from the bladder. To obtain a "double voided" specimen the patient is asked to urinate into the toilet, and then some time later, perhaps 30-60 minutes, another specimen is obtained for testing.

Urine Pregnancy Test

One of three young women in the sample did not have a pregnancy test on admission. Omission of the routine pregnancy test is consistent with my observation that Primary Care services for women are largely missing from the DYRS health program.

Issue: No urine pregnancy test obtained at intake

Recommendation: The admission pregnancy test should never be omitted. The need for primary care for women is discussed further in the **YSC Conclusions** section below.

TB skin test:

17/18 youth had a current TB skin test within one year. One youth did not have a current TB skin test. He had a TB test placed during a prior admission within one year, but it was never read and no result was documented in the EHR. Nevertheless, the admitting NP appears to have considered this test to be complete and did not order a new one. (CR)

One youth (EH) with history of a positive TB skin test ("latent TB") was managed well by obtaining additional history from the youth, family, and health records: he had no symptoms of TB, had completed preventive therapy, and had a normal chest x-ray in the recent past.

The TB skin test is supposed to be read at 48 to 72 hours after placement. One youth's admission TB skin test was read 9 days after placement, well outside the routine timing recommended for an accurate reading. (AD) While it may be possible to determine at a late reading that a test had been positive, this is not certain and should not be accepted.

Issue: A TB skin test not read within the recommended time frame of 48 to 72 hours after the test was placed should not be treated as a valid test.

Recommendations: (1) Only TB skin tests that have been read and the results documented can be considered to be completed tests. (2) TB skin test readings performed after 72 hours should not be accepted. All TB skin test readings should occur within the recommended 48 to 72 hours.

Reading and interpretation of the TB skin test is based on the size of the firm inflammatory reaction ("induration") that occurs in the skin at the injection site. No induration at the injection site ("0mm") is a reliable negative result. In general, guidelines for interpretation of the TB skin test state that induration greater than 10mm is positive, 5-10mm is equivocal, and less than 5mm is negative.

One youth's (DM) reading was recorded as "1mm" and interpreted as negative, which is certainly within published guidelines. However, the TB skin test is difficult to inject properly into the skin and may go too deep or too shallow. When that occurs, a person with latent TB may show a false negative reaction because insufficient antigen was injected. In my experience any reaction (*i.e.,* induration) less than 10mm may be the result of improper injection in a person with latent TB who would be a true positive if tested properly.

> **Issue:** A TB skin test reaction of 1 to 9 mm induration may be a false negative due to inadequate injection of antigen.
>
> **Recommendation:** Repeat any TB skin test that shows induration less than 10mm on the opposite arm, paying meticulous attention to the proper intradermal injection of the test material.[7]

Vision Screening

18/18 youth had current vision screenings, and 8 of the 18 youth had abnormal vision. Two of the youth with abnormal vision were never referred to the optometrist. The remaining six youth with abnormal vision were referred to optometry, but none of them had seen an optometrist as of my review. One youth with vision screening 20/60 who was referred was still in care at the time of my review and had been waiting more than 4 months for an optometry assessment. Lack of access to optometry services was an issue in prior health care reviews of DYRS facilities.

> **Issue:** Youth with abnormal vision screening do not have access to optometry services, either because they are not referred to optometry or because they are referred to optometry and not seen.
>
> **Recommendation:** Lack of timely access to optometry services must be addressed. Vision screening and follow-up are discussed in more detail in the **YSC Conclusions** section below.

[7] There are two FDA-approved blood tests for TB, which are not prone to injection errors as TB skin tests are. However, whereas TB skin test results can be interpreted by a practitioner on site, blood tests must be sent to a laboratory for analysis, which may increase test administration costs. On the other hand, blood tests do not require patients to return for a reading 48 to 72 hours after test administration, which may be beneficial in an environment like the YSC where youth may be released after test administration but prior to having results read. DYRS should consider the costs and benefits of using a blood test rather than a TB skin test.

Hearing Screening

15/18 youth in the sample had current hearing screening within one year, while 3/18 did not. The missing hearing screenings went largely ignored after Intake. Of those without current hearing screening at intake, in no case did I find an order by the admitting NP for hearing screening to be completed later.

> **Issue:** When no current hearing screening was found at Intake there was no follow-up hearing screening after Intake.
>
> **Recommendation:** When a hearing screening is not current and not performed at intake, the admitting NP should write an order for it to be done later.

Seven-day follow-up visit

17/18 youth in the sample had a 7-day follow-up visit. The 7-day follow-up visit is intended to make sure the initial health assessment was fully completed and any abnormal findings were followed-up. This was done effectively in a number of cases when missing elements or abnormal screening tests were identified and remedied. However, 4/17 records with missing elements were not identified and remedied at the 7-day follow-up visit.

While 17/18 had the 7-day visit, three youth with overdue hearing screening and another with an overdue TB skin test were not identified and remedied at the 7-day visit (see Table 1). Since 4/17 (about 25%) assessments had missing elements that were not remedied at the 7-day follow-up visit, the quality of the 7-day visits is inadequate.

> **Issue:** Missing or abnormal elements of the intake medical assessment are not adequately identified and remedied at the 7-day follow-up visit.
>
> **Recommendation:** The NPs who perform the 7-day follow-up visits should be provided with additional guidance, training, support, and monitoring to improve performance of this important function. Perhaps youth from this sample could be used as examples of needs that were missed.

Overall Recommendation Regarding Completeness at the YSC

Order Missing Elements on the Day of Admission

I observed that when orders for various tests or screenings that still needed to be completed were written, such orders were generally carried out timely. If ordered, a hearing screening, TB skin test, request for consent for immunization, or confirmation of medicine is very likely to get done promptly by nursing staff.

Issue: Admitting NPs do not consistently write orders for missing elements of the Intake health assessment to be completed later.

Recommendation: The NP providing the medical intake should routinely write orders for all needed tests, screenings, consent requests and confirmation of medicine that were not completed at the time of admission.

Observations of Problem Lists, Treatment Plans and Plan Implementation at the YSC

YSC Table 3 is a summary of my observations of the Problem Lists, Treatment Plans and Plan Implementation for the sample youth.

Problem List

I found that 13/18 youth in the YSC sample had complete Problem Lists including all evident problems and 5/18 youth in the YSC sample had incomplete Problem Lists (one was missing two problems). Missing problems included:

- Two of the three young women in the sample (CR; AS) stated they were sexually active without any contraception, but "No Contraception" was not on their Problem Lists.[8] An informed choice concerning contraception is a routine part of women's health care and should be on every woman's Problem List (or perhaps subsumed under Women's Primary Care). Women's Primary Care is discussed further in the **YSC Conclusions** section below.

- One youth had a history of being hospitalized in the past for two weeks with coma and pancreatitis. (AD) Serious illness with coma and organ failure may have long term effects on mental function, health, and wellbeing. I determined that this past medical history was significant enough to be listed as a problem. The plan would be to find out from the youth, family and health care providers what happened, what care he needed after hospital discharge, and any ongoing special needs identified as a result of this illness and hospitalization. Care for youth with significant past trauma or medical illness is discussed further in the **YSC Conclusions** section below.

- An obese youth (DB) was found to be pre-diabetic. While obesity was listed as a problem on the Problem List, pre-diabetes was not. Pre-diabetes might be subsumed under obesity, but I determined that it should be a separate problem

[8] I did not assess whether “no contraception” was listed on Problem Lists for male youth. For female youth there are birth control options, such as hormonal contraception, that could be initiated while they are in DYRS custody. For male youth, education about the risks associated with unprotected sex is important.

because specific medical treatment is available: metformin to support weight loss and normal blood sugar.[9]

- Two youth had a vision screen of 20/30 but abnormal vision was not included on their Problem Lists and no referral to optometry was made. (AS; EW) Four other youth with 20/30 vision did have abnormal vision listed and were referred to optometry. Management of abnormal vision is discussed further in the **YSC Conclusions** section below.

- There was one youth in the sample who had lactose intolerance (MS). He did not provide history of lactose intolerance on admission, but it was noted three weeks later.[10] This condition was addressed in the EHR as a "food allergy" but it was not listed on the Problem List. If the lactose intolerance had been listed on the Problem List, it might have led to additional treatments beside avoidance of lactose. Lactose intolerance is discussed further in the **Discussion of Clinical Management Issues** section below.

Treatment Plans

12/18 youth had all evident problems included on their Problem List and Treatment Plans for all problems. There were five youth with incomplete Problem Lists (detailed above) plus one additional youth with a listed problem without a Treatment Plan.

