EXHIBIT A
(2017-03-22-x)

?3/22/17 Closing the ML without noting Heat no date visible

To: Golding, Michael@CDCR
Cc: [redacted]@CDCR
Subject: RE: ML EOP Psychiatry Rule Change Proposition

No we don't tell them about every change. Since they use our numbers I do let them know when we make a major change that has a significant impact. For example, the change we are making regarding 5 day follow ups. We can certainly change the rule back to 30 days if you believe that speaks more to the spirit of "monthly". The problem is and has always been that the Program Guide is not always written clearly – at least not as concretely as needed for computer rules. For example Does monthly mean once per month? Does it mean every 30 days?

Do you want us to change it back?

[redacted] Ph.D., CCHP
[redacted]
DHCS Mental Health Program
[redacted] (cell)
[redacted] (desk)

From: Golding, Michael@CDCR
Sent: Wednesday, March 22, 2017 3:01 PM
To: [redacted]@CDCR
Subject: RE: ML EOP Psychiatry Rule Change Proposition

HI,

Thanks. I hope you are doing well.

My rules would be very different. I have no doubt the court experts would not agree with me!!

But thank you for letting us look at this. [redacted] is reporting that even the 4th visit or so for an inmate is 45-days after the last visit, even if the patient does not move to another locations. If she is right about that, that does seem to very clearly violate the program guide. So check this out: If a psychiatrist sees somebody 7 weeks after their last appointment (three weeks after the program guide says for once monthly EOP visits), we will report to the court that the person is 6/7 or 86% compliant. Hmmm. That does not pass the sniff test. Three weeks late for mandatory monthly appointments and we are 86% compliant? That seems weird!!

I am more concerned that if we change a rule, and if that rule has a large impact on our numbers and what we report, we probably ought to let the court know. I am now wondering whether they have seen all of the updates that could have made *a significant change* in the way we report our numbers. Have we done a lot of this? It may be that this change has no real impact on the numbers. If so, then I get it. I just think that should be evaluated.

Has anything we are giving the court for staffing incorporated these new rules, without at least looking at how much the reporting will change the % compliance that we are telling the court? It started in December. For example we are looking at EOP Timely Compliance between 8/1/2016 and 1/31/2017 which would utilize the new rule (presumably) for two months.

By the way, this has nothing to do with my personal opinion! If it were up to me, I would group all CCC and EOP together and maybe separate inmates by level of violence, so that the non-violent can have access to safety (and create) a reason not to be violent. I personally would give clinicians far more choice about how frequently to see patients, etc. and judge outcomes (30 day readmission rates, rates of hospitalization, etc.) But it is not up to me.

Best,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Wednesday, March 22, 2017 2:14 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR
Subject: FW: ML EOP Psychiatry Rule Change Proposition

Here is the original request. Some of the issue is the computer is literal. PG says "Monthly". We previously translated that to every 30 days, since most months have around 30 days. Julie's email below though explains how the new rule actually can also meet that requirement. Let us know if you disagree and want it changed back. I thought I consulted with you on this (at least I should have). We always try to keep the rules as true to the PG rules as possible while also ensuring patient care is the focus.

[redacted], Ph.D., CCHP
[redacted]
DHCS Mental Health Program
[redacted] (cell)
[redacted] (desk)

From: [redacted]@CDCR
Sent: Wednesday, March 22, 2017 2:09 PM
To: [redacted]@CDCR
Subject: Fwd: ML EOP Psychiatry Rule Change Proposition

Sent from my iPhone

Begin forwarded message:

From: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Date: December 5, 2016 at 1:57:15 PM PST
To: "CDCR MHPolicyUnit@CDCR" <m_MHPolicyUnit@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Subject: ML EOP Psychiatry Rule Change Proposition

Good Afternoon,

I would like to propose an update to the EOP Psychiatry rule. Per the Program Guide 12-4-9 a psychiatrist will see each EOP inmate patient monthly...We have found that the rule of once every 30 days makes it very difficult for the doctors to schedule their caseloads to be seen if they have time off, etc. Most doctors would like to continue continuity of care, therefore when they take a week off they would be able to schedule the inmates to be seen around that week and still remain compliant, without needing backup coverage. I spoke with Dr. Leidner and we discussed how the rule could be rewritten to still remain compliancy within the once a month rule.

Psychiatrist contact due within 45 days or within one calendar month of the previous contact, whichever is shorter.

An example:
If an inmate was seen on March 20th, then he would have to be seen by April 30th which would not exceed one month, or if an inmate was seen on the 1st of the month, then he would need to be seen by the 15th of the next month in order to be compliant with the once monthly rule.

The way the rule is written now, once every 30 days, actually makes for more than 12 contacts per year. An inmate seen on the 1st, would have to be seen on 30th of the same month.

With psychiatry retention so low here at CHCF, we are trying to find ways to make the job more appealing to the doctors and I think that with this small change in the verbage, it would help them to feel like we are trying to work for them and help make their jobs more manageable.

[redacted]
AGPA
[redacted]
CHCF Mental Health - CCHCS
[redacted] pager
[redacted]@cdcr.ca.gov

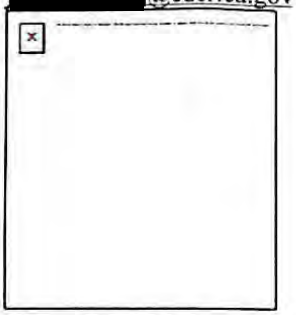


EXHIBIT B
(2017-03-30)

Mental Health Staff Psychiatrist Staffing vs Compliance
2/23/2017

SITES	Total Allocated January 2017	Total Filled January 2017*	Precent Vacant January 2017**	Timely Psychiarty Contacts[1] (Access to Care Banner) 8/1/2016-1/31/2017***	Psychiatrist Continuity of Care[2] (Quality of Care Banner) 8/1/2016-1/31/2017***	MAPIP[3] (QM Dashboard-Pop Health Management) 8/1/2016-1/31/2017***	MH Mission
ASP	5.0	3.6	71%	100%	N/A	100%	CCCMS
CCI	7.0	4.5	65%	91%	N/A	93%	CCCMS
CCWF	12.0	7.5	63%	97%	99%	92%	FEMALE
CHCF	24.0	17.4	73%	72%	88%	92%	MHCB/EOP/CCCMS
CIM	12.0	10.5	88%	99%	N/A	95%	RC/CCCMS
CIW	9.0	8.4	93%	97%	75%	98%	FEMALE
CMC	19.3	15.5	80%	99%	97%	98%	MHCB/EOP/CCCMS
CMF	17.0	13.7	81%	99%	89%	97%	MHCB/EOP/CCCMS
COR	14.5	9.6	66%	84%	58%	98%	MHCB/EOP/CCCMS
CRC	6.0	5.5	92%	93%	N/A	99%	CCCMS
CTF	7.0	4.3	61%	92%	N/A	95%	CCCMS
DVI	4.5	5.1	113%	100%	N/A	99%	RC/CCCMS
FSP	3.0	3.4	112%	97%	N/A	96%	CCCMS
HDSP	6.0	4.0	67%	99%	N/A	94%	CCCMS
KVSP	9.0	4.2	47%	88%	59%	95%	EOP/CCCMS
LAC	13.0	8.6	66%	86%	55%	89%	EOP/CCCMS
MCSP	17.0	14.7	86%	87%	84%	90%	EOP/CCCMS
NKSP	11.0	7.0	64%	98%	N/A	93%	RC/CCCMS
PBSP	4.0	3.0	76%	86%	N/A	92%	CCCMS
PVSP	5.0	4.0	81%	98%	N/A	100%	CCCMS
RJD	16.0	12.2	76%	78%	73%	96%	EOP/CCCMS
SAC	22.0	11.7	53%	66%	81%	89%	MHCB/EOP/CCCMS
SATF	17.0	9.0	53%	95%	93%	96%	MHCB/EOP/CCCMS
SCC	3.0	3.0	100%	100%	N/A	96%	CCCMS
SOL	7.5	4.0	53%	84%	N/A	92%	CCCMS
SQ	9.0	13.3	148%	99%	98%	96%	RC/CCCMS
SVSP	13.0	5.8	45%	78%	90%	90%	EOP/CCCMS
VSP	11.0	7.0	63%	73%	81%	99%	EOP/CCCMS
WSP	10.0	7.1	71%	98%	N/A	78%	RC/CCCMS

Footnote

1 Percentage of patient-weeks during which patients were up-to-date on their required psychiatry contacts.

2 Percentage of psychiatrist contacts seen by the most frequent provider.
All psychiatry contacts seen in person during the 5 months before the start of the reporting period through the end of the reporting period (6 months total) for any patient who has been EOP in the same housing program at the same institution, without interruption, for the past six months.

3 Percentages in this column represent the average compliance for MAPIP Measures 1A-1G. These percentages do not capture MAPIP Measure 1A-1G that are baseline, 3 months or triggered by medication dose changes.

* Includes registry

** Percentage compliance < 90% highlighted in red

*** Percentage compliance > 90% highlighted in green

EXHIBIT C
(2017-03-5591-14)

clinical psychologists, psychiatrists, licensed social workers, and therapists (including registry and supervisors). (Tebrock Decl. ¶ 10.) These staff serve patients in approximately 6,900 Enhanced Outpatient Program beds, 450 Mental Health Crisis Beds, and eighty-five Inpatient Acute or Intermediate Care beds. (Tebrock Decl. ¶ 9.) Over the past year, inmates were seen timely by their primary clinician ninety percent of the time, by their psychiatrist ninety percent of the time, and by their treatment team ninety-eight percent of the time. (Tebrock Decl. ¶ 10.)

To ensure medication monitoring for its patients, CDCR uses a detailed monitoring tool titled "Medication Administration Process Improvement Process." This tool facilitates necessary and appropriate systemic monitoring of medication management, including blood levels, for the following types of medication: (1) Antipsychotics; (2) Clozapine; (3) Mood Stabilizers, including Carbamazepine, Depakote, and Lithium; and (4) Antidepressants. CDCR clinicians generally maintain high levels of compliance, with most institutions achieving compliance above the ninety-fifth percentile. (Tebrock Decl. ¶ 11, Exh. 1.) CDCR's systemic, statewide compliance with its medication-administration measures totals ninety-six percent over the past twelve months. (*Id.*)

CDCR clinicians, and particularly its psychiatrists, provide quality treatment at very high compliance rates despite the current staffing vacancies. (Tebrock Decl. ¶ 8.) Eleven institutions with staffing-vacancy rates under ninety percent achieved greater than ninety percent compliance for psychiatry services. (*Id.* & Exh. 2.) For example, at Avenal State Prison, despite a twenty-nine percent vacancy rate for psychiatrists, the clinical staff achieved a 100 percent compliance rate for timely psychiatry contacts and medication management. (*Id.*) Similarly, the institution with the highest staffing-vacancy rate for the period, Salinas Valley State Prison, with only 5.8 of thirteen psychiatrist positions filled (a fifty-five percent vacancy rate), again showed satisfactory mental health performance indicators in certain areas: ninety percent for psychiatry continuity of care, ninety percent for medication management and seventy-eight percent for timely psychiatry contacts. (Tebrock Decl. ¶ 8, Exh. 2.)

In describing vacancy rates, the Staffing Report mischaracterizes CDCR's staffing as "static." (Staffing Report at p. 6.) In reality, over the past three years as the population requiring

EXHIBIT D
(2017-04-12-1316hrs)

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Wednesday, April 12, 2017 1:16 PM
To: Golding, Michael@CDCR
Subject: New EOP compliance rules
Attachments: CHCF January 2017 compliance EOP.pdf

4/12/17 B

Hi Dr. Golding,

I have been reviewing Dashboard Psychiatrist Contact Timeframes compliance data, and ran across something that I thought would be of interest. As previously discussed, the EOP follow-up appointment timeframe was changed in December to "within 45 days or within one calendar month of the previous contact, whichever is shorter", rather than 30 days. I discovered in Dashboard that this means if someone is seen by the end of the following month, they are considered compliant. For example:

Patient A is seen 12/2/16 for a routine EOP psychiatry appointment. Current Due Dates states his next appointment is due by 1/16/17 (45 days later). The compliance checks are done every Sunday, so on 1/1/17, 1/8/17, 1/15/17, 1/22/17, and 1/29/17 the program checks to see if the psychiatry contact timeframe is still within compliance. Since the next appointment is due 1/16/17, the compliance checks on 1/1, 1/8, and 1/15 all state "Yes" for compliance. However, the compliance checks on 1/22 and 1/29 also state "Yes" for compliance, because it is not yet the end of "one calendar month", if you interpret that to mean the entire month of January. This means the compliance for this EOP patient would be 100%, despite going almost 2 months (from 12/2/16 to 1/31/17) without being seen by psychiatry.

Further, let's say this patient was seen on 12/2/16, and his next appointment was not until 2/3/17. The weekly compliance checks in December and January would all state "Yes" for compliance. The first compliance check in February is on Sunday, 2/5/17, so all of the weekly compliance checks in February and March will state "Yes" for compliance because they'll see he was seen on 2/3/17. This EOP patient was seen twice in four months, yet is listed as 100% compliant for all of those months.

Last note, since compliance is checked weekly, the longer you can stretch that compliance interval, the less impact being out of compliance will have. If you use a strict 30 day deadline, and are late in seeing the patient by 1 week, your compliance percentage will be 4/5 = **80%** (because you have 4 weeks of compliance, and 1 of non-compliance). If you stretch the interval of compliance to almost two months (e.g. from 12/2/16 to 1/31/17) like the compliance reports are currently doing, and again are late in seeing the patient by 1 week, your compliance percentage is now 9/10 = **90%** (because you have 9 weeks of compliance, and 1 of non-compliance).

Hopefully this all makes sense. I attached a compliance report for one of the yards at CHCF for the month of January, and highlighted the relevant entries to help clarify the above. Let me know if you have any questions.

[redacted], **MD**
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

EXHIBIT E
(2017-05-11-1447hrs)

May 11, 2017 1

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Thursday, May 11, 2017 2:47 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: FW: EHRS MA question for [redacted]

from what I understand there are powerplans that have all PG required appointments embedded in the business rules so the schedulers (OTs) schedule the appts within PG timelines. So a separate order to schedule an appt sounds like it may be a workaround and having a separate scheduling process puts the PG timelines at risk.
[redacted]

Hi [redacted]

With all due respect, I think we should also loop in the psychiatrist, [redacted], as you suggest looping in the psychologist [redacted]. I know you don't know [redacted] well, which is perhaps why you did not think of him.

No one knows more about psychiatry scheduling (using the EHRS) than [redacted]. I know you don't know the history of the implementation of the EHRS and the effect it had on our psychiatry team, but there is quite a history. Psychiatrist don't practice as efficiently in CDCR because we utilized the CDCR model of psychologist as clinical-decision-maker and psychiatrist as consultant, when designing the EHRS for psychiatrists.

[redacted] was placed under the leadership of psychologists and outnumbered in decision making by psychologist (as consultants and at HQ) 3-4 to 1 when deciding about multiple EHRS decisions involving psychiatric clinical practice in CDCR. [redacted] was forced to train psychiatrists on the EHRS (by himself!!) at 14 institutions, when psychologists had 5-6 people, medical physicians 5-6, nurses had many, etc. He stayed and worked nights, weekends and holidays. There are as many psychiatrists as medical physicians and somehow it was thought OK that psychiatrists should have one representative to cover the whole state. The EHRS leadership team for some reason had little interest in what our HQ psychiatrist ([redacted]) might want or need to help psychiatrists practice in the field or be trained.

[redacted] fought valiantly and by himself to try to enable psychiatrists to have just a little bit of flexibility and efficiency in their EHRS practice, including in utilizing the scheduling functions. The fact that he didn't lose all his battles (I conjecture) will soon become more apparent, as I suspect the efficiency of psychiatrists (in numbers of patients seen per day) will not be as compromised (prelim data suggests) as the compromise in the efficiency of others. [redacted] at some point seemed to get that there were problems with the EHRS arrangement and made and is making welcome changes. You are a very welcome change!

But you are new and I hope you will begin to see [redacted] as a brilliant, kind, talented, and underappreciated resource who can help people with EHRS questions. We have already begun imposing the CDCR psychologist-clinical leader/psychiatrist-consultant-model on DSH, as questions about the EHRS have come up. Even as DSH begins to follow the CDCR model and [redacted] is not the person who primarily is allowed to make decisions about EHRS psychiatry questions at DSH, perhaps you would be willing to loop [redacted] in just at HQ (as you loop [redacted] in), when HQ questions come up and psychologists are determining how psychiatrists will clinically use the EHRS.