I assessed the development of treatment plans for those problems that were included on the Problem List. 17/18 sampled youth had plans for every problem that was listed on admission and most of those plans were effectively initiated during the first few weeks in care.[11]

- One youth had been shot multiple times six months prior to admission with injuries to his neck and several limbs. (MB) His history of multiple gunshot wounds was listed as a problem, but there was no meaningful plan to obtain more information about what ongoing care he may have needed for orthopedics, orthotics, physical therapy (PT), occupational therapy (OT), speech therapy, or chronic disability resulting from these injuries.

  In addition to seeking hospital records, the Treatment Plan should have included obtaining more history from the youth and his parents regarding these injuries and follow-up needs identified at that time.

[9] Obesity management was ordered (*i.e.*, diet, exercise, weights, etc.) but no follow-up at chronic care clinic was ordered, so the Treatment Plan was incomplete / inadequate.
[10] Because this problem was not known to medical staff at the time of admission, this youth is not counted among the five youth with incomplete Problem Lists in this section.
[11] As noted above, some youth had evident problems that were not listed on their Problem Lists.

Treatment Plan Implementation

9/18 youth had Problem Lists with all evident problems included, Treatment Plans for each problem, and Treatment Plans were implemented for all evident problems. Among the 9 youth who did not have a Treatment Plan implemented for all evident problems:

- 5/10 youth had one or more evident problems not listed on their Problem Lists and thus a Treatment Plan was not implemented (CR, AS, AD, DB, EW).

- 1/10 youth had all evident problems listed on the Problem List, but no Treatment Plan was developed for one problem (MB).

- 4/10[12] youth (one of whom also had an evident problem not listed on the Problem List) had a listed problem with a Treatment Plan that was not implemented (DB, DP, TG, DM).

- A youth (DB) with obesity (and pre-diabetes) had initial orders for obesity management, but was not referred to the chronic care clinic for support and follow-up assessments for management of weight loss through diet and exercise.

- A youth (DP) with G6PD deficiency was not counseled by the dietitian about diet needs of his condition.[13] On admission, this youth had an Alert posted to avoid certain medicines and foods to prevent hemolytic episodes. He was also referred to the dietitian for education and counseling regarding foods that can precipitate a hemolytic episode. He was seen by the nutritionist, but she did not address dietary restrictions for people with G6PD deficiency.

- For one youth (TG) who needed immunizations, the parent or guardian could not be reached to request consent at the time of admission. There were no follow-up efforts to obtain consent.

- Another youth (DM) had parental consent on admission for needed immunizations, but no immunizations had yet been given three months after admission at the time of this review.[14]

An additional six youth were referred to optometry for assessment of abnormal vision screening (i.e., the problem was included on the Problem List and a Treatment Plan was developed), but none were ever seen by an optometrist. While the referral at the time of admission might be a good Treatment Plan for abnormal vision screening, it was

[12] One youth appears in two categories and therefore the numerators sum to 10, but only nine youth are implicated.
[13] Glucose-6-phosphate dehydrogenase (G6PD) is an enzyme that participates in human metabolism. There is an inherited condition where the body makes too little G6PD, called G6PD deficiency. People with G6PD deficiency may break down red blood cells rapidly (a hemolytic episode) when exposed to certain drugs or foods.
[14] The vaccine was ultimately administered over three months after the youth's admission. This supports my recommendation that NPs write orders for any treatment not administered at the time of admission.

ineffective, as the health program was unable to provide the optometry services. This is discussed further in the **Conclusions** section below.

YSC Conclusions

In this section I will try to address some of the more significant issues raised in this review of the Medical Intake process at the YSC.

Health Care Needs of Women

There does not appear to be a routine approach to well women's care: no detailed gynecological history is obtained, there is no offer of pelvic exams, there is no cervical cytology screening even for youth with history of other STDs, and apparently no offer of contraception.

The DYRS policy on Contraception and Family Planning[15] explicitly states that youth should be educated about family planning, and hormonal contraception should be made available upon request.

> **Issue:** No routine primary care for women is offered or provided at Intake.
>
> **Recommendation:** Pelvic exams and contraception are routine aspects of Women's Primary Care and should be included in the DYRS health program. This is discussed further in the **Clinical Management** section below.

Vision Testing and Optometry

8/18 youth had abnormal vision screening. Six youth were 20/30; one youth was 20/40; and one youth was 20/60. 6/8 youth were referred to optometry (two youth with 20/30 were not referred). None of the eight youth with abnormal vision, including the six youth who were referred were seen by optometry. For example, one youth had 20/60 vision screening. (JF) He was referred to optometry on 5/18/22. He was released from DYRS custody over three months later and had not seen optometry prior to release, three months after admission. Because on-site optometry services are essentially unavailable on a timely basis, optometry referral is not an adequate Treatment Plan for youth with abnormal vision screening.

Also, I believe all youth with abnormal vision screening, and certainly those with 20/40 vision or worse, require additional history from the youth and family regarding vision problems and glasses.

> **Issue:** Forty four percent of youth in the sample required optometry services; however, no optometry services were provided to any youth in the sample.

[15] See footnote 4.

Recommendation: If youth cannot be evaluated timely by on-site optometry, then timely access should be made available off-site in the community. This is particularly important for youth with the worst vision screening results, such as the two youth in the sample with 20/40 and 20/60 vision.

Ongoing needs of youth with history of significant trauma or serious medical illness

One youth in the sample had recent hand trauma and his acute follow-up care was managed well at the YSC.

Two other youth in the sample had past major trauma or past serious medical illness requiring prolonged hospitalization. I found little or no additional history was obtained for these youth regarding continuing disability, chronic pain management, or need for orthopedic, medical specialty, OT, PT or Speech services.

Such significant past health problems can have residual chronic effects including physical disability, pain, and PTSD. A recent Perspective article in the New England Journal of Medicine[16] discussed the importance of approaching traumatic injury as a chronic condition. The same logic applies to significant medical illness.

Issue: For youth with past history of serious illness or significant trauma, more attention is needed to chronic health needs resulting from those events.

Recommendation: Past major health events such as significant trauma or serious medical illness should be listed on the Problem List because there are often associated chronic health needs. Additional history regarding past follow-up plans and current needs are necessary to make an adequate Treatment Plan. Needed special services and medical or surgical follow-up should be provided.

Emphasis on acute needs; less attention to chronic needs

I observed that the Medical Intake process is generally well organized and complete. However, the gaps observed tend to be aspects of health care that are related to chronic health needs. Inadequate history of vision problems or glasses and inadequate access to optometry services were observed. I observed limited attention to significant past trauma or serious medical illness. Contraception services were not provided to sexually active young women. I would also include inattention to overdue hearing screening among the chronic needs gaps as well.

Issue: Chronic health needs are overshadowed by the acute care, intake and release services required in a rapid turnover detention center.

[16] "From Survival to Survivorship - Framing Traumatic Injury as a Chronic Condition" (NEJM 387:581-583; August 18, 2022).

Recommendation: Some youth have ongoing chronic health needs that require better assessment and management. Despite the fact that most admissions to the YSC stay less than two weeks, still there are currently many youth in care for months or years. Their long-term chronic health care also needs to be well organized, complete, and effective.

Review of Continuity of Care at the Time of Transfer to New Beginnings

Health goals at the time of transfer from one secure residential program to another include: continue care without interruption including necessary medicine; update or complete documents, labs, or screening tests required by the agency health program; and identify health problems in need of ongoing management.

The goals of this review include:

- Determine the quality and completeness of the transfer receiving process at NB;
- Develop recommendations to improve the transfer receiving and continuity of care process.

Standards

I identified the routine required elements of the intake medical assessment in the DYRS health policies that specify what to do at intake and how often they are to be done. The DYRS Transfer Screening Policy[17] explicitly states that at the time of transfer health staff "shall (1) identify any missed initial assessments; (2) schedule any required assessments...." This is an objective measure, as each required element is either up to date, due, or overdue. At transfer any missing, due, or overdue elements should be identified and addressed.

I also referred to the EHR screen that is essentially a guideline for the "Medical Intake 7 day follow-up visit". This screen provides program standards for when a required element is "due". It states that a test within 3 months of its expiration date should be repeated on admission. I have applied this standard to the review of tests done at the time of transfer.

The Problem List is a tool for keeping track of the active and chronic health problems. Everything of importance to the youth's ongoing health program should be listed. I used my clinical experience and training to assess the adequacy of the Problem Lists, Treatment Plans and implementation of those Plans.

[17] See footnote 5.