Maybe even in the future, it will be relevant that [redacted] knows more about the psychiatric use of the EHRS than anyone else. [This comment is not directed at you, [redacted], I know you are aware of none of this! :-)] I actually think that if we start treating [redacted] as a psychiatric leader when it comes to the psychiatric use of the medical record, our inappropriate psychologist/psychiatrist model may not continue to infect DSH. We can change CDCR for the better and perhaps not damage (much) clinical practice at DSH if we can start at HQ.

May 11, 2017 (2)

I hope this letter is not upsetting. I don't mean it to be. You have been wonderful (really). But there is much behind the angry refusal of all (100%) of our colleagues in the leadership meeting to allow the executive directors of DSH to come to leadership (CMH) meetings. They said explicitly (and you heard) that psychiatrists and other leaders at DSH and CDCR are not and will not be the top leaders of CDCR, so they can't come, while the psychologist (CMH's) can. I said nothing during the meeting.

The problem is that our leadership team is correct in their assessments of the current role of psychiatrists in CDCR. And they essentially explicitly admitted that they expect that the DSH leadership will not really be the leaders like the psychologist chiefs of mental health will, because they don't want the DSH executive directors at the CMH meeting. That's why DSH psychiatrists are so afraid of us. They know (very accurately) exactly what we are. Somehow DSH psychiatrists have been able to guess exactly what our leadership thinks, despite what we say to them in public!

Our leadership team may have made a *faux pas* in their public claims about psychiatry in CDCR and about how they see their DSH colleagues in the future. What they said did not look good (to me and you). But sometimes a *faux pas* occurs when people are caught in the act of telling the truth!

There is also much behind the (per Dr [redacted]) "nuclear reaction" of the CMH's when they heard the news that psychiatrists might be able to make independent clinical decisions about patient care in CDCR, because they no longer would answer to the psychologist CMH's who were empowered to make controversial clinical decisions about patient care. And there is much behind at least one CEO's insistence that there must be one decision maker (the Psychologist Chief of Mental Health), if there is a disagreement about issues, which frequently are clinical issues. Many CEOs and psychologists apparently don't understand the medical practice act, the law, or what good treatment of patients require.

But I am (now) really telling you that [redacted] is good! Please consider [redacted] when you have questions about how psychiatrists should be allowed to clinically use the EHRS. Consider looping him in. I say that not because psychologists can't ably represent psychiatrists. They can and have. There are many wonderful ones in CDCR who have fought very hard to enable psychiatrists and psychologists to mutually assist each other in caring for patients. But in this environment, some of them have not always done so. Just think about how a gentle and brilliant man like [redacted] was treated by the HQ EHRS team last year and you'll get the idea.

I will loop [redacted] into the discussion about scheduling for psychiatric patients in the EHRS, because he still happens to know the most about the issue, even if the psychiatrist is considered the consultant to the psychologist in how the psychiatrist will use the EHRS.

Thanks,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

May 11, 2017 (3)

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

---

From: Golding, Michael@CDCR
Sent: Thursday, May 11, 2017 10:13 AM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: Re: EHRS MA question for [redacted]

Hi,
I think there are medical practice act and licensing board considerations associated with not allowing psychiatrists to have significant impact on deciding when appointments are made.
I am not a lawyer, but my guess is that it is illegal if it has happened. If the EHRS mental health leadership has suggested that we now begin enforcing these types of determinations, I would be surprised Surely they have not!
Dr. [redacted] is pointing out that scheduling is a completely different issue (and mechanical process) than asking for scheduling to occur, which is what psychiatrists (and their MA assistants need to do).
But if the EHRS leadership in mental health and our executives think psychiatrists should not be able to influence this process of when patients should be seen; that is, if [redacted] attempts to allow psychiatrists to make suggestion to OT's about when patients should be scheduled is misguided, please feel free to let me know.
At that point I think we would need to consult CDCR attorneys for further clarification.

Best,
Michael

Sent from my iPhone

On May 11, 2017, at 9:32 AM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

> I am thinking about the many PLO memos for SVSP regarding OTs deciding when to schedule the patients. Not good. I'm not an expert on ehrs but would assume the physician would need to send an order of what they want. [redacted] would know.
>
> Sent from my iPhone
>
> On May 11, 2017, at 9:18 AM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:
>
> > Hi Michael....from what I understand there are powerplans that have all PG required appointments embedded in the business rules so the schedulers (OTs) schedule the appts within PG timelines. So a separate order to schedule an appt sounds like it may be a workaround and having a separate scheduling process puts the PG timelines at risk. I am not an EHRS expert by any means....this is just my understanding.

The agreement with the development of the MA classification with CalHR and the State Personnel Board is that they will not do OT duties, including scheduling. I hope this helps clarify. Thx

[redacted]

May 11, 2017 (4)

From: Golding, Michael@CDCR
Sent: Wednesday, May 10, 2017 3:20 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: EHRS MA question for [redacted]

Hi [redacted]

I was not at the labor table with you so I want to clarify something about the agreement that our negotiators made for the nursing MA's that will help psychiatrists in certain ways.

Creating an order for someone to do scheduling (a completely separate EHRS process) is not considered scheduling, is it?

The MA should be able to do an order for scheduling (but not the scheduling), as directed by the psychiatrist? Right? Otherwise the psychiatrist has to do the orders needed to ask for scheduling, which is a waste of time for the psychiatrist.

It seems obvious to me, but I wanted to double check.

Thanks,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

<image002.jpg>

From: [redacted]@CDCR
Sent: Wednesday, May 10, 2017 3:02 PM
To: Golding, Michael@CDCR
Subject: EHRS MA question for [redacted]

Hi Michael,

When you have a minute, would you be able to ask [redacted] about the details of the "MAs cannot schedule" negotiated in the labor agreement? There are two separate processes, and I am trying to salvage one for our MAs.

Scheduling: As I am beginning to understand in the last 24 hours, MAs cannot actually schedule an appointment. I think this is what was referred to in the MA labor negotiations. That is fine.

May 11, 2017 (5)

Ordering a scheduling order: This is NOT scheduling, as the order is just a request to the scheduler to make an appointment. This is what we want to have the MAs be able to do on behalf of the Psychiatrists. I am flexible on whether they can write the order directly to the scheduler, or write the order for the Psychiatrists and have them co-sign the order.

For whatever reason, this is getting a lot of traction in the last 24 hours. I don't know why.

Thanks,

[redacted]

[redacted], M.D.
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Correctional Health Care Services
California Department of Corrections and Rehabilitation
[redacted] desk
[redacted]@cdcr.ca.gov

<image003.jpg>

<image002.jpg>

EXHIBIT F
(2017-08-32R)

CDCR#	MHPC Discharge Summary?	MHMD Discharge Summary?	Any indication that psychiatrist weighed in on discharge?	Prescribed meds?	Institution	Discharge medication order?	
[redacted]	Yes (8/24/17)	No	**No.** MHMD progress note (8/24/17) states "Plan/Disposition: -Pt to be leaving soon. -Continue full issue and suicide precautions. -Retain in MHCB. -Follow up in 3-4 days or sooner if needed."	No	CHCF	N/A	
[redacted]	Yes (8/21/17)	No	Yes. In Master Treatment Plan on day of discharge PC wrote "Psychiatry notified pt that psychiatric medications are available at CCCMS, if desired." Also, MHMD progress note two days prior to discharge stated patient was stable for discharge at next IDTT.	No	CHCF	N/A	
[redacted]	Yes (8/21/17)	No	**No.** MHMD progress note (8/18/17) states "This man's affect was depressed and suicidal ideas were present." "Continue Zyprexa 40 mg by mouth daily at bedtime number to continue follow-up every 2-3 days."	Yes	CHCF	Yes, on 8/21/17	
[redacted]	Yes (8/10/17)	Yes (8/10/17)	Yes	Yes	CHCF	Unable to assess (encounter deleted)	
[redacted]	Yes (8/29/17)	No	Yes. MHMD progress note (8/29/17) states "D/C to EOP."	Yes	CHCF	Yes, on 8/29/17	
[redacted]	Yes (9/3/17)	No	Yes. MHMD progress note (9/3/17) states "Will be discharged to EOP LOC at next idtt".	Yes	CHCF	Yes, on 9/3/17	
[redacted]	No	No	Yes. MHMD progress note (8/29/17) states "Continue current medication without change with the referral of the patient to EOP."	Yes	CHCF	Yes, on 8/28/17	
[redacted]	Yes (8/17/17)	No	Yes. MHMD progress note (8/15/17) states "Awaiting EOP discharge, continue MHCB for the interim."	Yes	CHCF	Yes, on 8/17/17	
[redacted]	No	Yes (8/30/17)	Yes	Yes	SAC	No	
[redacted]	Yes (8/22/17)	Yes (8/22/17)	Yes	Yes	SAC	No	Psychiatrist wrote the discharge order
[redacted]	No	Yes (9/12/17)	Yes	Yes	SAC	No	
[redacted]	No	Yes (8/28/17)	Yes	Yes	SAC	Yes, on 8/30/17	
[redacted]	No	Yes (8/24/17)	Yes	Yes	SAC	No	
[redacted]	No	Yes (9/5/17)	Yes	Yes	SAC	Yes, on 9/12/17	
[redacted]	No	Yes (8/30/17)	Yes	Yes	SAC	No	
[redacted]	No	Yes (8/29/17)	Yes	Yes	SAC	No	Psychiatrist wrote the discharge order

[redacted]	Yes (8/28/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/28/17	
[redacted]	Yes (8/24/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/24/17	
[redacted]	Yes (8/24/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/24/17	
[redacted]	Yes (8/29/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/29/17	
[redacted]	Yes (8/28/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/28/17	
[redacted]	Yes (8/28/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 8/28/17	
[redacted]	Yes (9/6/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	CMC	Yes, on 9/6/17	
[redacted]	Yes (8/22/17)	No	Yes. MHMD Progress Note (8/22/17) states "Discharge from CTC EOP Facility D PC2602 with 5-Day Follow Up"	Yes	CMC	Yes, on 8/22/17	
[redacted]	Yes (9/14/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	
[redacted]	Yes (9/20/17)	No	**No.** MH MTP states "The IDTT team is in agreement with discharging patient to EOP LOC", but the MHMD Progress Note (dated 9/20/17) does not mention discharging patient, and MHPC Discharge Summary does not mention psychiatry involvement.	Yes	SVSP	No	
[redacted]	Yes (9/22/17)	No	Yes. MHMD progress note (9/22/17) states "Patient to be discharged to the yard."	Yes	SVSP	No	
[redacted]	Yes (9/26/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	
[redacted]	Yes (9/26/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	
[redacted]	Yes (9/21/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	
[redacted]	Yes (9/22/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	
[redacted]	Yes (9/14/17)	No	**No.** No mention in MHPC Discharge Summary, MH Master Treatment Plan, or last MHMD Progress Note.	Yes	SVSP	No	

EXHIBIT G
(2017-09-05-1449hrs)

Sept 5, 2017 1 Discussion On Canning

Gonzalez, Melanie@CDCR

From: Golding, Michael@CDCR
Sent: Tuesday, September 05, 2017 2:49 PM
To: [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]CDCR
Subject: FW[redacted]
Attachments: image001.jpg

Hi,

Please do not forward, copy, print, or discuss unless ethically or legally obligated.
The root cause analysis committee is (correctly) documenting that had the psychiatrist not discontinued the antipsychotics, the event may not have occurred. They go into detail about that. That does not argue that the psychiatrist should not have discontinued the medications.

But it is absolutely also correct to say that had the psychologist called the psychiatrist on a psychotic patient (who was documented to be repeatedly screaming over 4-hours), medications (forced or otherwise) might have saved her eye. They refuse to say that which I find problematic.

Best,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: Golding, Michael@CDCR
Sent: Tuesday, September 05, 2017 1:51 PM
To: [redacted]@CDCR
Subject: Fwd[redacted]

Hi,

Conclusion: Please let me know your thoughts. We could begin a process of elevating these concerns, or we could try to manage important documentation and education locally.

Sept 5 2017 2

I am going to get more information from the CIW [redacted] Dr. [redacted] who has much to say about this case.

At this point, I think it's relatively simple. Some executive overseeing the root-cause-analysis committee actually needs to pursue further investigation or trust the existing documentation. The patient was grossly psychotic (religiously preoccupied) and screaming multiple times for four hours, as documented in the chart. Why nurses would somehow retrospectively not remember that (see Dr. [redacted]'s note below) is remarkable and worrisome.

A simple fix, consistent with the documentation in the chart, is to add a box to the root cause analysis chart saying that we might have prevented the enucleation had the psychiatrist been called about the (documented) many hours of screaming and documented grossly psychotic behavior.

The unwillingness of our psychologists to even consider that the enucleation might have been prevented (had the psychologist called the psychiatrist while admitting a documented screaming and psychotic patient) is quite concerning. This is true even if somehow the psychologist didn't tell the psychiatrist that the psychiatrist didn't need to be called because the patient wouldn't take the medicines.

It speaks to a much more global problem in CDCR about what the "full scope of practice of psychologists" (now being enabled also in our PIPs) in CDCR, means: For practical purposes, it seems to mean that certain psychologists will devalue or refuse to consider medical issues and so practice medicine without a license (by discharging and admitting patients without medical considerations). Of course this is dangerous for our patients.

Multiple of my team members (including me when I worked briefly at CHCF) know from personal experience that certain psychologists very much try to enable this unsafe practice. (I was personally instructed by a psychologist at CHCF to write discharge meds on a patient whom I didn't know. Worse, the psychologist writing the discharge knew absolutely nothing relevant about the patient he was discharging. And at the time and FAPP now, psychologists are the supervisors of psychiatrists.

I would like to get this particular [redacted] case sorted out with a bit of education and documentation on the root cause analysis level) here locally at HQ. I think that's simpler.

But if not, I am getting convinced that a new unbiased evaluation of the events with [redacted] needs to occur. Perhaps an HQ psychiatrist could insist with a new investigation. Or perhaps investigators outside of CDCR should be involved if we are unable to manage gathering relevant facts.

A psychiatrist was not involved with the investigation, while nurses and psychologists came to the conclusion that nurses and psychologists didn't need to call the psychiatrist.

Conclusion: Please let me know your thoughts. We could begin a process of elevating these concerns, or we could try to handle this locally.

I am going to get even more information from the CIW [redacted] Dr. [redacted]. She knows a whole lot of factual information about this case.

Best,
Michael

Sept 5, 2017 3

Sent from my iPhone

Begin forwarded message:

From: "Golding, Michael@CDCR" <Michael.Golding@cdcr.ca.gov>
Date: September 5, 2017 at 12:38:53 PM PDT
To: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Subject: Re[redacted]

Hi,

Can you give me the name of the tech who documented the screaming nearly every 15-minutes that (according to Dr. [redacted] discussion with nursing) did not occur.

Could you also give me the name of the psychologist who allegedly said to you that there was no need to call the psychiatrist because the patient would not have taken meds?

It's odd that they are reporting that the documented screaming wasn't occurring and that the psychologist whom (you say) told you that the psychiatrist wasn't called because the patient wouldn't take meds, somehow didn't actually say that.

This is making me more and more curious.

Best,
Michael

Sent from my iPhone

On Sep 5, 2017, at 11:18 AM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

Hi Michael,

I've spoken with Mr. [redacted] the chair of Patient Safety about your concerns. Given that there were no other reports of "screaming" and nursing is aware of the indications for notifying the psychiatrist on call, we have decided to not add the item you requested. The final action plan is attached.

[redacted], Ph.D., CCHP
Sr. Psychologist Specialist
Quality Management Program
Statewide Mental Health Program
California Correctional Health Care Services
Elk Grove, CA

Cell: [redacted]
Office: [redacted]
Email: [redacted]@cdcr.ca.gov

Sept 5, 2017 (4)

<image001.jpg>

I may be missing it – I have a hard time pulling up the Suicide Watch documentation. I find several mentions of chanting – sometimes loud – but not screaming.

Is your concern that she was no intervention for agitation when she was first placed in Alt Housing? Could you explain?

[redacted], Ph.D., CCHP
Sr. Psychologist Specialist
Quality Management Program
Statewide Mental Health Program
California Correctional Health Care Services
Elk Grove, CA

Cell: [redacted]
Office: [redacted]
Email: [redacted]@cdcr.ca.gov

From: Golding, Michael@CDCR
Sent: Monday, August 28, 2017 5:54 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Re: RCA[redacted]

No.
Actually it's documented that she was screaming just about every 15-minutes (by the 1:1).