Methods

Relevant DYRS policies were reviewed, including: Intake Screening,[18] Health Assessment,[19] Medication Management,[20] Contraception and Family Planning,[21] Transfer Screening,[22] and Continuity and Coordination of Care.[23] Policy does not require the STD tests (Chlamydia, Gonorrhea and Trichomonas) to be repeated at transfer.

Relevant sections of the EHR were reviewed. I developed record review checklists to document my observations of the content or completeness of:

- the Transfer Sending (TSEND) and Transfer Receiving (TREC) notes;
- the most recent Medical Intake or Overnighter medical screening (with additions) prior to the transfer;
- new Problems listed at the time of transfer based on the date the problem was entered;
- new Orders entered at the time of transfer based on "Chart Maintenance" notes written on the day of transfer;
- medical and nursing services provided during the first month at NB based on review of the EHR notes within that timeframe;
- for those with chronic care needs, Chronic Care Clinic appointments at NB following transfer; and,
- Medicine Administration Records (eMAR) regarding continuity of medicine at the time of transfer

In general, my review followed the required steps listed in the Transfer Receiving screen (TREC) in the EHR. The most recent Medical Intake (or Overnighter Medical Screening that was converted to a medical intake) was reviewed. Required immunization records, lab tests, TB, vision and hearing screenings were located in the EHR to determine if they were up to date, due, or overdue. Test results were reviewed to identify abnormal findings in need of follow-up.

The sample for this review was all youth transferred to NB during March, April, May and June 2022. There were 18 youth transferred to NB during this time frame.

Using the observations made while reviewing the health records of the sample youth, I developed three Tables to present my findings:

- **NB Table 1** presents observations regarding up to date, due or overdue required immunization records, labs and screening tests at the time of transfer;

[18] Intake Screening, policy no. V.e.2. (NB), eff. April 19, 2016.
[19] See footnote 2.
[20] See footnote 3.
[21] See footnote 4.
[22] See footnote 5.
[23] See footnote 6.

- **NB Table 2** presents observations regarding management of abnormal labs and screening tests at the time of transfer;

- **NB Table 3** presents observations regarding management of the Problem List and Treatment Plans at the time of transfer.

Observations of the Transfer Sending (TSEND) Notes

I do not have access to the data entry screens to see exactly which sections are completed by the EHR system using existing data and which are completed by the nurse. Based on my review, it appears that much of the TSEND note is filled out automatically by the EHR following routines programmed into the system, including the sections on allergies, active problems, current medicines, and open orders.

Sections that appear to be completed by the nurse include: preparation of medicines for transfer, a narrative overview of the patient's needs, and maybe portions of a field called "Follow-up care."

Some TSEND notes were prepared days (or even weeks) prior to transfer. However, all were signed off by a nurse on the day of transfer. One (KB) was initially completed 23 days prior to transfer and probably should have been redone rather than signed off on the day of transfer three weeks later. Data that is three weeks old in the "Current Vital signs" section is not "current" and should not be acceptable. Medicines, allergies, active problems, or other aspects of care or health needs may also have changed in the interim.

Issue: TSEND notes prepared days or weeks before transfer.

Recommendation: TSEND notes should be prepared on the day of transfer with truly current vital signs, medicines and active problems.

The Allergies section was always completed. Allergy lists on the EHR are not always properly updated, as the abbreviation "NKA" (No Known Allergies) often remains on the list after a food allergy has been entered.[24]

The list of Current Medicines was always completed by the system. Only medicines ordered for regular administration (usually daily) are listed. Medicines ordered to be given PRN (as needed) are <u>not</u> listed, such as the albuterol rescue inhaler prescribed for youth with asthma. The result is that important PRN medicines necessary for asthma management do not appear on the TSEND list.

[24] I also noted that several youth requested sick call after admission to NB to claim they had seafood allergies. Perhaps retaking the allergy history at the time of transfer to NB would improve the accuracy and completeness of the allergy list. On the other hand, the timing of these complaints also suggests that youth may have been coached by other residents at NB to report seafood allergy to avoid having to eat the fish on the NB menu.

Issue: Orders for necessary "as needed" (PRN) medicines are not included on the TSEND medicine list.

Recommendation: PRN medicines should not be excluded from the TSEND medicine list. All current medicine orders should be included on the TSEND medicine list.

The "Medicines prepared for transfer" section was always checked "Yes".

The "Overview" section was sometimes not completed at all. Sometimes this section was used to document COVID vaccine status. I think it would be useful for the staff at NB to have the COVID vaccine status documented on TSEND routinely. Accurate COVID vaccination status requires reviewing all the vaccine cards in the system, as I observed one youth whose community vaccine card was documented and yet, another one was started when a vaccine or booster was given at the YSC.

The Current Vital Signs section was always completed. For those TSEND notes prepared days in advance, this information is out of date and needed to be updated. I could not tell whether or not the vital signs were updated on these notes.

The "Follow-up Care" section seems to almost always list the date of a recent tuberculosis skin test (TB test). This appears to be automatically completed by the EHR system using the most recent TB Test Result note in the system. In only one case was a need for care actually listed in this section. That was an upcoming appointment with an allergist to test for aspirin allergy. (KB)

Observations of the Transfer Receiving (TREC) Notes

I do not have access to the data entry screens for TREC. Only some notes listed the items "Received" with the youth, such as medicines or a COVID vaccine card. It appears this field is on the TREC entry screen, but often it is left blank.

There should be a uniform approach to the "Received" field by all health staff. I think it is most appropriate to list the medicines received with the youth and to note any necessary medicines that were not received.[25] I do not know if perpetual inventory and daily count sheets for controlled substances are sent with the medicines. If so, those should also be documented to have been Received.

Issue: Medicine and physical documents received at transfer are not consistently listed on the TREC note.

[25] In the sample only one prescribed medicine was not received. That was "Sleepy time" tea prescribed for sleep. (ED)

Recommendation: All medicine and documents received with the youth should be routinely recorded on the TREC note. If no medicine or documents are received, it should be noted to avoid any ambiguity.

In most cases the TREC note was completed by a nurse practitioner (NP). In a few cases it was completed by a nurse (RN).

The following TREC sections were checked "Yes" in all charts: Chart reviewed, TSEND reviewed, Medical intake reviewed, Allergies reviewed, Problems reviewed, Medicines reviewed. I could not confirm most of these statements. However, I did review the most recent Medical Intake myself to see if anything due or overdue was there to be found and acted upon. Observations based on my Medical Intake review are documented in **NB Table 1** and discussed in the next section.

The "Youth Concerns" section was always completed. The receiving RN or NP almost always stated there were "None". In one case this section stated "None" but there was also a "General Note" (GEN) on the same date that the youth stated he was having severe dental pain. (KB)[26]

The Vital signs section was always completed. I observed that the recorded vital signs were normal in all cases.

The Youth Appearance, Youth Response to Transfer, and Transport Staff Concerns sections were always completed. Youth were observed to be normal and accepted transfer without issues. There were no transport staff concerns.

Mental Health Risk questions were completed in all cases and none indicated any acute risk of self-harm, hallucinations or desire to meet with a counselor.

The Plan and Disposition was always to admit to the general population, often via a two week stay in a COVID quarantine unit. The one young woman in the sample was admitted directly to the girls' unit after consultation with the Medical Director.

Open Orders were the same as those recorded on the TSEND note, plus any new orders entered by the receiving RN/NP.

Response at Transfer to Missing, Due, or Overdue Immunization Records, Labs, and Screening Tests

NB Table 1 sums up information obtained from the sample health records regarding the timeliness and completeness of the intake immunization record, labs and screening tests required by policy.

[26] He was given Tylenol and referred to Dental Sick Call, apparently without any indication of urgency. He was not scheduled to see the dentist until 11 days later (and refused care at that time).

Timeliness standards are derived from DYRS Policy, except for the Immunization Record for which no DYRS standard was identified in policy. For the purpose of this review, an immunization record within the past year was deemed to be adequate. Some guidance for completion of this type of intake record review is provided on the screen for the Medical Intake 7-day Follow-up note. That screen instructs reviewers to order a new test if it is due, overdue, or expiring within 3 months. This guidance is explicit for TB test (annual), syphilis (RPR) and HIV (every 6 months); and vision and hearing (annual). I have applied the same standard to the CBC (annual) also.[27]

In the sample, 9/18 youth (50%) were up to date on all required tests at the time of transfer. Several of these youth were brought up to date at the YSC prior to transfer.

Only one youth's DC immunization record was more than one year old. In general, immunizations are assessed consistently at YSC Intake, consent is requested from a parent, and immunizations are given when parental consent and youth assent are obtained.