Strange that that didn't make it into the document reporting the series of events in the 4-hours prior to her enucleating her eye.

Best,
Michael

Sent from my iPhone

Sept 5, 2017

5

On Aug 28, 2017, at 5:33 PM, [redacted]@CDCR [redacted]@cdcr.ca.gov> wrote:

I would have to go back and read the chart again, but I don't remember that being mentioned. I do know she was chanting in her cell prior to Alt Housing placement.

[redacted], Ph.D., CCHP
Sr. Psychologist Specialist
Quality Management Program
Statewide Mental Health Program
California Correctional Health Care Services
Elk Grove, CA

Cell: [redacted]
Office: [redacted]
Email: [redacted]@cdcr.ca.gov

From: Golding, Michael@CDCR
Sent: Monday, August 28, 2017 5:03 PM
To: [redacted]@CDCR
Subject: FW: RCA [redacted]

Hi [redacted]
For some reason, the report does not mention that prior to the patient pulling out her eye, she was said to be screaming repeatedly.

Why doesn't the report say that? Was she not screaming?

The report makes it sound like she was peaceful, refused to strip out, and then all of a sudden pulled out her eye. But my understanding is that that is not what happened.

What am I missing?

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Sept 5, 2017
6

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

<image001.jpg>

From: Golding, Michael@CDCR
Sent: Monday, August 28, 2017 10:00 AM
To: [redacted]@CDCR
Subject: RE: RCA[redacted]

I am concerned about medication use, yes.

I am hoping to see the report.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

<image001.jpg>

From: [redacted]@CDCR
Sent: Monday, August 28, 2017 9:54 AM
To: Golding, Michael@CDCR
Subject: RE: RCA[redacted]

Do you have some concerns about it? One of their issues was that she was allowed to refuse meds at the RC. She had already stopped taking the meds she was on when she arrived (Dr. [redacted] had continued the jail's meds). The psychiatry intake was pretty thin but she stopped the meds because the patient had been refusing and said she did not want them. According the doc she did not appear psychotic at the time. When she got to CIW she saw [redacted] via telepsych and he did what I thought was his usual good job. Again, she did not appear floridly psychotic and he did not start her on meds, which she said she did not want. She then proceeded to decompensate very rapidly until the incident.

In my opinion it's hard not to be biased by such an awful event so I thought they were pretty harsh about allowing the patient to be off meds. They did note that the psychiatrists did not mention that the patient did not meet criteria for PC2602.

[redacted], Ph.D., CCHP
Sr. Psychologist Specialist
Quality Management Program
Statewide Mental Health Program

sept 5, 2017 8

California Correctional Health Care Services
Elk Grove, CA

Cell: [redacted]
Office: [redacted]
Email: [redacted]@cdcr.ca.gov

From: Golding, Michael@CDCR
Sent: Monday, August 28, 2017 9:38 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: RCA [redacted]

Let me know what Mr. [redacted] says.
Thanks,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov<image001.jpg>

EXHIBIT H
(2017-10-25-1156hrs)

Oct 25 2017 Dr. [redacted] Resignation ltr & my comment to [redacted]

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Wednesday, October 25, 2017 11:56 AM
To: [redacted]@CDCR
Subject: FW: Absence from the Institution-[redacted]
Attachments: image001.jpg; ATT00001.htm; Absence from the Institution-[redacted].pdf; ATT00002.htm

Hi,

Not an emergency. Read later, perhaps when you have time. The letter from the [redacted] at CIW is interesting and listed below what I am saying.

Our [redacted] at CIW has a very intense ability to get things done, which is favored by very few in our system and perhaps she is disliked by several others. She questions people a lot and speaks fervently. See her letter to me below which I think means she is quitting CIW to find multiple leadership options where her skills will be respected.

I guess that she is not going to be someone whom we will be able to keep because of her perhaps negative six month probation evaluation. My guess is that she will be ultimately failed on probation. So I expect she is going to leave to lead medical professionals and save lives elsewhere, rather than wait around to be failed, appeal in court, etc. That is my guess, but I am not sure.

I would say that in terms of organizing psychiatrists to take care of patients, she has been amazing. Remember Ms. [redacted] the juvenile justice young woman who seemingly was so difficult to manage? As soon as she and her psychiatry team took care of her, the patient stabilized immediately. You heard nothing more. Multiple of the most notorious female patients were completely stabilized by her and her team (list provided upon request). She knows how to advise and organize her psychiatrists to appropriately and successfully treat patients, pharmacologically and otherwise. Her kind of leadership in suicidal patients (wanting Lithium, Clozapine, Depot neuroleptics in these patients, wanting consistent care by a therapist despite locations) of course is exactly what would stabilize patients.

Ability to get institutions to successfully treat patients is not what we value, if doing so means that others will be made upset. She is a physician in a setting in which we do not want that. She does insist on excellent care for the patients from her psychiatrists and others. In her short six month tenure, despite all odds, she and her team were beginning to stabilize the sickest female patients and if she had had any support, she would have followed through and cut suicides and readmissions.

She definitely made a start. I am going to be trying to get the types of interventions she recommends going (statewide) using our single PRN psychiatrist and aspects of the telepsych team to try to teach people how to do this

1. Create lists of patients who are frequently readmitted, perhaps females because the population is less,
2. These few frequently readmitted patients get temporary same-therapist-care regardless of their physical location for focused anti-suicidal treatment [using telepsychology if necessary and pilot with women]
3. Much more lithium/clozapine/depot neuroleptics for many of these patients and Depot Naltrexone for narcotics and EtOH abusers.

Like me, Dr. [redacted] knows that these ideas are battle tested and work, that other systems do it, we do not, and I think the 30-day crisis bed readmission rate at CIW is a whopping 30%. Dr. [redacted], if she had help, could make that stop and would have, with support. She obviously is doing far better than that in the PIP (albeit with far more time). If she had some influence over care in the MHCB, there would be a lot of focus on getting patients on long-acting meds, making sure that patients got consistent therapist follow-up at CIW (and even other female institutions) and all the things that she and I know work! Her influence is restricted to the PIP.

Oct 25, 2017 2

Needless to say there has not been a single leader in mental health at CIW who has been fighting to get her the support staff to be able to look at these patients and engage in the type of local QM she recommends (from a psychiatric perspective) to save these patient's lives. What she recommends below actually works and has dozens of "supporting" studies --studies consistent with her conclusion.

I am almost sure that she is going to leave as she is not going to wait around for our system to fail her on probation. There are several patient's lives that were saved by her and her team and could be saved by her and her knowledge (and yes her demand that psychiatrists be involved in clinical decisions about patients when psychiatrists know what to do).

She will be gladly welcomed as a medical leader of psychiatric physicians in dozens of other places, if she has not been already.

Her note below is interesting.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Tuesday, October 24, 2017 11:25 PM
To: Golding, Michael@CDCR
Subject: Fwd: Absence from the Institution-[redacted]

Dr. Golding,

I know you and I have spoken about the sustainability of my staying in the [redacted] position at CIW.

Despite my optimism, work ethic and dedication to balancing leadership at CIW with the goal of integrating psychiatry firmly into the MH department, the challenges and resistance are so prominent (and overt), that I have grown more convinced that my position can only be a rubber stamp one. I still have no admin support despite having 17 direct reports. I don't even supervise those whose legal assessments (MDOs) that I must sign an affidavit for. I don't supervise the PC2602 coordinator. I'm not included in Coleman preparation or the new DSH transfer process. In short, I'm a rubber stamp [redacted].

oct 25, 2017 3

If leadership at HQ, including [redacted] or Dr. [redacted] are to inquire about why retention of psychiatrists continues to be a dilemma at CDCR, I would point to my falling example of trying to bring psychiatry to the table. How an institution with two inpatient psychiatric units doesn't value the input of a [redacted] is rather baffling. After all, patients are not admitted to psychiatric hospitals for acute therapeutic interventions as none exists. CBT is the shortest therapeutic intervention with evidence of efficacy—it's highly structured and 12 week's long—yet we don't even offer this in any outpatient program let alone in our inpatient units.

For example, our MHCB has a readmission rate of 30%—chronically.

The currently action plan to address this only involves the psychologists (the CMH has unilaterally decided to remove all LCSW from the MHCB) reviewing treatment plans.

No UM review of medication optimization—ie are we utilizing evidenced based treatments such as Lithium for chronic SI, long acting injectables, which are shown to reduce hospitalization, pc2602s, clozapine, etc.). I review the CTC census with the psychiatrists weekly and do this as case reviews, but it hasn't been ever thought of before nor readily accepted as a concomitant action plan. Shocking actually given in the original Coleman vs Wilson, a key finding was under-utilization of involuntary medications.

Lastly, if you review the memo below, you will see just how deep the line in the sand has been drawn.

The Chief of Mental Health is a designation not a title. There are three Chiefs—two Chief Psychologists, one with the arbitrary designation of CMH, and a Chief Psychiatrist. Our [redacted] has already made my position equal in rank to the [redacted] who has the designation of [redacted].

When absent, the [redacted] Dr. [redacted] has uniformly designated the other [redacted] as the [redacted] designee, despite our difference in rank. He doesn't even approach it somewhat fairly by switching between us.

Now in the absence of his [redacted], he has skipped over the other [redacted], me, and designated a Supervising Psychologist as his designee in his absence.

Personally, this doesn't offend me. However, more broadly, it represents the inhospitable environment that psychiatrists experience at CIW. Perhaps why I am the first [redacted] at CIW in five years. Perhaps why the most senior psychiatrist here has only been here 4.5 years.

His message to the staff is that psychiatry is separate and psychologists are favored. This isn't lost on my staff. Psychiatrists do not feel integrated, nor does their input seem valued, as evidenced by Dr. [redacted] display of choosing a lower ranking psychologist as his designee when a [redacted] is present.

The CMH is a designation that either a psychiatrist or a psychologist can have. There is little justification to not choose his colleague, the [redacted] except to continue to divide.

Psychiatrists only stay in institutions where they feel invested, valued and heard. They have many other options. As we've discussed, I have other options. Ones that allow me to be effective in a leadership role, not just a rubber stamp. I'm not a "Mental Health Provider". I'm a physician who specializes in psychiatry. As such, I provide a natural bridge between Mental Health and Medical. This unique skill set, should be valued, not suppressed as we approach Joint Commission Accreditation.

I can and likely will find a position where my skills and license are maximized. CDCR will not be able to maintain quality psychiatrists unless they make a true effort to bring them not just to table, but empower them to have a voice.

Oct 25, 2017 4

The only benefit from doing so is that will improve patient care and outcomes. We are physicians, not "mental health providers who prescribe" and our skill set and large body of knowledge is under-utilized and under-valued by the current organizational chart where there are no supervising psychiatrist in any program—including the inpatient units. (Our MHCB has not had a Psychiatrist as a clinical director for years). There is no psychiatrist in a supervisory in a licensed inpatient psychiatric unit. It's run completely by therapists. That is incongruent with every community model, including other correctional settings. Hence, I'm not surprised at the high re-admission rates and high overflow utilization. Those who have spent at least four solid years admitting and discharging from inpatient units—psychiatrists—have no authority in managing MHCBs—at least at CIW. Those trained in therapy do.

In short, I thank you for your mentorship and support and hope you can understand should I choose to take a leadership opportunity elsewhere.

Best,

[redacted]

[redacted] MD
[redacted]
California Dept. of Corrections
California Institution for Women
[redacted]

Begin forwarded message:

From: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Date: October 24, 2017 at 1:22:20 PM PDT
To: CDCR CCHCS CIW HealthCareStaff <CDCRCCHCSCIWHEALTHCARESTAFF@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Subject: Absence from the Institution- Chief of Mental Health

Sent on Behalf of [redacted], MA, CCHP
[redacted]
California Institution for Women

Please disseminate as appropriate to ensure awareness.

[redacted]
Administrative Assistant (A) to
[redacted], MA, CCHP
[redacted]
California Institution for Women
[redacted]

EXHIBIT I
(2017-11-15-1143hrs)

~~Wed~~ 11/15/17 11:43 AM

Genetin, Arianna@CDCR

From: Golding, Michael@CDCR
Sent: Wednesday, November 15, 2017 11:43 AM
To: [redacted]@CDCR
Subject: Fwd: Cases re liability

Please Print and give to me.
Do not forward.
Michael

Sent from my iPhone

Begin forwarded message:

From: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Date: November 15, 2017 at 10:08:58 AM PST
To: "[redacted]@CDCR" [redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "Golding, Michael@CDCR" <Michael.Golding@cdcr.ca.gov>, "[redacted]@CDCR" [redacted]@cdcr.ca.gov>
Subject: Cases re liability

All:
I write seeking a meeting with this group to discuss a meeting we at MH had with our field psychiatry team re the scope of practice of psychiatrists and psychologists. I am going to change the duties of the psychologists in the PIPs to allow them, with the IDTT, to make admissions and discharge decisions. The psychologists at CIW and SQSP already do this but we need to adjust processes at CHCF, CMF, and SVSP to be consistent across the state. There is considerable concern from the psychiatry team at the new PIPs that they will be exposed to liability when a psychologist makes a poor decision. They apparently referenced some 'case law' to support their position but I am unaware of such case law. Can you do some research about whether there are cases where a physician has been held responsible for the decision of an independently licensed person (psychologist)? If so, I want to see what we can do to address their concerns. If the concerns are not real, then I need to disabuse them of the notion. This may well come up st the labor table too so I'd like to have something we can share publicly and with labor.

With the holidays, I assume it will be hard to meet next week but if you can do research in the next couple of days, perhaps we can we a meeting on schedule within a week or so.

I've CC'd [redacted] here to coordinate schedules.
Thanks
[redacted]

Sent from my iPhone

EXHIBIT J
(2017-11-21-1749hrs)

Nov 21, 2017 1

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Tuesday, November 21, 2017 5:49 PM
To: [redacted]@CDCR
Subject: Rec Therapy over Psychiatric Appointments
Attachments: Psychiatry three hours per week allowed.pdf

HI [redacted],
Hope you had a nice vacation and are planning some fun for Thanksgiving.

You said something in a meeting with [redacted] and me and I think you may not be aware of the ramifications of what you said. I know you didn't mean harm, but perhaps you may want to reconsider.

Conclusion: Your comment that psychiatrists should schedule patients around groups seems innocent enough. But it obligates sometimes very scarce resources (needed for patient transport) to be utilized to transport patients to groups, first, after which any remaining transportation resources can be utilized by psychiatrists to "schedule around" the groups. Your decision is therefore making a triage decision that groups are more important for patients than medical appointments with psychiatrists. These groups, for example RT groups, often involve patients watching television. So although you may not be aware of the consequences of your decision, your decision (and the decisions of your predecessors) continues to deny patients access to sometimes desperately needed medical services, when there are scarce patient transportation resources, which is all too common.

What Your Decision Practically Means

1. Denying that there will periodically or frequently be an inability to bring patients to see mental health providers in CDCR is simply denying reality. In those contexts in which the ability to transport patients is quite scarce, saying that psychiatrists should schedule appointments with patients around groups means taking and using finite resources to transport patients to groups, and therefore taking resources away from transporting patients to psychiatry appointments.
    a. Psychiatrists often just require 10-minutes from group time to see a patient, but they are forbidden by the psychology leadership in institutions from even 10 minutes with a patient if they are participating in a two hour Rec Therapy group. (see below).
    b. Thankfully, we have found brave psychology leaders who disobey HQ executive orders and local executive orders, because they want patients to get help.
2. Patients don't get medical care when psychiatric physicians think the patient really needs it.

Effect on Psychiatrists:
Our psychiatrists have been angry about these priorities for years and have recently been made very angry by our MH executive leadership's apparent renewal of this decision – independent of psychiatric opinion to the contrary -- for example at SAC and SVSP (details below).
They are mad about these choices because

1. they say they have been denied the right to care for patients,
2. they think their patients don't get the right care because of your predecessor's and the current executive mental health team's support of this decision,
3. they feel more than a bit devalued by the choices that the executive MH leadership team has made and makes
4. they recognize that your choices and similar decisions of your predecessors do precipitate morbidity in our patients, likely higher readmission rates, create an unwillingness of psychiatrists to work here, and probably have increased suicidality and suicides of our patients over the long term, even though that obviously is not your intent.