In total, nine youth (50%) had one or more due or overdue lab and/or screening test. Youth admitted to the YSC more than 5 months prior to transfer to NB were most likely to have due/overdue tests. For only one of the nine records with a missing element were all due/overdue elements identified and ordered at the time of transfer at NB (GJ).[28] For eight of nine youth with one or more due or overdue lab and/or screening test, all missing elements were not remedied at the time of admission. Six of those youth with missing elements continued to have some due/overdue elements 30 days after transfer.(MD, PD, DG, FG, DS, KW)

The RN/NP chart review at TREC is failing to identify and remedy more than half of the due/overdue required tests.

In the YSC sample discussed above I found very few missing required tests overall. But some tests were missed at the time of admission, and a few of those were not remedied later at the YSC. In the NB sample discussed here, some of the overdue tests had in fact been overdue since admission to the YSC, as might have been expected. For one youth the CBC due on admission to the YSC was never done prior to transfer to NB. For another, it was an overdue TB test that was not done on admission to the YSC nor prior to transfer. These overlooked due/overdue tests are supposed to be found and remedied at the YSC during the Medical Intake 7-day follow-up visit. Sometimes they are not. Then later they should be identified and remedied at the time of transfer to NB.

Both the Medical Intake 7-day follow-up review at the YSC and the TREC review at NB are failing to identify needed labs and tests. The review appears generally to be done

[27] One could argue that it is not necessary to obtain RPR and HIV tests every six months if the youth has been in custody continuously. On the other hand, sex and sexual abuse do occur in secure institutions. Three charts were found for which the sole due/overdue elements were RPR and HIV based on the 6-month requirement.

[28] The RN who saw the youth completed an exemplary TREC form for youth GJ on 5/10/22.

pro forma, without the attention to detail that a true record review requires. On the other hand, even the best RNs and NPs are surely missing things because the documentation is scattered and must be sought out in the EHR. I found sometimes they are difficult to locate. Better system support is needed to improve performance by making it easier to find the test dates and results. (See **Comments and Recommendations** below.)

Issue: Missing, due or overdue required immunization records, labs and screening tests are not consistently identified and remedied at the time of transfer to NB.

Recommendation: RN/NP staff at NB should be more thorough in their review of the status of required labs and screening tests. Better system support is needed to make it easier for them to find the most recent labs and screening tests and review the results.

Response at Transfer to Abnormal Labs and Screening Tests

NB Table 2 sums up observations of the sample health records regarding the response to abnormal labs and screening tests at transfer and at NB thereafter. Three youth had two abnormal labs. In NB Table 2 each abnormal lab result is assessed separately which results in 21 rows for 18 youth in the sample.

- 5/18 (28%) youth in the sample had NO abnormal labs or screening tests;
- 3/18 (17%) youth in the sample had abnormal labs or tests already listed on the Problem List, Treatment Plans had been developed and initiated, and NO action was necessary at transfer (EC, EH, AW).
- 3/18 (17%) youth in the sample had abnormal labs or tests and RECEIVED necessary action at the time of transfer (MD, DG, GJ).
- 7/18 (39%) youth in the sample had abnormal labs or tests but DID NOT RECEIVE necessary action at transfer (TB-one of two abnormal tests, ED, PF, FG, MP2-the second of two abnormal tests, DS-who had **two** abnormal tests, and KW-abnormal lab after transfer).

Abnormal TB test: One youth had a history of a previous positive TB test without active disease (Latent TB) in 2018. Latent TB was already on the Problem List at the time of transfer to NB. He had received preventive therapy in 2018-19 under direction of the infectious disease clinic at Children's National Medical Center. Treatment was documented in the DYRS EHR. No action was needed at the time of transfer to NB.

Abnormal vision: In the sample, 5/18 (28%) youth had abnormal vision screening at the YSC and four of those five youth had abnormal vision on their Problem List prior to transfer. For the one youth whose abnormal vision was not on his Problem List at the YSC, the problem was identified upon transfer to NB (MD), a repeat vision screening was abnormal, and he was referred to optometry. At the time of my review, five months had elapsed since the referral and the youth still had not been assessed by an optometrist.

Among the four youth with abnormal vision on their Problem List prior to transfer to NB, one had replacement glasses ordered at the YSC and delivered at NB after transfer. The other three already had been referred to optometry while at the YSC. At the time of my review they had been waiting between 3 to 9 months for their optometry appointments. Several youth requested sick call after transfer to NB to have their blurry vision addressed. In several prior reports I observed that optometry referral is not an effective way to address abnormal vision screening at the YSC and NB.[29]

Issue: Youth with abnormal vision screening are referred to optometry but many are never assessed and never receive needed glasses.

Recommendation: The optometry program for both the YSC and NB needs careful review to determine why some youth are never seen. This issue has been observed repeatedly over many years without evidence of improvement.

Abnormal CBC: In the sample, 5/18 (28%) youth had an abnormal CBC on the record at the time of transfer (TB, ED, GJ, MP2, DS).[30] Only one of the five was identified at NB upon transfer.

- Abnormal CBC with low neutrophil count (neutropenia) was observed in 4/18 youth in the sample. In one case these abnormal values were identified at NB upon transfer and a repeat CBC was ordered (but never done) (GJ). For a different youth (KW) the abnormal CBC was obtained after transfer to NB, so it was not there for evaluation upon the youth's admission to NB. DYRS facility health staff rarely recognize and evaluate neutropenia as a problem. This condition is discussed further below under **Clinical Management Issues.**

- Abnormal CBC with increased red cell count (high RBC), decreased red cell size (low MCV), and/or decreased red cell hemoglobin (low MCH) without anemia (normal HGB and HCT) was observed in 2/18 sample youth. Neither was recognized or evaluated upon transfer to NB. This pattern of abnormal results is also discussed further below under **Clinical Management Issues**.

Issue: Abnormal complete blood count results are not consistently identified and addressed at Intake at the YSC nor upon transfer to NB.

Recommendation: Training for RN/NP staff in interpretation of the CBC is needed. Pediatric hematologists at Howard University who are experts regarding neutropenia and hemoglobin abnormalities in African-American youth could be consulted regarding clinical management of abnormal results such as neutropenia and

[29] I also observed that some optometry referrals appear to have been deleted in the EHR system without the youth ever being seen. I looked at current orders for youth with documented optometry referral who were not yet seen by the optometrist. I found some of these youth had no current optometry order. Perhaps there is a system algorithm in the EHR that deletes orders after a specified time frame, which could be a partial explanation why some youth with prior referrals are never scheduled for the optometrist.
[30] A sixth youth with an abnormal CBC was identified after transfer (KW).

microcytic (small red cells), hypochromic (low red cell hemoglobin) red cells without anemia.

Abnormal Liver tests: One youth in the sample had persistently abnormal liver tests. It is unusual to find an adolescent with persistently abnormal liver tests. This abnormal lab result had been identified previously and was already on the Problem List. I found no Treatment Plan for this Problem other than to repeat the labs. No plan was developed at TREC. Abnormal liver tests is discussed further below under **Clinical Management Issues**.

Pre-diabetes: Youth with mild elevations of blood glucose and hemoglobin A1C are considered to be pre-diabetic. Two youth in the sample were pre-diabetic. Pre-diabetes was already on their Problem Lists at the time of Transfer to NB. One was referred to chronic care clinic at NB upon transfer for management of obesity and pre-diabetes. The other youth had no Treatment Plan for pre-diabetes upon transfer to NB other than repeat A1C.

Abnormal Lipids: One youth had persistently elevated blood fats (lipids) with high Total and LDL cholesterol. Elevated lipids was already on the Problem List at the time of transfer to NB. This youth had not yet received diet education regarding a low saturated fat/ low cholesterol/ high fiber diet. No referral to the dietitian was made upon transfer to NB. Finally, 6 months after transfer to NB a dietitian referral was made for the needed education and counseling.

Issue: Persistently abnormal lab tests without adequate Treatment Plans.

Recommendation: Youth with persistently abnormal lab tests should be routinely reviewed with the agency Medical Director for guidance on management of these problems. Clinical guidelines for initial management of problems like neutropenia, abnormal liver tests, pre-diabetes, or high cholesterol will support more consistent and complete care for these youth at DYRS.

Response at Transfer to New or Unlisted Problems

NB Table 3 lists new or unlisted problems I found reviewing the sample youth health records and the response upon transfer to NB and during the first month after transfer.

- 9/18 (50%) youth had no new or unlisted problems at the time of transfer;
- 5/18 (22%) had an abnormal CBC that was not recognized/ not on the Problem List;
- 1/18 (6%) had abnormal vision not on the Problem List;
- 1/18 (6%) had seasonal allergies that were not on the Problem List;
- 1/18 (6%) had lactose intolerance that was not on the Problem List;
- 1/18 (6%) had gynecological problems that were not recognized or listed on the Problem List.

Issue: Active health problems not added to the Problem List upon transfer to NB.

Recommendation: RN/NP staff should routinely update the Problem List upon transfer to NB based on their review of labs, screening tests, and the allergy list.

Abnormal CBC: The abnormal CBCs were discussed briefly in the previous section. Clearly, if the abnormality was not identified at the YSC, it would not be listed on the Problem List upon a youth's transfer to NB. For one youth, an abnormal CBC was identified by NB staff upon transfer but was not added to the youth's Problem List. For another youth, the abnormal result was obtained at NB after transfer, but also never listed on the youth's Problem List. There remained four more youth with abnormal CBCs that were not listed on the youth's Problem List and there was no Treatment Plan.

Seasonal allergies: One youth had seasonal allergies and was receiving medicine to relieve his symptoms. However, his seasonal allergy was not on the Problem List and was not added upon transfer to NB.

Lactose intolerance: One youth had lactose intolerance. This was identified upon transfer to NB and "no milk" was placed on the allergy list. Lactose intolerance was not added to the Problem List, no detailed diet history regarding milk and milk products was obtained, and no plan other than "no milk" was considered at TREC. Lactose intolerance is discussed further below under **Clinical Management Issues**.

Women's Health- Contraception: The one young woman in the sample was sexually active but had no hormonal or other contraception plan. No contraception in a sexually active female is a health problem that needs to be addressed. "No Contraception" was not listed on the Problem List and there was no Treatment Plan for this problem developed at Intake at the YSC or upon transfer to NB. Contraception is discussed further below under **Clinical Management Issues**.

Women's Health- High risk for cervical dysplasia: The same young woman had been admitted to YSC five times in the past 18 months. At every admission she was diagnosed with chlamydia or trichomonas or both. This history of STDs places her at extraordinarily high risk for repeated HPV infection, cervical dysplasia and subsequent cervical cancer at a young age. The DC immunization record shows she received two doses of HPV vaccine, which is partially protective. However, only the most common strains of HPV that cause cervical cancer are included in the vaccine. Pelvic exams and cervical cytology testing for high risk adolescent youth is discussed further below under **Clinical Management Issues**.

Overall NB Conclusions

Regarding continuity of care at the time of transfer, I observed there were several aspects of the program that were very successful:

- All youth had a TSEND note;
- All youth had a TREC note;
- All medicines were continued without missing a dose;
- Chronic care clinic appointments continued as planned.

Regarding weaknesses in the transfer process, I observed that:

- Medicines received with the youth at NB were not consistently listed in the TREC note;
- Due or overdue labs and screening tests were missed in 50% of sample youth;
- Abnormal labs or screening tests were missed in 16% of sample youth;
- Active problems in need of follow-up were missed in 33% of sample youth.

Discussion of Clinical Management Issues at Both Facilities

Some of my observations and recommendations at both facilities are concerned with issues of clinical management such as interpretation of test results, additional history, further assessment, consultation with the Medical Director and specialist referrals. I have brought those issues together in this section for further discussion.

Abnormal CBC with low neutrophil count: Neutropenia (low neutrophil count) can be a benign ethnic or familial condition that is more commonly found among people of West African heritage. It can also occur as a temporary response to acute viral infection, or it can be a pathological condition resulting from medicine side effects, cancer chemotherapy or bone marrow disease. Every youth with low neutrophil count needs further evaluation including history of recurrent infections (throat, sinus, bronchi, lungs) or inflamed gums (gingivitis); and periodic repeat CBC tests. Youth with signs or symptoms of pathological neutropenia (recurrent infections; absolute neutrophil count below 750; medicine toxicity) need referral to hematology for further evaluation.

Abnormal CBC with increased red cell count (high RBC), decreased red cell size (low MCV), and/or decreased red cell hemoglobin (low MCH) without anemia (normal HGB and HCT): I believe this pattern of findings is most consistent with an inherited abnormal hemoglobin such as beta-thalassemia trait or perhaps sickle cell trait. Hemoglobin electrophoresis is needed to determine if either of these conditions is present. Both are more commonly found among African-American youth and a youth with either one would be at some risk for having a child with sickle cell disease (Hgb S/S or Hgb S/beta-thal).

Abnormal Liver Tests: Abnormal liver function can be a side effect of some medicines including treatment for latent TB, some psychiatric medicines, and alcohol abuse. Chronic hepatitis B or C infection can also cause this. The sample youth with

persistently elevated liver tests was also obese and is at risk for development of fatty liver disease. I think further evaluation by a liver specialist is needed for this youth.

Pre-Diabetes: Weight loss, exercise, and sometimes medicine (metformin) are used to manage pre-diabetes in overweight youth. Nutrition education and group activities for effected youth in need of weight loss can be helpful. An organized weight loss program using an evidence based short term intervention (YSC detained youth) or longer term intervention (long stay YSC and NB youth) could be implemented.

Abnormal Lipids: Youth with elevated blood lipids are at long term risk for heart disease and stroke. High blood lipids in children are generally managed with diet and exercise. Nutrition education is key to the dietary component. Reduced dietary animal fat and cholesterol as well as increased dietary fiber are common recommendations. Medicine may be needed for youth with familial lipid disease.

Lactose intolerance: Lactose intolerance is a fairly common problem in the general population. It is rarely listed on the Problem Lists in the DYRS facilities, little or no additional history regarding reactions to dairy products or food avoidance habits is documented, and I found that no consideration was given to making Lactaid tablets available. These gaps in care suggest the need for a nursing guideline on assessment and management of youth with lactose intolerance.

> **Issue:** Management of lactose intolerance.
>
> **Recommendation:** Develop a nursing guideline for assessment and management of youth with lactose intolerance that includes: additional history regarding reactions to dairy products, food avoidance habits and use of Lactaid tablets at home. Compensate for lactose intolerance by making menu substitutions routinely available. Educate youth about the condition. Make Lactaid tablets available when effected youth want to eat some dairy foods, ice cream for example. Assessment and follow-up of abdominal symptoms in youth with lactose intolerance should always consider lactose intolerance as a contributing factor to their symptoms.

Contraception: For sexually active female youth, lack of contraception is a health problem. All sexually active female youth need to make an informed choice about contraception. They should be educated about contraception, offered the varieties of hormonal and other forms of contraception, and provided with whatever method of birth control they choose. Even though agency policy requires that contraception be addressed, I observed no attention at all to contraception needs in the sample charts at the YSC or NB. This is a significant deficit in the health program and must be addressed.

Pelvic exams and cervical cytology: Current recommendations for the general adolescent population is to defer cervical cytology testing (Pap tests) until the early 20s. For the general population there are good reasons to defer exams and testing. But I believe this standard should not be applied to the highest risk adolescent women who

have frequent STDs, exchange sex for money, drugs, housing or other needs, or have many different sexual partners. Those youth are at extraordinarily high risk to be infected with HPV, develop cervical dysplasia, and later cervical cancer at a young age. Many young women admitted to juvenile justice residential programs are in these higher risk categories and in my opinion would benefit from pelvic exams and cervical cytology tests. Those with abnormal results should be informed of their risk, followed up clinically, and treated if found to have High Grade cervical lesions. I am not recommending aggressive surgical management of minor cervical lesions, but rather clinical follow-up, perhaps every 6 to 12 months, for repeat cervical cytology testing.

Issue: Important women's health problems are frequently omitted at Intake to the YSC or upon transfer to NB.

Recommendation: Pelvic exams and contraception are routine aspects of women's primary healthcare and should be included in the DYRS health program. DYRS needs a clearly stated policy and clinical guidelines regarding women's health that discusses a routine approach to contraception for every sexually active young woman, offer of pelvic examinations, and cervical cytology screening (Pap test) for higher risk youth.[31]

Obesity management: Five youth in the samples were overweight or obese. One of those youth was pre-diabetic. With such a large number of overweight or obese youth, the weight control/weight loss program should be a priority. Obese youth are referred to the dietitian, often have "no added sweets" diet orders, sometimes have regular weights obtained, and are referred to chronic care clinic for obesity management. But I see few positive results and the weight loss program needs improvement. As stated above, more nutrition education and group activities for youth in need of weight loss can be helpful.

Issue: Improve the weight loss program.