Nov 21, 2017 2

Examples:

1. SVSP PIP: I spoke with the scheduler (Ms. [redacted], a nice woman) at SVSP PIP yesterday. She explained that custody has a certain amount of time that can be utilized to be able to bring patients to appointments. Given that time, she explained to me that she has been instructed to allow the following to occur over a week,
    a. To be "fair", she says
        1. Group hours can be used for individual appointments so every single mental health provider (listed below) has more hours with patients than psychiatrists
        2. Social Workers get 2 hours per week with patients individually and 4 hours of groups (6-hours of transportation resources)
        3. Psychologists get 2 hours per week with patients individually and 2 hours for groups (4-hours of transportation resources)
        4. Rec Therapists get 2-hours per week and 8-hours of group time (10-hours of transportation resources)
        5. Psychiatrists have only **2 hours PER WEEK** for individual private appointments with 35-70 psychiatrically hospitalized patients! Since psychiatrists have no allocated group time, they can't utilize that to try to see a few more patients in individual sessions!
    b. The scheduler says she tries to be especially nice to psychiatrist and grants them 3-hours (not two) per week to see patients in a private setting 1:1, but often this can't be arranged and it is not "fair" to others to grant so much time to physician psychiatrists
    c. Although the scheduler is a nice person, she has no idea how utterly bizarre it is to allocate 10 hours per week for a rec therapist to be allowed to pull patients for appointments and only give 2-hours per week for a psychiatrist.
    d. Please see the attached document which shows that Dr. [redacted] a psychiatric physician at SVSP, has been allocated just 3-hours to see patients, over an entire week!! The scheduler said Dr. [redacted] asked for a 4th hour per week to see patients, but had to be denied to be "fair". Even [redacted] the otherwise excellent psychologist-executive director said that groups had to be prioritized over psychiatric appointments because ("the patients like groups")
2. SAC: I will be giving you a full report about SAC after I go there after Thanksgiving, But please note this: Even when SAC has failed EOP Hub certs because psychiatrists are not seeing enough patients and so we are in trouble with the courts
    a. Dr. [redacted], a senior psychologist at SAC nonetheless informed custody that groups take precedence over psychiatry appointments, including the ones that psychiatrists have determined to be medically essential. So
        ii. Psychiatric Patients were not seen appropriately or in a timely way at SAC
        iii. Her decisions contributed to failing EOP HUB certification (not following court mandates)
    b. This decision; that is, denying patients psychiatric care, was supported by the [redacted], a psychologist.
    c. So even when we are violating court mandates because patients haven't been seen by psychiatrists and therefore we didn't pass the EOP HUB CERT, it was still critical for the psychology leadership at SAC to intentionally prevent even short 10-minute appointments by psychiatrists, so as to triage patients into recreational therapy instead.
3. The HQ psychiatrists [redacted], and I have all worked in CDCR institutions and been told that groups take priority over psychiatry appointments. We have ended up seeing patients cell-side, as psychiatrists do, because of the absence of custodial transport staff and because your decision (and that of your predecessors) prioritizes the use of transportation resources for recreation therapist appointments, rather than psychiatry appointments. I know I speak for virtually all psychiatrists in CDCR (and I would guess nationally) when I say that executive (non-medical) Mental Health Leadership should not be making these types of medical triage decisions. We are insulted and our patients are being hurt.

Implications

Nov 21, 2017 3

Patient care is suffering. I don't know if there are medico-legal implications of not allowing a psychiatrist who cares for 35-70 hospitalized patients (at SVSP) to only see them 3-hours per week, rather than cell-side. I also don't know about the medico-legal implications of medical triage decisions being made by non-medical people.

I suggest

1. Rescind this chronically stated but unwritten policy and allow us to send a memo saying that if there are any difficulties scheduling patients to see psychiatrists, psychiatric appointments take priority over group therapy, particularly by rec therapists.
2. At the next CMH meeting, get in front of the Chiefs of Mental Health and tell them that psychiatric appointments take priority over Rec Therapy appointments.
3. Speak with the medical executives and CEO's and let them know that the appointments of psychiatric physicians, like those of medical physicians, have priority over REC therapy appointments, even when psychology executives instruct them to prioritize Rec Therapy.

It would be a major victory for our mentally ill patients if we recognize the reality that there will be periodically or frequently a lack of resources to transport patients. In those contexts, visits with a psychiatric physician are more important than transporting patients, for example, to Rec Therapy to watch television.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Treatment Center 2 Winter 2017 (December 4th - February 23rd)

Time	Room	MONDAY	ROOM	TUESDAY	Room	WEDNESDAY	Room	THURSDAY	Room	FRIDAY
8:00	Dining	Breakfast	Dining	Breakfast	Dining	Breakfast	Dining	Breakfast	Dining	Breakfast
	Group Rm 1	SW 1:1- [redacted]	IDT Rm	IDT'S Team A [redacted]	IDT Rm	IDT'S Team Gaines [redacted] Dr. [redacted] 1st Hour Allowed	IDT Rm	IDT'S Team B- [redacted]	Group Rm 1	RT 1:1's- [redacted] Dr [redacted] 2nd Hour Allowed
	Group Rm 2	BIT 1:1's - [redacted]	Group Rm 2	RT 1:1's- [redacted]	Group Rm 2	Psych Line -Dr. [redacted]	Group Rm 2	RT 1:1's- [redacted]	Group Rm 2	Psych Line -Dr. Gaines
	Group Rm 3	RT 1:1's [redacted]	Exam Rm	Clozaril Lab/Assments	Exam Rm	Clozaril Lab/Assments	Group Rm 3	RT 1:1's [redacted]	Group Rm 3	PsyD 1:1's - [redacted]
	Exam Rm	Nursing Treatments	Exam Rm	Nursing Treatments	Exam Rm	Nursing Treatments	Exam Rm	Nursing Treatments	Exam Rm	Nursing Treatments
9:00	IDT Rm	X	IDT Rm	IDT'S TEAM A	IDT Rm	IDT'S TEAM B	IDT Rm	IDT'S TEAM C	IDT Rm	Dr. G 3rd Hour Allowed Psych Line -Dr [redacted]
	Group Rm 1	Intro to Coping Skills - [redacted]	Group Rm 1	CBT Depression- [redacted]	Group Rm 1	Problem Solving - [redacted]	Group Rm 1	Cog.Therapy Psych Sxs - Kendis	Group Rm 1	GROUP
	Group Rm 2	APD - Woods	Group Rm 2	X	Group Rm 2	X	Group Rm 2	Stress and Relaxation - [redacted]	Group Rm 2	Emotion Regulation - Mitchell
	Group Rm 3	Poetry and Art Therapy- [redacted]	Group Rm 3	Anxiety, Panic, PTSD [redacted]	Group Rm 3	Open Art Studio [redacted]	Group Rm 3	CDCR-ICC	Group Rm 3	Anger Management - [redacted]
	Dining Rm	X	Exam Rm	Clozaril Lab/Assments	Exam Rm	Clozaril Lab/Assments	Dining Rm	X	Dining Rm	X
10:00	IDT Rm	X	IDT Rm	IDT'S TEAM A	IDT Rm	IDT'S TEAM B	IDT Rm	IDT'S TEAM C	IDT Rm	SW 1:1's Anthony
	Group Rm 1	Intro to Coping Skills - [redacted]	Group Rm 1	CBT Depression- [redacted]	Group Rm 1	Mindful Meditation- [redacted]	Group Rm 1	Substance Abuse & Mental Illness - Kendis	Group Rm 1	Empowerment thru Spirituality- [redacted]
	Group Rm 2	Emotion Regulation- [redacted]	Group Rm 2	GROUP	Group Rm 2	PsyD 1:1's [redacted]	Group Rm 2	Stress and Relaxation - [redacted]	Group Rm 2	Problem Solving - [redacted]
	Group Rm 3	Poetry and Art Therapy - [redacted]	Group Rm 3	Anxiety, Panic, PTSD [redacted]	Group Rm 3	Open Art Studio [redacted]	Group Rm 3	CDCR-ICC	Group Rm 3	GROUP
	Exam Rm	Med Line - Dr [redacted]	Dining Rm		Dining Rm	X	Dining Rm	X	Dining Rm	X
11:00	In-Cell	Lunch/Hot Water Pass	In-Cell	Lunch/Hot Water Pass	In-Cell	Lunch/Hot Water Pass	In-Cell	Lunch/Hot Water Pass	In-Cell	Lunch/Hot Water Pass
	Exam Rm	Med Line - Dr [redacted]	Group Rm 1	X	Group Rm 1	X	Group Rm 1	X	Group Rm 1	X
11:30-13:30	Yard	Yard All Patients A-B-C-D	Yard	Yard All Patients B-A-D-C	Yard	Yard All Patients C-D-A-B	Yard	Yard All Patients D-C-B-A	Yard	Yard All Patients A-B-C-D
12:00	Group Rm 1	SW 1:1's- [redacted]	Group Rm 1	PsyD 1:1's - [redacted]	Group Rm 1	SW 1:1- [redacted]	Group Rm 1	PsyD 1:1's - [redacted]	Group Rm 1	CANTEEN DISTRIBUTION
	Group Rm 2	RT 1:1's [redacted]	Group Rm 2	PsyD 1:1's - [redacted]	Group Rm 2	SW 1:1's [redacted]	Group Rm 2	PsyD 1:1's [redacted]	Group Rm 2	CANTEEN DISTRIBUTION
	Group Rm 3	X	Group Rm 3	X	Group Rm 3	CME, UMC, MD meeting	Group Rm 3	X	Group Rm 3	X
3rd Watch										
1445-1615	Group Rm 1	Drumming Group- [redacted]	Group Rm 1	Problem Solving [redacted]	Group Rm 1	Exercise - [redacted]	Group Rm 1	Social Skills thru Rec & Leisure - [redacted]	Group Rm 1	APD - [redacted]
	Group Rm 2	SW 1:1 [redacted]	Group Rm 2	SW 1:1's- [redacted]	Group Rm 2	SW 1:1's [redacted]	Group Rm 2	PsyD 1:1's [redacted]	Group Rm 2	PsyD 1:1 [redacted]

Nov 21, 2017 4

EXHIBIT K
(2017-12-04-1043hrs)

In enucleation case, nurse called psychologist -- don't know difference between psychiatrist & psychologist & psychologists listed as physicians

12/4/17 1

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Monday, December 04, 2017 10:43 AM
To: Golding, Michael@CDCR
Subject: FW:

See below.

This is the psychologist who admitted Ms [redacted] During the RCA, when I asked why the psychiatrists on call wasn't contacted, the officer indicated that he thought Dr. [redacted] was the psychiatrist. Apparently, nursing also thinks he's a physician.

Please note that our new identificaiton badges (CIW only) just state, Dr. [redacted] and the title. No degree or the title that the person is licensed under.

This is incongruent with California's health care provider identification code that was passed in 2009.

[redacted] MD
[redacted]
California Institution for Women
California Dept. of Corrections
Cell: [redacted]

I CHECK EMAIL SEVERAL TIMES DURING THE DAY, HOWEVER AM NOT LOGGED IN AT ALL TIMES. IF THIS REQUIRES AN URGENT OR TIMELY RESPONSE, PLEASE CALL OR TEXT THE CELL NUMBER ABOVE.

From: [redacted]@CDCR
Sent: Monday, December 04, 2017 10:40 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject:

Hello [redacted]

I'm not sure who completes this daily list, but there is an error. [redacted] is not a physician. He is a psychologist. [redacted] PhD.

All patients admitted have an MHMD who is informed on call of the admission and places orders in at the same time, thus there is always an admitting physician (MHMD) for each admission.

Thx.

DMH 72

CONFIDENTIAL
DECEMBER 3, 2017
SACRAMENTO NOTIFIED/ INITIAL AND TIME:
CENSUS: 13

RM	INMATE PATIENT NAME	CDC#	DOB	ADMIT DATE	ADMIT TIME	PHYSICIAN	TYPE of SVCS	LEVEL of CARE	DIAGNOSIS	PL
1301	VACANT									
1302	VACANT									
1303	[redacted]			02/20/18	18:20		MED	NON_ACUTE/ LONG TERM	FACTITIOUS PARAPLEGIA	
1304	VACANT									
1305	OBSERVATION CELL									
1306	OBSERVATION CELL									
1307	[redacted]			10/02/17	22:27		MED	ACUTE	MULTIPLE MYELOMA, ACTINIC KERATOSES, HCV, CHRONIC ITP, EBVV, PACEMAKER, GERD, HTN, CHRONIC LEUKOPENIA, ALLERGIC RHINITIS	OS
1308	[redacted]			10/18/17	12:07		MED	ACUTE	HUNTINGTONS DISEASE, DIFFICULTIES SWALLOWING	OS
1309	VACANT									
1310	[redacted]			12/2/17	2000		MH	ACUTE	DTS	
1311	VACANT									
1312	[redacted]			11/29/17	1840		MH	ACUTE	DTS	SI
1313				12/01/17	1940		MH	ACUTE	DTS	S
1314				11/30/17	17:50		MH	ACUTE	DTS	SI
1315				11/20/17	23:07		MH	ACUTE	DTS	SI
1316				11/29/17	13:40		MH	ACUTE	DTS	SI
1317				11/20/17	17:25		MH	ACUTE	DTS	SI
1318				11/27/17	18:25		MH	ACUTE	DTS	SI
1319				11/23/17	23:20		MH	ACUTE	DTS	SI
1320				11/22/17	15:18		MH	ACUTE	DTS	SI

[redacted]
California Institution for Women
California Dept. of Corrections
Cell: [redacted]

[redacted]

I CHECK EMAIL SEVERAL TIMES DURING THE DAY, HOWEVER AM NOT LOGGED IN AT ALL TIMES. IF THIS REQUIRES AN URGENT OR TIMELY RESPONSE, PLEASE CALL OR TEXT THE CELL NUMBER ABOVE.

EXHIBIT L
(2017-12-06-1748hrs)

HIPAA

Pls not brought at SAC

Golding, Michael@CDCR

12/6/17 1

From: Golding, Michael@CDCR
Sent: Wednesday, December 06, 2017 5:48 PM
To: [redacted]CDCR
Cc: [redacted]@CDCR
Subject: FW: CSP-SAC and Diminished Psychiatry Contacts with Patients
Attachments: Copy of Psychiatrist productivity.xlsx

Hi [redacted]

You asked me to investigate why psychiatrists at the California State Prison Sacramento (CSP-SAC) apparently are not documenting that they are seeing many patients. Your concern was that psychiatrists had decided not to see patients or perhaps there were other explanations. Given the paucity of patients seen, it was asked that I speak with the psychiatrists to try to encourage them to see more patients. This concern was particularly relevant at the time I was asked because SAC had just failed an Enhanced Outpatient (EOP) court mandated inspection which would have certified that the institution was able to appropriately care for Enhanced Outpatients (called an "EOP Hub Cert.")

Conclusion: The HQ psychiatry team found substantial barriers to psychiatrists being able to see patients at CSP-SAC. Although there may be issues with the motivation of psychiatrists, the problems at CSP-SAC are so grave and severe in terms of patient access to psychiatrists that the focus needs to be on fixing these institutional factors. We cannot ascertain particular problems with psychiatrist motivation, because the barriers to patient care seem so much greater. Even if for some reason a particular psychiatrist did not want to treat patients, that observation could not be measured when the institution will not allow the patient to be seen, regardless of the psychiatrist's motivation.

I think patients are in danger because of institutional and professional interference with the ability of psychiatric physicians to be able to care for patients and the HQ psychiatry team is very worried.

Recommendations:

1. Speak with the warden and high level HQ custody supervisors in order to encourage custodial staff to bring patients for psychiatric treatment.
2. Speak with relevant parties at HQ regarding the appointment priority hierarchy, and the need for psychiatry appointments to take precedence over groups (just like medical appointments do). In emergency situations (like at SAC), Mental Health leadership needs to be told that preventing even a 10-minute appointment with a psychiatrist (to make sure a recreation therapist has 120 rather than 110 minutes with a patient) is certainly immoral. Whether or not it is illegal is a different question. Certainly mental health leadership has been apprised of this situation, including again in this document. Patients should be prioritized and are placed at risk because of this behavior.
3. Educate psychiatrists and MAs about the importance of making sure there is a scheduling order placed for every appointment. This could be directed just at the psychiatrists who had the biggest difference between number of notes and number of appointments (Dr. [redacted] at 21, Dr. [redacted] at 13, Dr. [redacted] at 15, and Dr. [redacted] at 12), or at all psychiatrists. Likewise the MAs could be spoken to as a group, or the MA supervisor could be spoken with and asked to make sure the MAs all place scheduling orders appropriately.
4. Educate Dr. [redacted] and MA [redacted] that the psychiatrist must be the one to check patients in and out on the ambulatory organizer, or the MA will get credit for the appointment.
5. Attempt again to educate nursing that MA's paid for by mental health were supposed to help psychiatrists and they were not supposed be pulled away to help medical instead.
6. Allow psychiatrists to try to undo the damage done by the HQ Mental Health leadership in its EHRS design for psychiatrists. This will take time. We need to follow he workflow designed for medicine to restore productivity at SAC and elsewhere (no powerforms, VERY few powerplans, no checking patients in and out, using notes to track appointment compliance rather than check in/out). This is much more efficient than the workflow designed by mental health leadership for psychiatrists (lots of powerforms, lots of powerplans, immense

pressure for psychiatry to use even more powerplans than they already are, checking all patients in and out, using check in/out to track appointment compliance, etc.