Recommendation: Consider providing more nutrition education on weight control. Group activities for youth in need of weight loss can be helpful ("biggest loser" competitions, sports teams, support group meetings, etc.). Organized programs

[31] I understand that the current consensus professional recommendation is not to provide cervical cytology screening for the general population of women under 21. However, youth in detention are not the general population and some are at particularly high risk for sexually transmitted diseases including HPV that causes cervical cancer. When I monitored results of cervical cytology in about 200 New York state delinquents I found that 18% had abnormal or atypical results, an extraordinarily high number of positive findings.

Because the prevalence of abnormal cervical cytology was so high, we continued cervical cytology screening even though it was no longer recommended for the general population. The goal was to educate patients with positive findings about their risk and encourage routine follow-up. No surgical procedures were contemplated unless the cytology showed a High-Grade lesion.

using evidence based short term interventions (YSC detained youth) or longer-term interventions (long stay YSC and NB youth) are needed.

Observations of EHR System Issues

Some of my observations and recommendations are impacted directly by some EHR system issues. I have brought those issues together in this section for further discussion.

Expiration dates on the Problem List: I observed that chronic or continuing problems were dropped from the "active" Problem List due to an "end date" that was attached to the problem, perhaps at the time it was first entered. It appears that an end date of one year from date of entry may be entered automatically by the system.

While it is correct to have end dates for acute, self-limited problems (headache; sore throat; etc.) asthma that is chronic and essentially incurable should not have an end date at all on the Problem List. I observed that asthma was not on one Problem List, yet the youth was being treated for asthma continuously. I reviewed his entire Problem List, not just those deemed "active" that are displayed automatically on the opening screen of the EHR. In fact asthma had been entered many times, but had "expired" and was no longer on the "active problems" list.[32] This should not happen to problems that have no practical end date.

Specialist Referrals Dropped from the System: Several youth in the sample with optometry referrals were still waiting for optometry 3 to 9 months after the referral was made. To check the date of their original referral, I looked up the youth's pending orders on the Fusion Order Manager. In some cases I did find the pending optometry referral. However, in one record where I had good evidence from other documents in the record that a referral was made, and no optometry visit had occurred, I found no pending order for optometry. Is the EHR system programmed to automatically drop orders after a certain amount of time has passed? If so, this could help explain why some youth are not given an appointment for optometry even though many months have passed since the referral was made.

System support for routine chart review: Routine chart review is mandatory at every Medical Intake, at the Medical Intake 7-day follow-up visit, and when a youth is transferred from the YSC to NB. Part of that review is to determine if required immunization records, labs or screening tests are due or overdue. Yet there is no single, easily accessible source for this information in the EHR. Several different folders in the Documents area of the EHR must be consulted to find the dates and results of these tests. It is not a simple task. Yet the information sought is simple: date of most recent test and results of the test cross referenced to the frequency requirements defined in Policy for each test.

[32] EH had asthma listed five or more times with expiration dates. Finally, someone entered it without an expiration date so now it stays active and shows up on the current active list.

Perhaps a guideline on a search routine for locating the most recent tests and results in the EHR would help. For example, the practice of recording vision and hearing tests on the medical intake note means they do not show up in the Vision and Hearing folder in the EHR. So, to check the date and results of a vision test, first check the Vision and Hearing folder under Documents; but it may also be necessary to check Medical Intake or Overnighter Screening notes too, as some vision tests are recorded only there. This practice should stop. Similarly, sometimes the administration of the TB test is documented only on the Medical Intake note, and then would not appear in the TB test folder.

Even more helpful would be an accessible, up to date Table or Report generated by the EHR system that simply lists the most recent immunization record, labs and screening tests, with their results and flags the ones that are due or overdue.

Issue: Some EHR system issues are impeding health services at the time of transfer.

Recommendation: (1) Review and improve systems that: automatically set end dates when health problems are entered; and may automatically delete orders for specialist referrals after some specified time has passed without an appointment. (2) Develop systems to make dates and results of required labs and screening tests more readily accessible to RN/NP staff who provide Intake, 7-day Intake Follow-up, Transfer Receiving and Annual Health Assessment services.

TABLE 1: Elements of the Intake Medical Assessment:

Observations of the YSC Sample

Patient:	EH	AS	CR	JW	KK	MS	AD	RH	CB	MB	JF	MP	DB	TG	DM	DP	AU	EW
Meds taken at home	1	0	0	0	1	1	1	0	0	0	0	1	0	0	1	0	0	0
Meds continued	1	na	na	na	1	1	1	na	na	na	na	0	na	na	1	na	na	na
History (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Physical Exam (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Allergies (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Immunizations (within 1 month?)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Chlamydia (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Gonorrhea (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Trichomonas (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
HIV (within 6 months)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Syphilis (within 6 months)	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1
Complete Blood Count (within 1 year)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Urine Dipstick (this admission)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Urine Pregnancy (this admission)	na	1	0	na	na	na	na	na	1	na	na	na	na	na	na	na	na	na
TB skin test (within 1 year)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Vision screen (within 1 year)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing screen (within 1 year)	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	0
7 day follow-up	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1

1= present 0= absent

TABLE 2: Elements of the Intake Medical Assessment:
Summary of Observations of the YSC Sample

Element	Completed	Comment
Medicine history	18/18	6/18 were taking medicine at home.
Medicine continued on admission	5/6	Of those taking medicine at home, 5/6 were continued on their medicine.
History (this admission)	18/18	12/18 had important positive findings by history, an indicator of good history taking skills.
Physical Exam (this admission)	18/18	6/18 had positive findings on examination that confirmed the history or identified new problems.
Allergy History (this admission)	18/18	9/18 had history of drug or food allergy. For 1/9 no Alert was sent on the day of admission.
Immunizations (within 1 year?)	18/18	12/18 needed recommended immunizations. 1/12 no consent requested. 8/11 parents **refused** consent for needed immunizations.
Chlamydia (this admission)	18/18	5/18 tested positive for chlamydia. They were treated and later tested negative.
Gonorrhea (this admission)	18/18	3/18 tested positive for gonorrhea. They were treated and later tested negative.
Trichomonas (this admission)	18/18	1/18 tested positive for trichomonas. They were treated and later tested negative.
HIV (within 6 months)	18/18	0/18 tested positive for HIV.
Syphilis (within 6 months)	17/18	0/17 tested positive for syphilis. One youth did not have a current syphilis test within 6 months.
Complete Blood Count (within 1 year)	18/18	One youth had an abnormal CBC with low white blood cell count and low neutrophil count. Further evaluation was planned. Hematology workup and referral was interrupted by his early release.
Urine Dipstick (this admission)	18/18	10/18 had positive initial urine tests with normal follow-up tests a few days later after hydration.
Urine Pregnancy (this admission)	2/3	There were three young women in the sample. 1/3 did not have a pregnancy test on admission.
TB skin test (within 1 year)	17/18	One youth had last TB test more than one year prior to this admission; no new test was done. One TB skin test was read late (9 days after it was planted; should be read at 2 to 3 days).
Vision screen (within 1 year)	18/18	8/18 had abnormal vision screening. Six were 20/30. One 20/40. One 20/60. Only six were referred to optometry. None were seen by optometry.
Hearing screen (within 1 year)	15/18	3/18 hearing screens were not done. 0/15 were abnormal.
7 day follow-up	17/18	1/18 seven-day follow-up visits was not done. 4/17 of the 7 day visits failed to identify and remedy missing hearing screening (3) and overdue TB skin test (1). Some missing elements were remedied in other records.

TABLE 3: YSC Observations of the Problem List and Treatment Plan

Patient	Problem List Complete ?	Problems not listed on admission	Problems listed had Plans ?	Plans implemented ?
EH	1	na	1	1
AS	0	sexually active- no contraception; vision 20/30 - no referral	1	1 (should have had optometry)
CR	0	sexually active- no contraception	1	1
JW	1	na	1	1
KK	1	na	1	1 (optometry)
MS	1	na	1	1
AD	0	Follow-up re: history of coma, pancreatitis, 2 wk hospitalization	1	1
RH	1	na	1	1 (optometry)
CB	1	na	1	1
MB	1	na	0	0 No meaningful plan re: multiple gun shot wounds 6 mos ago
JF	1	na	1	1 (optometry 20/60)
MP	1	na	1	1
DB	0	Pre-diabetes - no plan; no ccc referral	1	0 Obese - no ccc referral
TG	1	na	1	0 No consent sought for immunizations (optometry)
DM	1	na	1	0 Needed immunizations; consent obtained; none given. (optometry)
DP	1	na	1	0 nutrition did not address G6PD deficiency
AU	1	na	1	1 (optometry 20/40)
EW	0	Vision 20/30 - no referral	1	1 (should have had optometry)

1 = complete 0 = incomplete (optometry noted for tracking purposes)

NB Table 1: Due/Overdue Records, Labs and Screening Tests at Transfer

Test	Immunization Record	Syphilis (RPR)	AIDS (HIV)	Blood Count (CBC)	Tuberculosis (TB)	Vision	Hearing	Comment
Standard	**Annual**	**6 mos**	**6 mos**	**Annual**	**Annual**	**Annual**	**Annual**	
Youth Name								
KB	1	1	1	1	0	1	1	Overdue TB test missed at Intake and TREC. Done later at NB.
TB	1	1	1	1	1	1	1	NONE due or overdue
EC	1	0	0	1	1	1	1	Due RPR and HIV missed at TREC. Done at NB later.
MD	1	0	0	0	0	0	0	Due/overdue HIV, RPR, CBC, Vision ordered at TREC. Due TB and Hearing not done.
PD	1	1	1	1	1	0	0	Overdue Vision and Hearing missed at TREC.
ED	1	1	1	1	1	1	1	NONE due or overdue
PF	1	1	1	1	1	1	1	NONE due or overdue
DG	0	0	0	0	0	0	0	Due RPR, HIV, CBC ordered at TREC. TB, Vison, Hearing not done.
FG	1	0	0	1	1	1	1	Due RPR + HIV missed at TREC.
SH	1	1	1	1	1	1	1	NONE due or overdue
EH	1	1	1	1	1	1	1	NONE due or overdue
GJ	1	1	1	1	0	1	1	Overdue TB found and remedied at TREC.
CL	1	1	1	1	1	1	1	NONE due or overdue
MP2	1	1	1	1	1	1	1	NONE due or overdue
CR	1	1	1	1	1	1	1	NONE due or overdue
DS	1	0	0	1	1	1	1	Due RPR and HIV missed at TREC.
AW	1	1	1	1	1	1	1	NONE due or overdue
KW	1	1	1	0	1	1	1	Overdue CBC not done

0 = Test due or overdue

1 = Test not due or overdue

NB Table 2: Abnormal Lab and Screening Tests at Transfer

Youth	Abnormal Test	Abnormal Result	Found at TREC	Action Taken at TREC	Status Now (9/2022)
KB	None				
TB	CBC	Low WBC; low neutrophils	no	none	Missed at Intake and TREC. Not found or evaluated yet
TB	Vision	20/40	On Problem List already	none needed	Optometry referral 6/2022. Not seen yet after 3 months. Were glasses brought from home?
EC	Vision	20/70; 20/50	On Problem List already	none needed	Replacement glasses ordered at YSC; Delivered 5/3
MD	Vision	20/30	YES	Retest ordered	Optometry referral 5/2022. Not seen yet after 5 months.
PD	None				
ED	CBC	Low neutrophils	no	none	Missed at Intake and TREC. Not recognized or evaluated yet
PF	Metabolic panel; A1C	Increased glucose; increased A1C	On Problem List already	none	No management plan for pre-diabetes other than repeat A1C. Not overweight or obese.
DG	Metabolic panel; A1C	Increased glucose; increased A1C	On Problem List already	Referred to Chronic Care for Pre-diabetes	Chronic care clinic follow-up for obesity and pre-diabetes
FG	Metabolic panel	Increased liver tests	On Problem List already	none	No management plan for obese youth with persistently elevated liver tests
SH	None				
EH	TB	Positive test 2018; neg CXR; completed preventive therapy	On Problem List already	None needed	Latent TB; Treated 2018; Treatment documented in DYRS EHR.
GJ	CBC	Low neutrophils	YES	Ordered repeat CBC	Repeat CBC never done; Not evaluated yet
CL	None				
MP2	CBC	RBC high; MCV and MCH low; NOT ANEMIC	On Problem List inaccurately as "Anemia"	none	Not evaluated yet. Needs hemoglobin electrophoresis.
MP2	Vision	20/70	On Problem List already	none needed	Optometry referral 12/2021. Not seen yet after 9 months.
CR	None				
DS	CBC	RBC high; MCH low; MCV low normal; NOT ANEMIC	no	none	Abnormal lab not recognized or evaluated yet. Needs hemoglobin electrophoresis.
DS	Lipids	Increased Total and LDL cholesterol	On Problem List already	none	Needed diet counseling; finally ordered 9/14/22
AW	Vision	20/30	On Problem List already	none needed	Optometry referral 3/2022. Not seen yet after 6 months
KW	CBC **(done after transfer)**	Low neutrophils	na	na	Abnormal lab not recognized or evaluated yet at NB.

NB Table 3: Management of the Problem List and Treatment Plans at Transfer

Youth	Evident Problem Not Included on Problem List After Transfer to NB	On Problem List at Transfer?	Identified at TREC?	Listed at TREC?	Mgmt Plan at TREC?	Addressed Later/ Comment
KB	None					
TB	Abnormal CBC (neutropenia)	No	No	No	No	Neutropenia missed at Intake and TREC
EC	None					
MD	Abnormal vision	No	Yes	No	No	Retested after transfer. Added to Problem List and referred optometry
PD	None					
ED	Abnormal CBC (neutropenia)	No	No	No	No	CBC repeated later at NB, but not added to Problem List
PF	None					
DG	None					
FG	Seasonal allergies	No	Yes	No	Yes	Getting medicine. Not on Problem List.
SH	None					
EH	None					
GJ	None					
CL	Lactose intolerance	No	Yes - Allergy list	No	Yes	"No milk" on allergy list; not listed on Problem List.
MP2	Abnormal CBC (high RBC; low MCH; low MCV; not anemic)	No	No	No	No	No
CR	No contraception;	No	No	No	No	No
CR	High risk for cervical dysplasia	No	No	No	No	No
DS	Abnormal CBC (high RBC; low MCH; low MCV no anemia)	No	No	No	No	No
AW	None					
KW	Abnormal CBC (neutropenia) after transfer to NB*	na	na	na	na	First CBC, done after transfer, showed neutropenia. Not recognized, not added to Problem List. No management plan.

* Because KW's CBC was done at NB after transfer, it is not relevant to the Transfer receiving review.

Attachment 2

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
450 H Street NW, Washington, DC 20001

MEMORANDUM

TO:	Mark Jordan Executive Director, Office of Independent Juvenile Justice Facilities Oversight (OIJJFO)
FROM:	Trey Stanback, DYRS Interim Director Dr. Khandra Tyler-Beynum, DYRS Medical Director
DATE:	February 14, 2023
RE:	Response to the OIJJFO's Report Regarding Comprehensive Medical Assessments, First Dose Administration, and Psychotropic Medication Management at the Youth Services Center and New Beginnings Youth Development Center

Background

In response to the vacature of the Jerry M. litigation, the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) was established in 2021 to regularly monitor and publicly report on DYRS's management of the District of Columbia's two secure juvenile facilities – New Beginnings Youth Development Center (NBYDC) and the Youth Services Center (YSC).

This memorandum reflects the Department of Youth Rehabilitation Services (Agency) response to the OIJFFO's report titled, "Comprehensive Medical Assessments, First Dose Administration, and Psychotropic Medication Management at the Youth Services Center and New Beginnings Youth Development Center" (Report).

Agency Response

The Agency would like to thank the OIJJFO for the thorough analysis in developing this Report. Regarding the recommendations in this Report, the Agency agrees with and will implement:

- ***Recommendation 1:*** *To promote more complete comprehensive intake health assessments, nursing staff should write orders for all due or overdue tests, labs, screening, and other procedures that are not completed during the initial comprehensive exam.*
- ***Recommendation 2:*** *Improve access to vision services at both facilities.*
- ***Recommendation 3:*** *Offer contraceptive health services to female youth.*
- ***Recommendation 4:*** *Enhance the quality of 7-day follow up and New Beginning intake quality assurance functions.*
- ***Recommendation 8:*** *Review the PMMP and Medication Management Policy to update as new information concerning the medications has been published.*

- ***Recommendation 11:*** *Implementation of the PMMP should be reviewed periodically as part of the DYRS's interval continuous quality improvement programs.*

The Agency also partially agrees with the following recommendations:

- ***Recommendation 10:*** *When ordering psychiatric medications, doctor's notes should reflect that they completed or reviewed current labs and assessments and review the periodic assessments required by the PMMP. Similarly, doctor's notes should reflect the monitoring expectation for the ordered medications.*

Agency Response: The Agency agrees to the extent that clinical notes should reflect a review of labs and include a pertinent plan for medication monitoring.