7. Move psychiatric offices from hallways where patients and staff can observe patients, hear therapy, and read patient notes. The same accommodation that psychologists have (they are given actual offices), should be afforded to psychiatrists.

12/6/17 2

Introduction: The below document demonstrates that other disciplines and employees either actively or passively prevent psychiatrists from seeing patients at CSP-SAC. Furthermore, the Cerner system has markedly decreased the productivity of psychiatrists statewide, including at SAC. (see attached).

Short List of Problems with evidence of these problem presented below the list:

1. Patients are not brought by custody to see psychiatrists

2. HQ mental health argued to incentivize patients to go to groups but not see psychiatric physicians, against the wishes of HQ psychiatrists. These incentives to go to group are working to decrease psychiatric visits.

3. When patients are in groups, custody is willing to bring patients to see psychiatrists, because the patients are already out of cells so easy to access. Psychiatrists have used these opportunities to ask for just 10-minutes with patients (out of say a 120-minute recreation therapy group). Custody has been willing to honor these requests of psychiatrists because the patients are easy to access, but local Mental Health leadership has been cracking down on these attempts to get patients psychiatric care, by successfully forbidding custody from bringing patients to see psychiatrists in these circumstances.

   The [redacted] and senior psychologists do this because it might be that a patient could get a 10 minute discussion with a psychiatrist and a 110-minute discussion with a recreation therapist, instead of the recorded and mandated 120 minute visit with the recreation therapist. The 120-minute amount is monitored by the court and so the psychologists want this number to be accurate.

   Some non-psychiatric clinicians have disobeyed MH leadership to try to allow 10-minutes of psychiatric mental health care for patients every month or so to try to protect the patient's lives.

4. MA's that are supposed to help psychiatrists are pulled from psychiatrists by nurses to support medical practitioners because mental health care. So if choices need to be made, MA's (paid for by mental health) are taken from psychiatrists and used for medical care, decreasing the efficiency of the psychiatrist. HQ psychiatry warned of this, but HQ mental health leadership (at the time) argued that psychiatrists could not supervise these MA's and so nursing was given control of them, with exactly the expected problems.

5. Psychiatric offices should not be placed in hallways with access by patients and staff to the confidential conversations of psychiatrists with patients and access of patients and staff to the notes of psychiatrists.

6. The Cerner implementation for psychiatric physicians was designed almost entirely by MH leadership with no experience in medical management of patients, against the vigorous objections of HQ psychiatrists who claimed publically (at work) and repeatedly that the design would be disastrous. It has been. Not all of the decline in productivity is due to the faulty design decisions, but a good portion of it has been. Psychiatry's decrease from September 2015 to November 2017 is **65%**, while general medical physicians have experienced declines in productivity of about 36%. (Analysis available upon request.) Those numbers pretty clearly demonstrate that the workflow followed by medicine (no powerforms, VERY few powerplans, no checking patients in and out, using notes to track appointment compliance rather than check in/out) is much more efficient than the workflow followed by mental health leadership for psychiatrists (lots of powerforms, lots of powerplans, with immense pressure for psychiatry to use even more powerplans than they already are, checking all patients in

and out, using check in/out to track appointment compliance). These numbers may be inaccurate, but they are derived from the same source that is being given to measure compliance for the courts and these are numbers being used to say that psychiatric productivity at SAC has fallen. The statewide graph (attached) should help provide context.

12/6/17 3

The following information was gathered from interviews with custodial staff, general medical physicians, psychiatric physicians, nurses, and psychologists.

CTC: Rare custody barriers; there are a couple COs who push back when asked to bring patients they feel will be a lot of work, but overall custody is very helpful. Office space is limited, and the times available for seeing patients are short (due to breakfast, pill line, lunch, change of shift – usually they can see patients from 7:30 – 10:30, and 11 – 1:30), but the psychiatrists denied any significant problems with office availability thanks to COs bringing patients promptly and the psychiatrists and psychologists working well together. There are lots of PC 2602s to do, which somewhat decreases ability to see many patients. Biggest complaint from two of the psychiatrists was how many trainings (SRE, Columbia scale, etc) they have to do. Overall the CTC psychiatrists feel things run smoothly.

MHCBU: "All 3 or 4 custody officers will put on their sunglasses and sleep. If you ask them for patients to be pulled they'll say 'oh, he won't come out'" without even attempting to get the patient. It was stated the psychologist has an office, but the psychiatrist does not have an office and has to sit in the hallway to see patients or do any work. He reported it's really noisy in the hallway, there is no privacy, and other prisoners can listen to the appointments and even see his computer/notes, if they are in a nearby cell. There are lots of PC 2602s.

PSU A1: Approximately 70% of patients do not show up for their scheduled appointment – 50-60% of those say that they did not attend their appointment because custody never came to pick them up. Custody is mostly helpful when directly asked to do something, although a few are resistant to helping out the psychiatrist. Dr. [redacted] has forbidden patients from being taken out of groups to see the psychiatrist. The psychiatrist ends up seeing most patients cell-front, which can be time-consuming due to the psychiatrist needing to find them (the patient may be on the yard, in the law library, out to court, in group, or at a medical appointment). There are lots of PC 2602s. MAs come and go frequently – he has had 5 MAs since February – so he has to spend time to train them on expectations each time he gets a new one. Medical had priority over Psychiatry for MAs, so two of the five left because they were re-assigned to Medical.

PSU A2: Custody will pull patients when requested, unless the patient is in a group. He said Dr. [redacted] informed custody that groups take precedence over psychiatry appointments, and that patients are never to be taken out of a group for a psychiatry appointment. Overall custody is helpful. Patients frequently (~50%+) refuse to attend appointments, and must be seen cell-front, which can result in time spent tracking them down.

PSU B: They were 50% staffed in PSU B until October. No custody issues. The psychology supervisor, Dr. [redacted], did not allow psychiatrists to pull patients from groups, but she was transferred to PSU A recently, so psychiatrists are now able to pull patients from groups. 90+% of the psychiatrist's patients refuse their 1:1 appointments, largely "because they don't want to be stuck in there for an hour or two" (custody transports patients in groups, so although the appointment with the psychiatrist may only be 10-15 minutes, they have to sit in the treatment center for 1-2 hours before or after the appointment waiting until custody transports the group back). The psychiatrist sees about 50% of her patients cell-side, due to them refusing both their 1:1 with her and their group. She no longer schedules appointments in advance, due to 90+% of them not coming, so all scheduling orders are placed in arrears by the MA, who places the order, schedules the appointment, and checks them in and out.

A3 EOP: Over 50% of patients do not show up for their scheduled appointments, which the psychiatrist believes is mostly due to them refusing, but could also be due to custody failing to bring them. He said custody is pleasant and helpful overall. He is able to pull patients out of groups without any push-back. He goes cell-front to see the patients that are not in group and that refuse their appointment, and has some difficulty tracking these patients down. There are a fair number of PC 2602s to do, which takes away from direct patient care time.

12/6/17 4

A5 Ad Seg EOP: One psychiatrist said "Custody won't bring any patients". He clarified that he has patients scheduled, they are ducated, but custody refuses to bring patients for any psychiatry appointments. He stated custody will bring patients for psychology 1:1 appointments, and for groups. He reported he tries to see his patients with the psychologist during the psychology appointment whenever possible, or pull them from group, but frequently ends up having to see patients cell-side. Often the patients aren't in their cell, and "custody says they don't know where [the inmate] is", so he has to go all over the yard trying to find his patients, which takes a significant amount of time. He noted that although he does pull patients from groups, it is "frowned on" to do so, and he has heard other psychiatrists have been told they are not allowed to do that by Dr. [redacted] Another psychiatrist stated "I cannot see the patients in a confidential setting on the block", and explained that custody will not pull patients out of their cell for a psychiatry appointment, only for groups and psychology appointments. He noted he can only see patients in a confidential setting if he pulls them out of group to see him, and said that custody is cooperative with pulling patients out of groups for him. He sees most of his patients cell-front, and denied significant problems with tracking them down, as they are usually either in their cell or on the yard.

A6 EOP: "Custody is very rude and there are lots of problems. When psychiatrists try to see their patients they are told that they cannot bring the patient because it's yard time, shower time, they're not in their cells yet, or 'we have a shortage of staff and can't'. "If you schedule 6 patients, 1 or 2 will be brought, but the others won't because custody refuses." "Two psychiatrists have left SAC because of working in A6." He reported he ends up having to see most of his patients cell-side, but this takes a lot of time because there are 3 blocks, and "custody will often refuse to even open the block for you". If he is eventually let in to the block, often the patient isn't in his cell, so he then has to try to find out where the patient is.

A7 EOP: 75+% of patients refuse their appointment, especially if they are scheduled for yard at the same time. He tries to see the patients who refuse cell-side, but often can't find them, and spends a lot of time checking their cells, work, yard, groups, etc, which decreases the amount of time he has available for patient care. He reported there are lots of PC 2602s to do, and in order to complete the paperwork and hearings he often has to devote one full day per week to PC 2602s.

Scheduling:

Most of the psychiatrists had more notes than scheduling orders, meaning they are forgetting to place the scheduling order in arrears or not communicating to the MA to place the scheduling order in arrears. On average, the psychiatrists had 5.7 more notes than scheduled appointments in September. We are assuming that scheduled appointments all had a note, and that all notes signified a face-to-face contact – both of which could be false assumptions (Andres Murillo is looking into this for me, but we don't have the results back yet).

Dr. [redacted] appears to have only seen 2 patients in September (based on scheduling orders), because her MA checks all cell-front appointments in and out for her. Because of this, the MA got credit for all of those appointments (n = 36), not Dr. [redacted]

Recommendations:

1. Speak with the warden and high level HQ custody supervisors in order to encourage custodial staff to bring patients for psychiatric treatment.
2. Speak with relevant parties at HQ regarding the appointment priority hierarchy, and the need for psychiatry appointments to take precedence over groups (just like medical appointments do). In emergency situations (like at SAC), psychology leadership needs to be told that preventing even a 10-minute appointment with a psychiatrist (to make sure a recreation therapist has 120 rather than 110 minutes with a patient) is certainly immoral. Whether or not it is illegal is a different question. Certainly mental health leadership has been apprised of this situation, including again in this document. Patients should be prioritized and are placed at risk because of this behavior.
3. Educate psychiatrists and MAs about the importance of making sure there is a scheduling order placed for every appointment. This could be directed just at the psychiatrists who had the biggest difference between

12/6/17 5

number of notes and number of appointments (Dr. [redacted] at 21, Dr. [redacted] at 13, Dr. [redacted] at 15, and Dr. [redacted] at 12), or at all psychiatrists. Likewise the MAs could be spoken to as a group, or the MA supervisor could be spoken with and asked to make sure the MAs all place scheduling orders appropriately.

4. Educate Dr. [redacted] and MA [redacted] cia that the psychiatrist must be the one to check patients in and out on the ambulatory organizer, or the MA will get credit for the appointment.
5. Attempt again to educate nursing that MA's paid for by mental health were supposed to help psychiatrists and they were not supposed be pulled away to help medical instead.
6. Allow psychiatrists to try to undo the damage done by HQ MH leadership in its EHRS design for psychiatrists. This will take time. We need to follow he workflow designed for medicine to restore productivity at SAC and elsewhere (no powerforms, VERY few powerplans, no checking patients in and out, using notes to track appointment compliance rather than check in/out). This is much more efficient than the workflow designed by mental health leadership for psychiatrists (lots of powerforms, lots of powerplans, immense pressure for psychiatry to use even more powerplans than they already are, checking all patients in and out, using check in/out to track appointment compliance, etc.
7. Move psychiatric offices from hallways where patients and staff can observe patients, hear therapy, and read patient notes. The same accommodation that psychologists have (they are given actual offices), should be afforded to psychiatrists.

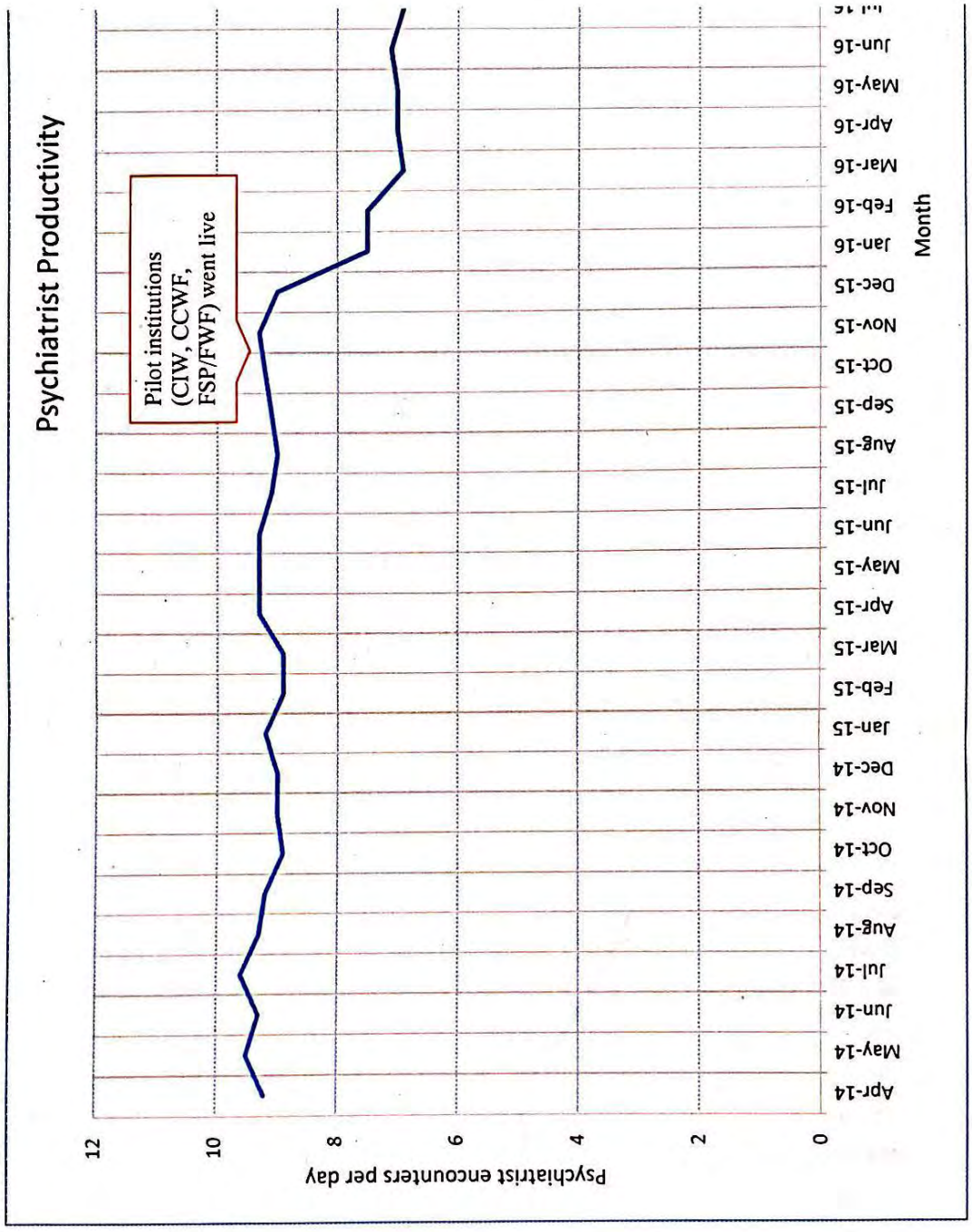
Conclusion: The HQ psychiatry team found substantial barriers to psychiatrists being able to see patients at CSP-SAC. Although there may be issues with the motivation of psychiatrists, the problems at CSP-SAC are so grave and severe in terms of patient access to psychiatrists that the focus needs to be on fixing these institutional factors. We cannot ascertain particular problems with psychiatrist motivation, because the barriers to patient care seem so much greater. Even if for some reason a particular psychiatrist did not want to treat patients, that observation could not be measured when the institution will not allow the patient to be seen, regardless of the psychiatrist's motivation.