However, the Agency disagrees with the following recommendations:

- ***Recommendation 12:*** Pelvic exams and cytology screenings should be offered to all female youth.

Agency Response: The Agency disagrees with the rationale to routinely offer pelvic exams and cytology screenings for adolescents as this is not the standard of care under the current guidelines supported by the United States Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics (AAP). For at least a decade, the USPSTF and the AAP recommend deferring these examinations to age 21 or when clinically necessary. Consideration of the natural course for most HPV infections in immunocompetent hosts (transient), paired with the observations that it normally takes several years to progress from infection to cancer, do not support this recommended approach. There is no clear benefit to cancer risk reduction or outcomes by performing screenings before 21 years of age. Furthermore, one must consider the risks of patient harm caused by over-screening, especially since HPV infections are quite common among those who are sexually active.

- ***Recommendation 13:*** Readminister any TB skin test that results in an induration of less than 10mm. Alternatively, consider using an FDA-approved TB blood test.

Agency Response: The Agency's current practices related to the screening and testing of tuberculosis align with the Centers for Disease Control (CDC) recommendations in correctional settings. DYRS's two secure facilities are currently considered minimal TB risk facilities. The current TB screening and testing program is also successful. In the past, blood tests were cost-prohibitive to administer. As fiscal resources permit, the Agency will revisit our practices related to the TB testing modality utilized.

- ***Recommendation 14:*** *Reduce false positive urine test results by having youth void their bladders twice when obtaining urine specimens for initial dipstick screenings.*

Agency Response: The Agency disagrees with this recommendation. In addition to the urine point of care (POC) urinalysis, urine specimens collected from youth are used to detect common sexually transmitted infections (STIs). For STI testing, it is best to collect the first catch urine in a patient who has not recently voided. The recommended approach of encouraging youth to dilute their urine before collection (in an effort to decrease the likelihood of abnormal urinalysis results) may negatively impact the sensitivity of STI test results. As an alternative, the Agency will consider discontinuing routine urinalysis and instead reserve the use of POC urinalysis on a prn basis as clinically indicated. This practice better aligns with the current standards of care endorsed by the American Academy of Pediatrics.

Conclusion:

Thank you again to OIJJFO for your thorough analysis and for allowing the Agency the opportunity to provide feedback on the Report. We look forward to our continued work together.

Attachment 3

[redacted]
Male DOB: [redacted] [redacted]

[redacted]2022 - **Transfer Sending: Transfer - Sending**
Provider: [redacted] **NP**
Location of Care: DCDYRS - Youth Services Center

Sending Transfer

Receiving Facility: New Beginning
Transfer Type: Facility to Facility Transfer
Reason: Programming

Allergies
* NKDA (Critical)
* SEASONAL ALLERGY (Critical)
* NKA (Critical)
* IBUPROFEN (Severe)
* BANANA (Moderate)

Active Problems
Ankle joint pain, Right (ICD-719.47) (ICD10-M25.572)
Overweight (BMI 25-29.9) (ICD-278.02) (ICD10-E66.3)
Dry skin, generalized (ICD-701.1) (ICD10-L85.3)
Low HDL cholesterol (ICD-272.5) (ICD10-E78.6)
Pre-diabetes (ICD-790.29) (ICD10-R73.09)
Sleeping difficulties (ICD-780.59) (ICD10-G47.8)
Marijuana use (ICD-305.20) (ICD10-F12.10)
ADHD, combined (ICD-314.01) (ICD10-F90.2)
Substance abuse (ICD-305.90) (ICD10-F19.10)
Asthma, mild, intermittent (ICD-493.90) (ICD10-J45.20)
Allergies, seasonal (ICD-477.0) (ICD10-J30.2)
Immunization delay (ICD-V15.9) (ICD10-Z28.9)
Encounter for routine child health examination with abnormal findings (ICD-V20.2) (ICD10-Z00.121)

Current Meds
* MUSCLE RUB TO RIGHT ANKLE BID; Route: EXTERNAL
* ACETAMINOPHEN 325MG TABLET 2 bid prn; Route: ORAL
* SLEEPY TIME TEA qhs prn; Route: ORAL
* AQUAPHOR OINTMENT qhs PRN; Route: EXTERNAL
ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% INH NEBU (ALBUTEROL SULFATE) 4 Times daily prn; Route: INHALATION
* MELATONIN 5 MG TAB 3 QHS PRN; Route: ORAL
AMPHETAMINE-DEXTROAMPHET ER 30 MG ORAL XR24H-CAP (AMPHETAMINE-DEXTROAMPHETAMINE) QD; Route: ORAL

Medications Prepared for Transfer?: Yes
Overview of Acute & Chronic Problems: Mom declined cvoid vaccine
CC- Obesity clinic F/u [redacted]2022 and repeat A1C also scheduled
F/u Allergy immunology clinic for Aspirin challenge (? reactions to Ibuprofen)

Classifications

Last Documented Complete Medical Intake: [redacted]2022 4:59:32 AM

[redacted]
Male DOB: [redacted]

Last MAYSI Suicide Ideation Screen: 0 ([redacted]2022 5:21:09 AM)
Last MAYSI Thought Disturbance Screen: 3 ([redacted]2022 5:21:09 AM)

Current Vital Signs:

Current Weight: 161.4 lbs**BP Position:** Sitting
Sitting BP: 119 / 64

Pulse rate: 72 **Respirations:** 27

Follow Up Care

Date PPD Read: [redacted]2021 5:38:40 PM
PPD Results in mm: 0

Open Orders:
Orthopedic Surgery [OS]
Behavioral Health (DYRS) [BHDYRS]
Diet - No concentrated sweets [Sweets]
Psychiatric Follow Up YSC [PsychFUYSC]

Transfer Status

Is the youth appropriate for transfer to the receiving facility (allergies, MAYSI, medications)? : Yes

Electronically signed by [redacted] **DNP on** [redacted]**2022 at 3:43 PM**

Attachment 4

[redacted]
Male DOB: [redacted]

[redacted]2022 - Transfer Receiving: Transfer - Receiving
Provider: [redacted] DNP
Location of Care: DCDYRS - Youth Services Center

Transfer Reception Screening

Receiving Facility: DCDYRS- New Beginning
Date/Time: [redacted] 2022 5: 34 PM**Sending Facility:** DCDYRS - Youth Services Center
Has chart review been completed? Yes
Transfer-Sending form reviewed? Yes
Medical Intake reviewed? Yes
Allergies reviewed? Yes
Problems reviewed? Yes
Medications reviewed? Yes
Describe any concerns that the youth had during the transfer from the sending facility: Youth denies any concern or complaint.

Classifications

Last Documented Complete Medical Intake: [redacted]2022 4:59:32 AM
Last MAYSI Suicide Ideation Screen: 0 ([redacted]2022 5:21:09 AM)
Last MAYSI Thought Disturbance Screen: 3 ([redacted]2022 5:21:09 AM)
Additional MAYSI Information: MAYSI-2 Cpmpleted, SI: 0, TD: 0

Current Vital Signs:

Current Weight: 166 lbs **Current Height:** 65.5 inches
BP Position: Sitting
Sitting BP: 100 / 54
Temperature: 98.9 degrees
Temperature site: Temporal**Respirations:** 19 **Pulse Ox%** 100

Observations

Describe the yout'92s general appearance: Youth is alert, oriented to person, place, time, and pain stimulus. Ambulatory without difficulty. In no distress. Able to make [redacted]needs known. Denies any complaint. Appears happy, comunicates freely and in a friendly manner.
Describe the yout'92s response to being transferred/incarcerated: Youth denied any complaint or concer, says he preferred NB to YSC.
Did the transport team indicate any specific concerns about the yout'92s physical or mental health?: No concern reported by the transportation team.
Are you thinking of hurting or harming yourself?: No
Do you hear voices or see things that others do not? : No
Do you want to talk to someone more about any problems bothering you?: No

P: Plan/Disposition

General Population
Comments: Notified the Shift Commander that youth is not COVID-19 vaccinated, therefore needs to quarantine for 14 days.

Orders

Open Orders
Orthopedic Surgery [OS]
Behavioral Health (DYRS) [BHDYRS]

[redacted]
Male DOB: [redacted]

[redacted]

Diet - No concentrated sweets [Sweets]
Psychiatric Follow Up YSC [PsychFUYSC]
Chronic Care [CC]
Return to Clinic in 60 days [RTC60]
Hemoglobin A1c [001453]

Electronically signed by [redacted] **DNP on** [redacted] **2022 at 9:02 PM**