Best,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

12/6/17 6


Psychiatrist Productivity
Pilot institutions (CIW, CCWF, FSP/FWF) went live
Psychiatrist encounters per day
0
2
4
6
8
10
12
Month
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Encounters per Psychiatrist
9.2
9.5
9.3
9.6
9.3
9.2
8.9
9
9
9.2

12/6/17 8

Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
8.9	8.9	9.3	9.3	9.3	9.1	9	9.1	9.2	9.3	9	7.5	7.5

Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
6.9	7	7	7.1	6.9	7.1	6.9	7	6.8	6.7	6.2	5.8	5.4

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
5.3	4.9	5	4.8	4.3	3.9	3.5	3.2

EXHIBIT M
(2017-12-11-1622hrs)

Dec 11, 2017 1

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Monday, December 11, 2017 4:22 PM
To: Golding, Michael@CDCR
Subject: RCA Process for Pt [redacted]
Attachments: scanned notes [redacted].pdf; RCA.docx

Dr. Golding,

I am writing you in the context of a significant and sentinel case both for CDCR and CIW, that of patient [redacted] This patient self-enucleated her left eye while on a one: one, while in a holding cell in the TTA after being formally admitted to the our MHCB.

The context of my concerns are in regards to the associated RCA for this case however, I am not only writing as the [redacted] but as a member of her treatment team and a committee member on the RCA.

Some important background, I became involved with [redacted] care from 4/21/17, the day following her admission to Riverside University Medical Center for evaluation of the affected orbit, which resulted in surgical debridement and prophylactic treatment to prevent an infectious process..

[redacted], MD our [redacted] and I communicated daily with the treatment team, as well as the psychiatry consult service. If you recall, a great deal of effort went into preparing for her transition back to CIW. I was professionally encouraged by the degree of cooperation employed in the aftermath of this case.

I say this in regards to all staff—I sent several emails out highlighting the impressive collegiality and dedication of the staff—nursing and custody truly going above and beyond. My own staff quietly raised the bar for all physicians, not just those at CDCR. This inmate required q8hr face to face MD evaluation for restraints—either hard or mittens, one point or five points, a physician can to come in to evaluate the patient and renew those orders. The psychiatrists did this for 27 days—voluntarily signing up for shifts without my having to assign a single shift. (The longer duration of restraints needed was given the use of mittens we employed to protect the intact eye until a therapeutic steady state was reached on her long acting injectable antipsychotic agent).

Needless to say, she was stabilized under the expert clinical care provided by the PIP team, led by [redacted], MD and was one of the first patients to transfer to Patton under the newly implemented LRH process. She has returned from PSH, and has transitioned successfully to EOP level of care.

My intent in reviewing the aforementioned is not for a pat on the back. We did our job. Nothing less should be expected of any team at any facility because nothing less would be expected for a patient in the community.

Rather, I highlight the above because this case is one that we should utilize to learn from. As you know, M & M (mortality and morbidity rounds are embedded in our medical training. We know that even the best intentioned physicians in hospitals with the highest accreditation standards are still capable of bad outcomes. We can't predict every possible variable.

As physicians, you know that we rely on Mortality and Morbidity (M& M) rounds to identify these variables. Our M & M process is based on the Socratic method of discussion and discovery. The aim is not to reverse the course of a series of events. And no 844 is signed by the one or two physicians involved. The intent is greater. It's to allow the collective group to help understand the case in retrospect, piece by piece. We walk away from M & M rounds all owning that case even if we didn't play a direct role.

I understand that CDCR is not an academic center or primarily a healthcare delivery system—and therefore such M & M rounds aren't part of the larger process. The RCA is what most resembles this.

Therefore, I asked to be on the RCA committee for patien[redacted]because I sincerely believed that this was a case that needs careful review as there are lessons for all to walk away with.

Unfortunately, this was perhaps the most disappointing process I've been involved with at CDCR. I'm not sure I can call it a process. I can say that the process I've reviewed regarding RCA's at CDCR was not followed.

The initial RCA facilitator, [redacted] set the foundation for a strong beginning. The meetings were weekly. The discussions were robust and thorough. Then upon Ms. [redacted] transfer to CRC, the RCA's coordinator role was handed over to [redacted], PhD.

Dec 11, 2017 2

the committee met less consistently at that point and progress was hastened. At some point in mid July, Dr. [redacted] sent out an email to the committee members that there would be a meeting—short notice given—to come up with the plan of action, fishbone, and to identify the root cause. Per the attached meeting minutes, all of this took place on 7/18/17. I was part of the committee but was on vacation when this was done. I was not involved in finalization of the root cause, plan of action, or the fishbone analysis. It was given to the [redacted] to sign, then presumably submitted to headquarters per the meeting minutes.

At the minimum, the plan of action should have been presented to the Patient Safety Committee for review (not alteration) and to document in that committee that the RCA was completed according to the prescribed process. I invested two months into this RCA, then to have the PAC and Root Cause completed and approved and sent to HQ while I was on vacation is disappointing to say the least.

Myself and the leadership committee did receiv emails from Dr[redacted] after a psychologist from headquarters and an RN came to CIW in August to review the RCA recommendations. Neither myself, nor any other member of the RCA committee were invited to the meeting. Our [redacted], Dr. [redacted]r was not either. I did attend however, as the [redacted] informed me about it.

I found the meeting to be odd in that I couldn't see where in the prescribed RCA process this step was delineated.

In my opinion, the integrity of the RCA process in question. Dr. [redacted] insisted that he did not want to tell CIW what to say on the RCA recs, however, to be mindful that these are looked at by lawyers, etc.

I find that extremely problematic. A representative from headquarters coming to tell select members of the leadership committee that the RCA recs on this case shouldn't suggest policy changes that will place undue pressure on CDCR.

Perhaps most disturbing, the following email was sent after the meeting by Dr. [redacted]:

From: [redacted]@CDCR
Sent: Wednesday, August 23, 2017 1:21 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject [redacted]RCA Recommendations Form

For your review, here are the RCA recommendations as suggested by Dr. [redacted] and Mr. [redacted] during our meeting. Could everyone review your items and let me know of any changes?
The first four recommendations apply to MHCB and its staff, and are under Dr. [redacted].

Dr. [redacted], the fifth recommendation is for you. I will also need an 844 once this training has been accomplished.

A [redacted] Perhaps most problematic in this is that I was an RCA committee member. Dr. [redacted] made amendments to the PAC (that I never even agreed to—not sure which other committee members were also left out) based on recommendations from a psychologist from headquarters and didn't run by the RCA committee or the patient safety committee.

I opposed the recommendations, specifically the one assigned to me. I specifically informed Dr. [redacted] at the ad hoc meeting that I will not recommend documentation review for the psychiatrists (at CCWF or anywhere) given we have a policy and process that addresses this, a peer review process for physician/psychiatrists that is spearheaded by HQ Telepsychiatry.
See below:

Chief Psychiatrists view is discounted/not included

From: [redacted]@CDCR
Sent: Friday, September 15, 2017 4:36 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]

[redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: [redacted] revisions

Dec 11, 2017 3

Please see attached for my revisions.

Dr. [redacted], as I indicated when the HQ?/Regional reviewers came to give us feedback/review our initial findings, while I have issues with the way the medication discontinuation was documented, I was not going to make recommendations regarding documentation for the purposes of the RCA given we have a HQ driven peer review process that is already in place to do that. There would be no utility in adding an additional recommendation. We could add that Peer Review of documentation is followed for MHMDs to ensure documentation standards are met. That would work.

I did add some specific recommendations that address this in others ways (i.e. not changing level of care for six months after a psychotropic is discontinued) and documentation in the chart of the decision making process for the level of change.

I also made some edits to the timeline/sequence of events which are congruent with a review of the chart.

Thx

[redacted]

From: [redacted]@CDCR
Sent: Monday, September 18, 2017 8:11 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE [redacted] my revisions

Does this need to go to [redacted] and [redacted]?

CIW already turned in revisions requested by Dr. [redacted] and [redacted] under their direction. I'm a little confused what we're doing at this point. Did HQ ask for further revisions?

From [redacted]

Good Morning,

It appears that [redacted]s recommendations are focused on policy changes/revisions that need to be taken up by headquarters separate from this Event & subsequent RCA. Remembering that institutions don't control policy, we cannot encumber ourselves with an action plan that includes re-writing policy and care guidelines.

I hope this helps. Thx

J[redacted], MA, CCHP
[redacted]

I didn't realize the final had been submitted. Miscommunication I guess. I didn't completely understand that Mr. [redacted] and Dr. [redacted] we're here to suggest revisions. This is my first RCA.

The end seems a lot less clear than the beginning did. Perhaps I'll learn as I go along.

[redacted], MD
[redacted]

California Dept. of Corrections
California Institution for Women
[redacted]

Dec 11, 2017 4

On Sep 18, 2017,

My revision of the Event Description—my edits are in caps.
On 4/20/2017 at approx. 2330, I/P [redacted] WHO WAS ADMITTED TO MHCB ALTHOUGH WAS HOUSED IN ALTERNATIVE HOUSING IN THE TTA, WAS INVOLVED IN A SENTINEL EVENT. APPROXIMATELY FOUR HOURS EARLIER, SHE HAD BBEN EVALUATED AND DETERMINED TO BE GRAVELY DISABLED BY THE ON SITE PSYCHOLOGIST WHO PLACED ADMISSION, WATCH AND ISSUE ORDERS. SHE WAS ON 1:1 SUICIDE WATCH BY AN LVN AND WAS TO BE IN A STRONG GOWN, HOWEVER REFUSED TO COMPLY WITH ISSUE ORDERS. IT WAS DOCUMENTED THAT SHE WAS 'PSYCHOTIC' AT THE TIME OF ADMISSION. DOCUMENTATION FROM THE 1:1 OBSERVER NOTED 'SCREAMING' EVERY FIFTEEN MINUTES FOR MOST OF THE FOUR HOUR PERIOD. SHE DID NOT RECEIVE MEDICATIONS DURING THE FOUR HOUR PERIOD PRIOR TO THE EVENT. THE PSYCHIATRIST ON CALL WAS NOT CONTACTED BY NEITHER NURSING, THE ADMITTING PSYCHOLOGIST, OR CUSTODY. AFTER TOUCHING HER EYE FOR SEVERAL SECONDS, while in the supine position on the floor, the I/P used her left hand to enucleate her left eye. The alarm was sounded and two correctional officers entered the cell. The I/P was asked to relinquish the eye, however, she put the eye in her mouth and ingested it. 911 call was initiated. THE PSYCHIATRIST ON CALL WAS CONTACTED AFTER THE INCIDENT AND ORDERED AN EMERGENCY INJECTION OF ZYPREXA 10MG TO BE ADMINISTERED INTRAMUSCULARLY PRIOR TO TRANSPORT. I/P was then transported by ambulance code III to Riverside University Health Systems.

Root Cause / Issue to be Addressed: Extreme psychosis			
Summary of the Improvement Activity: Training Refreshers for Staff			
Person Responsible for Implementation: Dr. M. Hewitt, CMH; Chair, Mental Health Subcommittee		**Person Responsible for Monitoring/Reporting Results:** Mental Health Subcommittee	
Action Step(s)	**Responsible**	**Deadline**	**Comments/Status**
• Mental Health Crisis Bed staff will be trained on writing appropriate Master Treatment Plans and MHCB admission (issue) orders; staff to be trained on IDTT.	MHCB Supervisor and MH QM Specialist	9/30/2017	• This will refresh staff on the MHCB admission process, including communicating with MHMD, Nursing and Custody at admission; safety issue; treatment planning; and IDTT.
• Mental Health Crisis Bed staff will be trained on DDP and interpreter use policy.	MHCB Supervisor and MH QM Specialist	9/30/2017	• Staff may always use assistance at their discretion regardless of IP's functional rating.
• Mental Health Crisis Bed staff will be trained on MHCB admission and alternative housing LOP and policy, INCLUDING CONTACT WITH PSYCHIATRIST ON CALL BY ADMITTING CLINICIAN.	MHCB Supervisor and MH QM Specialist	9/30/2017	• This will refresh staff on MHCB admission and alternative housing policy and procedure.
• Secondary trauma intervention will be provided for all staff involved in the incident.	MHCB Supervisor and MH QM Specialist	9/30/2017	• Staff present for such events may feel secondary trauma.
• RECOMMENDATION IS MADE TO DOCUMENT LEVEL OF CARE CHANGES AT RC (FROM EOP TO 3CMS OR 3CMS TO GP) IN THE CHART. • RECOMMENDATION IS ALSO MADE TO REFERENCE REVIEW OF COUNTY RECORDS AT RC BY BOTH MHMD AND PC AT INITIAL CONTACT (AS PART OF INITIAL EVALUATION INTAKE FORM?) • RECOMMENDATION IS MADE TO MAKE NO CHANGES TO LEVEL OF CARE FOR SIX MONTHS POST DISCONTINUATION OF PSYCHOTROPIC MEDICATIONS	HEAD QUARTERS MENTAL HEALTH LEADERSHIP		•
• Restraint procedure will be reviewed by Nursing, recommendations will be submitted to HQ, and appropriate Nursing staff will be trained on new procedures, if any.	Chief Nursing Executive	9/30/2017	• CIW may wish to review and implement methods of patient restraint observed in use at community hospital where IP was treated.
Performance Objectives/Measures (Goals)	**Date of Most Recent Data**	**Findings/Results Per Most Recent Data**	
•		• Baseline: • Most Recent Findings:	
•		• Baseline: • Most Recent Findings:	

I expressed my concern about the direction of this RCA to our CME and our new [redacted], Mr. [redacted] both of whom acknowledged the undefined process which was reviewed in Patient Safety Committee.

Dec 11, 2017 5

From: [redacted]@CDCR
Sent: Thursday, September 28, 2017 2:06 PM
To: [redacted]@CDCR <[redacted].[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR [redacted]@cdcr.ca.gov>
Subject: FW: [redacted] my revisions

[redacted],

I have no idea what happened to this RCA. It started strong and then I have no idea where it went (Hq?) or what went—summary and recs?

I never saw what was sent up: timeline, summary, recs, in their entirity. I don't how this process works, but the process this one followed was circuitious at best.

I do think my edits to the timeline are signficant to the case.

From: [redacted]@CDCR
Sent: Friday, September 29, 2017 2:37 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]CDCR [redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR [redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: [redacted] my revisions

Thanks Dr. [redacted]. I am trying to piece these all together to understand our current process, the gaps, and how we can enhance it. I have asked for RCA packets on [redacted] I have 3 of 4 (should have green Monday); I will schedule a meeting to cement a process as this was an action item from our September patient safety committee.

[redacted]

From: [redacted] @CDCR
Sent: Thursday, September 28, 2017 2:13 PM
To: [redacted]@CDCR <[redacted].[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted].[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted].[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted].[redacted]@cdcr.ca.gov>
Subject: RE: [redacted] my revisions

Dr [redacted],

Thanks for sharing. There were three or four RCAs on the Patient Safety agenda this past Friday and it was acknowledged that there is a gap in communicating findings and recommendations. What was reported at Patient Safety Committee was simpy the status of each RCA ie. 'closed', 'in monitoring phase' etc but again no details or clear acknowledgement of findings and/or recommendations so what we'd be monitoring without clearly assigning recommending of the RCA is anyone's guess.

Including a few other stakeholders.

[redacted], *MD*

<

Dec 11, 2017 6

Additional issues that were not included in the Root Cause, fishbone analysis or the recommended action items:

1. Please see the scanned fishbone (which I was not involved with although on the committee). I have written in what is missing.
2. Please see the scanned summary of events which has some amendments/edits I've made.

Main missing components:

(1)

1. The psychologist, [redacted] who admitted [redacted] did not have admitting privileges in the CTC. He had treatment privileges only. This was discovered after I inquired about potential liability for this case by the on call psychiatrist or the CTC psychiatrist. I was informed by [redacted], the [redacted] that only the psychologist was liable because he was admitting under his license and admitting privileges. Yet lo and behold, Dr. [redacted] was not aware that admitting privileges are different that treatment ones. None of the psychologists who had been placing admission orders since I started in 2016 had actual admitting privileges to the CTC. This was discussed and confirmed in the RCA committee. I acquired the psychologists admitting application from San Quentin and presented that our Licensed Inpatient Committee who approved it. Subsequently, [redacted]r, PsyD and the other 20+ psychologists who can treat in the CTC are now privileged to admit as well. A review of the files in Licensed Inpatient will confirm this.

2. [redacted], PsyD should have contacted the psychiatrist on call given the severity of this patient's illness—patients who are acutely psychotic are unpredictable, especially when they are new to CDCR and we do not have their historical record to review. However, had he reviewed the scanned documents from OC Jail readily available on Cerner, he would have seen that she had two admissions to their CTC for SI. When asked by me why he did not call the psychiatrist on call (we have a three person back-up system thus, one of us will ALWAYS answer). His response was that he thought she wouldn't take medication. He had not been told that it was required for him to contact the psychiatrist on call with the exception of when he is NOT going to admit. Thus to share the liability of sending somebody back to the yard was the only reason he was told to contact the psychiatrist on call. And indeed, I have and still do take call. I had taken been called by a psychologist for an admission, rather to inform me that someone was going out to the yard on a 5 day step down. Yes, nursing calls us to reconcile medications on admissions, but that is not the person who admitted the patient.

3. It's clear that Dr. [redacted]s clinical judgment was poor—his documentation on the note is reflective of this—however an LOP is in place that would have prevented reliance on his clinical judgment alone. See attached. Neither the acting supervising psychologist in the MHCB at the time, [redacted] or [redacted] were aware of this LOP. Not a single psychologist was aware of it either. It was agreed in an ad hoc meeting that Dr. [redacted] would provide training on this LOP to his staff. I can get you the minutes. Indeed he did not. I have documentation from psycholgoists in the CTC who all confirmed that they were never informed of this LOP. I have heard the same from psychologists in other units who have admitting prviliges.

I did provide the training and information to the five psychologists assigned to the CTC because it is our LOP.

The culture is such, however, that only the on call psychiatrist is contacted when a psychologist admits a patient to the CTC. During the day, Dr. [redacted], the CTC psychiatrists reports that he has not been contacted by the admitting psychologists once in the last two years. Nursing informs him once the patient is admitted and needs medication review.

Dec 11, 2017 7 ②

4. Based on feedback from the Licensed Inpatient ad hoc meeting where this training was agreed upon, I did revise the section on which provider can place which order. This was recently approved by the LGB. The indication for this was that nursing was asking the psychologists to place diet orders (those are medical orders) and psychologists had decided on their own that they could enter urine tox screens, which were acknowledged and collected by nursing. These are medical orders that a physician can only order, yet psychologists were doing them in the our CTC. Hence, me uenumerating their orders to make it clear for nursing.

5. What did not change, was the section that states the psychologist is to call/contact the psychiatrist when admitting. That LOP wasn't followed in this case or any other.

6. The process for this RCA, or any RCA, should have integrity if we expect staff to participate in it, but perhaps more importantly, if we are relying on this as the primary tool to review adverse cases. Another compelling misstep in this RCA had to do with the lack of respect for anonymity of the committee members in terms of their discussion. As you can see below, I had inquired in the RCA why the Dept of Health's licensing department had not been contacted given the patient had formally been admitted to a licensed unit. I understand that she was physically kept in the TTA in a holding tank because she refused to strip out and was not cooperative, but shouldn't we inquire from the Dept of Health as to what the policy regarding these complicated cases are (i.e. patient is formally admitted, but physically not on the licensed section of the unit) and adverse outcome occurs within five hours of her admission orders being entered? Wouldn't it be more judicious if we asked the Dept of Health for guidance on this in the event that our call to contact them (decision made by the CMH) was not the appropriate one? This case as passed, but there may be others. Dr. [redacted] sent my question out on email to every member of the leadership team as well the HPMs, and others. That is not in keeping with maintaining anonymity of the committee members' questions/comments/discussion. Dr. [redacted] clearly points out that her concern is regarding placing CDCR's relationship with licensing in jeopardy therefore will rely on the CHSA. No definitive answer was ever given on this.

7. The blurring of lines at CDCR between providers has not helped our patients who deserve transparency when it comes to knowledge about their care providers' area of expertise and licensure. Our current system of referring to psychologists and psychiatrists both as "MH Providers" is problematic given our scope is not equal, our foundation of knowledge and practice are based on different disciplines and we are licensed by different Boards. Physicians, including psychiatrists, have the broadest scope of licensure as physician and surgeons. By referring to us and psychologists as "MH Providers", the assumption can be made that our scope is congruent, that we bring the same skills, knowledge and expertise to the table. That we're interchangeable. When I came on as the [redacted], a psychologist was the Chair of the Clozapine Committee. I don't know what else to say other than, how does a system allow that?

Why are psychologists called 'clinicians', actually 'primary clinicians' when in the community, this term universally refers to physicians or Mid-Level Providers. Therapists are not referred to as clinicians. The use of this term is extremely misleading and further inflates the status of therapists as having more skills than they are licensed to have.

After all, everyone is called a 'Doctor' and even NOU's I read report that the psychologist on 'call' was contacted—when referring to the psychologist in house. See below and you will see that even inpatient Nursing doesn't know who is a physician and who isn't. [redacted] PsyD is listed as the admitting physician for a patient on the CTC census form. He is not new, he has been here for 1.5 years and yet nursing staff still think he's a physician? When I asked the Sargeant who was on the RCA Committee for [redacted] why the officer who

Dec 11, 2017 (3)

watched the patient 'screaming' and obsessively reading the bible, chanting, etc—didn't contact the psychiatrist on call? He stated that the officer thought "Dr." [redacted] was the psychiatrist."

We recently got new ID badges that do not help. They only add to the ambiguity of who is who. The badges simply say, "Dr. X, psychiatrist" or in the case of [redacted]: "Dr. [redacted]. It's not clear to anyone whether he is a physician or a psychologist.

The Joint Commission does not specific requirements for IDs, except that one must be shown to enter and exit, HOWEVER, THEY REQUIRE THAT THE STATE LAW IS FOLLOWED IN EACH STATE. We are not following our state's law on this, Business and Professional Code Division 2, Chapter 1, article 7.2, sections 680-680.5 (see below) which requires the professional license in 18 point font (i.e. clinical psychologist or physician).

Please let me know if you have any further questions. I will not be completing the recommended action item assigned to me by Dr. [redacted] because I fundamentally oppose the way this RCA was conducted. I stated this in the last patient safety committee. Perhaps most tragically, if my recommendations had been submitted to headquarters for review—the suicide that occurred most recently at CIW may have been prevented. Note that I recommended maintaining level of care for six months post d/c of psychotropic medications in RC as well as documentation of LOC in notes in RC. At least discussion of this with the RC may have prevented the LOC change even if the program guide had not changed.

An copy of this email is also attached. The 'scanned notes' are NOT pasted in this email. Please review those.

Best,

[redacted]

From: [redacted]@CDCR
Sent: Tuesday, July 25, 2017 12:55 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Question about Licensing

Hello. I hope everyone is having a good day today.

I have a question about licensing in TTA/MHCB/CTC. This came up in an RCA as a question from Dr. [redacted]:

Background Info

- IP had a Sentinel Event while in #104 awaiting admission to MHCB
- The incident was not reported to MHCB Licensing because the IP was not admitted to MHCB yet; therefore reporting was not required

Question: Should we contact MHCB Licensing (to get their input on whether it's reportable) from even though it's not required?

4,

Dec 11, 2017 9

On Jul 28, 2017, at 7:38 PM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

Sorry, I was reviewing this and realized I missed a question.

Dr. [redacted] I appreciate what you are saying. My feeling is there could be some impact to policy, licensing concerns, audits and the receivership, so that's why I'm deferring to [redacted] and Mr. [redacted]. I'm leery of taking action that could affect our relationship with licensing or conflict with some policy or directive from HQ, so I'm trying to check with our CIW experts about that.

I did inquire into how to recall or amend a completed and submitted RCA, and learned we would need to reconvene the group and have a consensus on adding this recommendation. I'm open to doing that once we are clear on all the effects and interactions with our other disciplines and administration. We would have to do this sort of investigation before making this recommendation, anyway, because it reaches out of CIW to our licensing, and that could have an effect beyond the institution.

I'm looking forward to what [redacted] can find out with her research. I love how we get these opportunities to learn every day at CDCR!

From: [redacted]@CDCR
Sent: Thursday, July 27, 2017 10:35 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Question about Licensing

I agree that this issue is more complicated since orders were in place. My understanding is that the patient was in alternative housing awaiting MHCB and had not been officially admitted, therefore would not be considered in the MHCB census on the date of the incident. I'll do more in depth research to bring clarity to the issue and provide guidance should (or when) this situation arise again.

From: [redacted]@CDCR
Sent: Thursday, July 27, 2017 10:02 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Re: Question about Licensing

Dr. [redacted], Thank you.

I had actually already asked this question of Mr. [redacted] and the CNE before my recommendation. I'm sorry that wasn't clear.

I understand that the TTA is not licensed and therefor typically not reportable for sentinel events as those patients are not yet admitted to a licensed facility. My question was that this was a patient was physically in the TTA but was actually admitted with orders in place. Ms. [redacted], that is the question and perhaps you know the answer. The patient had admit orders in place. Therefor, the standard rule isn't as clear and thus it may help to discuss with licensing in lieu of assuming that it falls under the general rule.

Dec 4 2017 10

My recommendation stands as this is a complicated area of monitoring for us and clarity would be helpful.

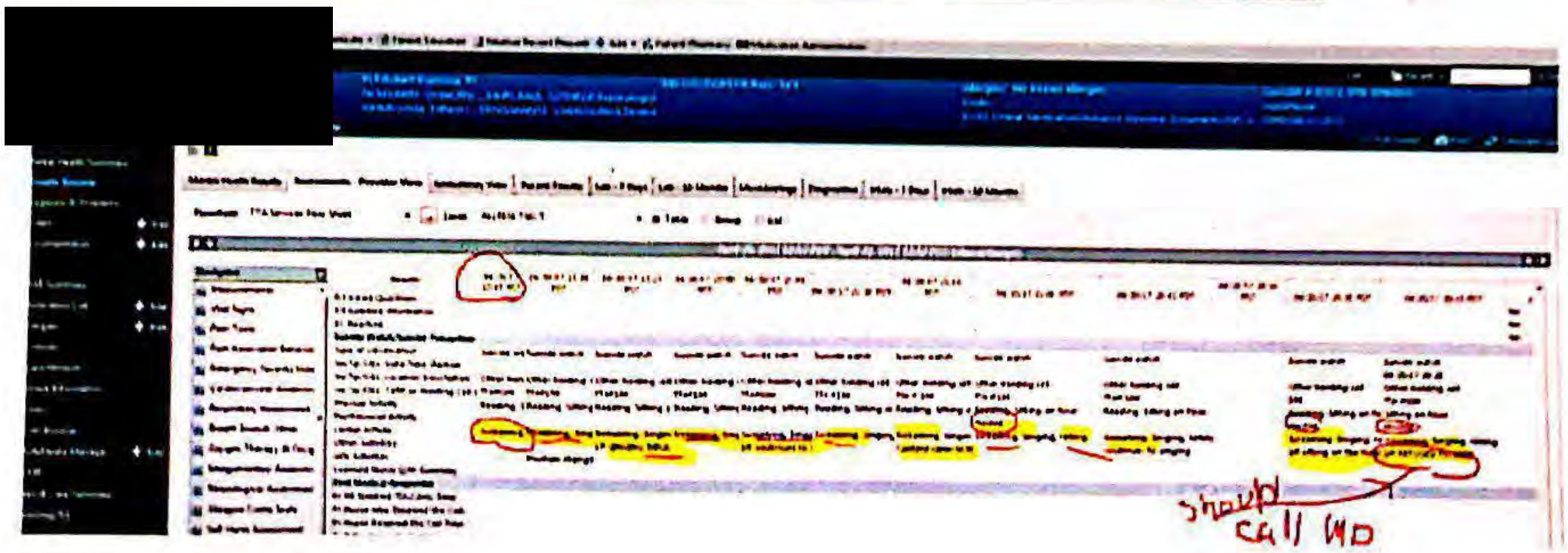
Maybe the three of us can discuss briefly in person?
[redacted], MD [redacted]

Mandatory Physician → chapter 12 "CTC Inpatient Rights 22 CCR 79799 (3) To be fully

V13.6

CHAPTER 6: Admission: Voluntary or Involuntary

I. POLICY:	Inmate-patients shall be admitted only upon written or verbal order of a Psychiatrist or Psychologist who has admitting privileges *No patient shall be admitted or accepted for care by a correctional treatment center except on the order of a physician (CT97)* The Clinical Director shall maintain an updated list with the names and phone numbers of all authorized staff personnel designated to provide admission and treatment orders in case of emergencies
II. PERFORMED BY:	Psychiatrists & Psychologists who have admitting privileges.
III. PURPOSE:	To establish procedures to admit inmate-patients to the MHCB
IV. GENERAL INSTRUCTIONS:	1. Only inmate-patients with admission orders will be admitted. 2. Admission orders and notes must include: A. Reasons for admission and initial treatment plan B. Admitting Diagnosis C. Initial general orders, e.g., (suicide watch or precautions, psychological testing, request for medical records, etc.) D. * Initial Medical orders e.g., (Laboratory, medications, diet, etc.) E. Mental status examination F. * Pertinent systems review G. * Brief physical examination including vital signs and pain assessment H. * Evaluate available laboratory reports *** Must be performed by a Psychiatrist. Admitting Psychologists must contact a Psychiatrist for completion of admission process.**
V. PROCEDURE (SEE FLOW CHART SECTION FOR SPECIFICS):	1. During regular working hours: • An inmate-patient referred for admission shall be pre-screened and evaluated for admission by a Psychiatrist or Psychologist, or if unavailable by staff designated by the Clinical Director, who will also write admission orders. 2. After hours and holidays: • Admission services are provided by the Psychiatrist on Call
ADMISSION TO CTC/MHCB FROM ADMINISTRATIVE SEGREGATION Inmate /patient meets criteria for CTC/MHCB admission (danger to self, danger to others, crisis intervention, decompensation in functioning)	



Dec 11, 2017 11

Documentation that patient was in distress—'screaming' and reading her bible incessantly for the four hour period prior to the self-enculeation. Pt is documented as being 'hostile'. This is the 1:1 sitter's documentation.

CONFIDENTIAL

DECEMBER 3, 2017

SACRAMENTO NOTIFIED/ INITIAL AND TIME:

CENSUS: 13

BM	INMATE PATIENT NAME	CDCR	DOB	ADMIT DATE	ADMIT TIME	PHYSICIAN	TYPE of BED	LEVEL of CARE	DIAGNOSIS	PLACEMENT STATUS	SOURCE OF ADMIT	
1301	VACANT											
1302	VACANT											
1303	[redacted]			11/29/17	16:20	[redacted]	MH D	[illegible]	[illegible]	MHCB	[illegible]	
1304	VACANT											
1305	OBSERVATION CELL											
1306	OBSERVATION CELL											
1307	[redacted]			10/03/17	22:37	[redacted]	MH D	ACUTE	[illegible]	MEDICAL [illegible]	[illegible]	
1308	[redacted]			10/18/17	12:07		MH D	ACUTE	[illegible]	MEDICAL [illegible]	[illegible]	
1309	VACANT											
1310	[redacted]			12/2/17	20:01		MH	ACUTE	DTS	PSY II	[illegible]	
1311	VACANT											
1312	[redacted]			11/20/17	15:56		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1313				12/01/17	10:03		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1314				11/30/17	11:30		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1315				11/20/17	23:07		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1316				11/20/17	13:40		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1317				11/20/17	17:25		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1318				11/27/17	18:25		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1319				11/23/17	23:20		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	
1320				11/22/17	15:18		MH	ACUTE	DTS	PSY II [illegible]	[illegible]	

'DR' [redacted]' IS NOT A PHYSICIAN. HE IS A PSYCHOLOGIST—THE ONE WHO ADMITTED PATIENT [redacted]

BUSINESS AND PROFESSIONS CODE - BPC
DIVISION 2. HEALING ARTS [500 - 4999.129] *(Division 2 enacted by Stats 1937 Ch 399)*
CHAPTER 1. General Provisions [500 - 865.2] *(Chapter 1 enacted by Stats 1937 Ch 399)*
ARTICLE 7.5. Health Care Practitioners [680 - 686] *(Article 7.5 added by Stats 1998 Ch 1013 Sec 1)*

680. (a) Except as otherwise provided in this section, a health care practitioner shall disclose, while working, his or her name and practitioner's license status, as granted by this state, on a name tag in at least 18-point type. A health care practitioner in a practice or an office, whose license is prominently displayed, may opt to not wear a name tag. If a health care practitioner or a licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for individual safety or therapeutic concerns. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself and in any capacity, except for an individual who is a registered nurse or a licensed vocational nurse, or as otherwise provided in Section 2800. Nothing in this section shall prohibit a certified nurse assistant from using his or her title.

(b) Facilities licensed by the State Department of Social Services, the State Department of Public Health, or the State Department of Health Care Services shall develop and implement policies to ensure that health care practitioners providing care in those facilities are in compliance with subdivision (a). The State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services shall verify through periodic inspections that the policies required pursuant to subdivision (a) have been developed and implemented by the respective licensed facilities.

(c) For purposes of this article, "health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(Amended by Stats. 2013, Ch. 23, Sec. 1. Effective June 27, 2013.)

Dec 11, 2017 13

BUSINESS AND PROFESSIONS CODE - BPC
DIVISION 2. HEALING ARTS [500 - 4999.129] (Division 2 enacted by Stats. 1937, Ch. 399.)
CHAPTER 1. General Provisions [500 - 865.2] (Chapter 1 enacted by Stats. 1937, Ch. 399.)

ARTICLE 7.5. Health Care Practitioners [680 - 680] (Article 7.5 added by Stats. 1998, Ch. 1013, Sec. 1.)

680. (a) Except as otherwise provided in this section, a health care practitioner shall disclose, while working, his or her name and practitioner's license status, as granted by this state, on a name tag in at least 15-point type. A health care practitioner in a practice or an office, whose license is prominently displayed, may opt to not wear a name tag. If a health care practitioner or a licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for individual safety or therapeutic concerns. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself and in any capacity, except for an individual who is a registered nurse or a licensed vocational nurse, or as otherwise provided in Section 2800. Nothing in this section shall prohibit a certified nurse assistant from using his or her title.

(b) Facilities licensed by the State Department of Social Services, the State Department of Public Health, or the State Department of Health Care Services shall develop and implement policies to ensure that health care practitioners providing care in those facilities are in compliance with subdivision (a). The State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services shall verify through periodic inspections that the policies required pursuant to subdivision (a) have been developed and implemented by the respective licensed facilities.

(c) For purposes of this article, "health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(Amended by Stats. 2013, Ch. 23, Sec. 1. Effective June 27, 2013.)

680.5. (a) (1) A health care practitioner licensed under Division 2 (commencing with Section 500) shall communicate to a patient his or her name, state-granted practitioner license type, and highest level of academic degree, by one or both of the following methods:

(A) In writing at the patient's initial office visit.

(B) In a prominent display in an area visible to patients in his or her office.

(2) An individual licensed under Chapter 6 (commencing with Section 2700) or Chapter 9 (commencing with Section 4000) is not required to disclose the highest level of academic degree he or she holds. all physicians

(b) A person licensed under Chapter 5 (commencing with Section 2000) or under the Osteopathic Act, who is certified by (1) an American Board of Medical Specialties member board, (2) a board or association with requirements equivalent to a board described in paragraph (1) approved by that person's medical licensing authority, or (3) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in the person's specialty or subspecialty, shall disclose the name of the board or association by either method described in subdivision (a).

(c) A health care practitioner who chooses to disclose the information required by subdivisions (a) and (b) pursuant to subparagraph (A) of paragraph (1) of subdivision (a) shall present that information in at least 24-point type in the following format:

HEALTH CARE PRACTITIONER INFORMATION
1. Name and license _____
2. Highest level of academic degree _____
3. Board certification (ABMS/AOBC) _____

(d) This section shall not apply to the following health care practitioners:

(1) A person who provides professional medical services to enrollees of a health care service plan that exclusively contracts with a single medical group in a specific geographic area to provide or arrange for professional medical services for the enrollees of the plan.

(2) A person who works in a facility licensed under Section 1250 of the Health and Safety Code or in a clinical laboratory licensed under Section 1265.

(3) A person licensed under Chapter 3 (commencing with Section 1200), Chapter 7.5 (commencing with Section 3300), Chapter 8.3 (commencing with Section 3700), Chapter 11 (commencing with Section 4900), Chapter 13 (commencing with Section 4980), Chapter 14 (commencing with Section 4990.1), or Chapter 16 (commencing with Section 4999.10).

(e) A health care practitioner, who provides information regarding health care services on an Internet Web site that is directly controlled or administered by that health care practitioner or his or her office personnel, shall prominently display on that Internet Web site the information required by this section.

(Amended By Stats. 2011, Ch. 351, Sec. 3. Effective January 1, 2012.)

OUR DOM IS OUT OF DATE, NOT CONGRUENT WITH STATE LAW.
OUR DOM:

Dec 11, 2017 14

33020.12.4 Nameplate

Revised October 19, 2009

All uniform personnel and other personnel who have direct contact with inmates, e.g., teachers, counselors, cooks, nurses, etc., shall wear and clearly display a nameplate.

Nameplates shall be phenolic engraving stock, 3 inches long, by ¾ inch wide, by 3/32 inch thick, with white letters on black stock. The corners may be slightly rounded to protect the wearer's clothing. The name letter size shall be ¼ inch high and shall be composed of the first initial of the first name, followed by a space, followed by the entire last name, centered both top to bottom and side to side. Regulation nameplate shall be worn on the outer garment unless an exception is made by the Warden.

A cloth name label sewn onto the garment is an acceptable substitute for the plastic nameplate for those peace officers wearing jumpsuits, battle jackets, and rain gear. Cloth name labels shall adhere to the following specifications:

- The name label shall have the initial of the staff members first name, followed by a space, followed by the entire last name;
- The name label shall be secured (sewn) above the right breast pocket;
- The name label shall have yellow lettering;
- The background of the name label shall be green/olive;
- The name label shall have ½ inch letters and one-inch tape.

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

[redacted], M.D.
[redacted]
California Institution for Women
16756 Chino-Corona Road
T: [redacted]
F: [redacted]
C: [redacted]
E: [redacted]@cdcr.ca.gov

I CHECK EMAIL SEVERAL TIMES DURING THE DAY, HOWEVER AM NOT LOGGED IN AT ALL TIMES. IF THIS REQUIRES AN URGENT OR TIMELY RESPONSE, PLEASE CALL OR TEXT THE CELL NUMBER ABOVE.

EXHIBIT N
(2018-01-16-1409hrs)

Reference MAPIP Tebrock rde

Golding, Michael@CDCR

1/16/18 2:09 PM

1

From: Golding, Michael@CDCR
Sent: Tuesday, January 16, 2018 2:09 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: MAPIP Dashboard Changes

Conclusion
1, Nothing has changed in the Coleman-agreed MAPIP drug monitoring rules from 3-4 years ago.
2. Monitoring of some (but not all) of the 3-year old rules has now become automated due to the availability of the EHRS
3. Since these rules have become automated, more of the monitoring requirements are now enforced
4. In enforcing more of the rules, *most of the MAPIP dashboard will now turn from green to red.*
5. This (kindly stated) implies that the manual monitoring by nurses over the last 3-years has been inaccurate and the automatic monitoring has been inaccurate
6. What we have been telling Coleman about MAPIP compliance in our system has been false. We have not been mostly compliant, though we told them we mostly were.
7. Psychiatrists and institutional managers may be upset for a bit when the MAPIP dashboard turns red, until they fix these problems

Apparent Facts:

1. MAPIP psychiatric drug monitoring standards were designed by our HQ psychiatry team, but with a lot of my input
    a. Coleman approved them 3-4 years ago
    b. For many (but not all) requirements, I selected some of the most lenient requirements from those of the Canadian system, the National Health Service in Britain, the American Psychiatric Association recommendations, etc. I did that because I understood that this was a prison setting. When there are many errors occurring, it is irrational to focus attention on those errors of possible lesser significance.

2. MAPIP parameters were being roughly (and apparently quite inaccurately) monitored automatically until the EHRS implementation, which has allowed more accurate data analysis, albeit an analysis that is still lacking in some rigor.
    a. The measurements were supposed to be monitored by a nursing manually for accuracy, using a tool that Karen Ray devised
    b. Our nursing staff manually performed spot checks and they appear to have dramatically missed major deficiencies made in drug-monitoring over the last several years, for some reason.

3. The MAPIP dashboard, given the more rigorously monitored requirements, will turn red soon. This indicates (probably) that for several years we have not been appropriately monitoring our psychiatrist's use of drugs

and

We have been violating Coleman Mandates for this monitoring
    a. This may be problematic because the reports written by our administrators about this process have indicated the opposite
    b. It seems we have been utilizing wholly inaccurate data to draw conclusions
    c. Our psychiatrists may become perturbed with pressure placed on them because of the "red" dashboard and our institutional administrators may also become concerned

Mitigating Factors:

4. Information has been hard to come by and it is difficult to know precisely what is going on
    a. Could it be that the psychiatrists are ordering the lab requirements but the institution is not successfully enabling the blood to be drawn?

i. It is possible to monitor that, if we could get the data about when a drug test is ordered by the psychiatrist, but not done. This data is retrievable.
ii. I have asked about retrieving the data, but it would take "3-weeks" for a programmer to make this information available

And

iii. The QM team (with merit) believes that it is important that the institution gets the drug monitoring done and for the dashboard to indicate what it does (particularly if red), regardless of the reason why the monitoring is not occurring.

Therefore

iv. the QM programmers will not be programming our computers to determine whether the problem is with the psychiatrist not ordering the lab or the institution not getting the blood draw done, when an order that is present.

b. It's difficult to know whether the psychiatrist is not ordering the drug, the patient is refusing to have the blood draw, or for example shortages of staff make it difficult to arrange blood draws or whether the blood is not being drawn and evaluated for a variety of other reasons.

5. The EHRS may contribute to the problem
   a. In a paper system after an order is written, the nurse (or someone) must continually try to get the order done. For example if a patient refuses an ordered blood draw, the nurse would go back to the patient day after day to try to complete the order. Only when the nurse asks the doctor to discontinue the order, for example because a patient refuses for several days, will the nurse be able to stop trying
   b. The EHRS changes that. Now if a patient refuses a blood draw, all the nurse needs to do is check an electronic box that says the patient refused and the message (that the patient refused) is assumed delivered to the physician. Unless the physician then takes the initiative to order the blood draw again, no additional attempts will be made.

   Therefore

   c. The EHRS can shift the onus of completing an order from the nurse to the doctor.

6. Institutions can improve the MAPIP dashboard problem
   a. When they focus on it, they will make sure that lab values are being done on psych patients more appropriately
   b. The silver lining is that by focusing on needed blood draws, this will cause the institution to focus on other psychiatric aspects of the patient, for example why does a particular patient refuse blood draws and could increased interaction with the patient help that.

Best,
Michael

1/16/18 2

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov


Save Our
Water
Learn easy ways to save water
during California's drought at
SaveOurWater.com

1/16/18 3

EXHIBIT O
(2018-04-26-1257hrs)

From: [redacted]@CDCR
Sent: Thursday, April 26, 2018 12:57 PM
To: Golding, Michael@CDCR
Subject: RE: Our Conversation

Having said what I said, I did want to provide you some observations.

The CEO's are generally like a weather vane and will swing in whatever direction the wind blows.

The Psychologists are not universally antagonistic. A few in the higher positions however are quite oppositional and hostile with psychiatrists.

The general run of the mill online psychologists and social workers are very respectful and work well with us. Those who aspire to higher supervisory positions may take cues from their current leaders and try to emulate them with a somewhat antagonistic attitude of oneupanmanship. An example is a psychologist on one of our EOP yards who was diagnosing a florid case of TD as a nervous tic and a mere mannerism and maintained that position even when I tried to explain that the man had TD because of a lengthy history of antipsychotic use.

I had another patient in crisis bed that I saw at the request of the staff who making a gesture of putting something around his neck and trying to pull the ends with his hands without completely encircling the neck. He wanted custody to go in. He had a law suit going on charging excessive force and had a detached retina because of that. He was hoping for custody to go in and get physical so that he could get the injury aggravated and have a further case against CDCR. I told the custody and staff that there was no acute danger to the patient and for custody not to go in but for staff to just keep a visual 1:1 on him. The patient calmed down after custody did not go in and was ok and an aggravation of his detached retina was avoided. An additional lawsuit on CDCR was also avoided. This was the case you were consulted on and you sided with me but these guys nevertheless used it against me.

I was written up the [redacted] and told that I had not followed the rules. She also did not like some of the views I had expressed earlier that a psychiatrist should weigh in before a patient is discharged. She failed me on probation because of this and other trumped up lies and fabrications. I sought a Skully hearing and won the case and retained my [redacted] positon.

EXHIBIT P
(2018-04-30-1244hrs)

Dear Dr. Golding,

I am writing you, now several months post my departure as the [redacted] at CIW. As I've embarked on a new journey outside of corrections—the first time in five years—I have gained some perspective from which I can reflect more thoughtfully on my experience as the [redacted] at CIW.

My intent in sharing it with you has no bearing on my career, or my trajectory in any personal way, as I intentionally chose to resign to avoid engaging further in a battle that seemed to that have a pre-determined victor.

I have a new position in a system of care which reflects the standards by which healthcare is delivered with patient safety as a priority. At, Presbyterian Inter-Community Hospitals, Psychiatry exists right along side other departments that comprise medical care, such as surgery and primary care. There is no silo separating "mental health" and it's ambiguous "providers", "Chiefs of Mental Health" and "Clinicians" from primary care. Leadership is based on licensure scope, thus physicians lead every department, not just in Psychiatry where we are the medical director and Chair (there are only two Chiefs—Chief Medical Officers and they oversee every department, including Psychiatry) and therapists—LCSW and/or psychologists, fall under psychiatrists. Just as Nurse Practitioners do given their narrower scope of practice. This is equivalent to the structure in every other department. Psychiatry is a branch of medicine, it is not distinct or separate. Any behavioral and therapeutic modalities fall within it—that is well defined by the ACGME and the American Board of Psychiatry and Neurology. Psychiatry does not fall under an umbrella of 'mental health' or 'behavioral health' as those are not defined or credentialed by a given specialty board. Only Psychiatry is.

This is basic yet important fact underscores the community standard—from academic centers such as USC and UCLA to community based systems of care, such as Kaiser Permanente and PIH. Even in Los Angeles County—the largest county provider of 'mental health' services in the country with the largest jail system in the country (200,000 inmates rotate through LA County jails per year), the Department of Mental Health is now overseen by the Department of Health Services, under a physician, Dr. [redacted] and the Chief of the Department of Mental Health is a psychiatrist, Dr. [redacted]

Given my experience as a [redacted] at CIW, which was largely based on deviation from the community standard described above, I find it relevant to provide reflection, almost as an exit interview, as I hope it will aid in remedying deeply rooted problems which ultimately impact patient care.

As you know, I viewed my promotion to [redacted] as a privilege. I took great pride in being entrusted with a leadership role at an institution—CDCR—that I believed in deserved whatever time, effort and challenges that were going to come my way as, in

the end, the goal was to improve inmate care. I was optimistic, but cautiously so, as even the process of my becoming Chief had hinted at signs of a competitive, barrier-laden process suggestive of concern about shifts of power at an institution that had managed to not have a [redacted] for over five years.

My reason for applying for the position was based on wanting to maintain the small, but incredibly competent and cohesive group of psychiatrists that I was a part of. It had come to a point where the Supervising Psychologists in each program were by proxy supervising the staff psychiatrist in that program. There was not a 'team-based' approach in providing care. The therapist was donned the 'primary clinician' and made all the important decisions, without needing agreement from the psychiatrist, and even in the IDTTs—the 'primary clinician' was the person who presented the case, spoke to the patient, and the psychiatrist was asked only to speak when it was about medications.

At CIW, in the one year period that I was there prior to becoming [redacted] no psychiatrist had attended the pharmacy and therapeutics committee (a psychologist—[redacted] attended in the place of the [redacted]), no psychiatrist had attended Licensed Inpatient committee, UM, QM, and perhaps most importantly, the Mental Health Subcommittee. This can all be confirmed via meeting minutes. Psychiatrists had not been involved, at all, in policy review for any of the programs outside of the PIP, even in the MHCB. In fact, nobody knew who the Clinical Director of the MHCB was when I became [redacted] I asked the [redacted], the [redacted], [redacted] and the [redacted]. The [redacted] thought it was the previous [redacted] of the PIP, [redacted] (it was not) or perhaps the new [redacted] I had appointed for the PIP, [redacted] (it was not). The [redacted] thought it was the [redacted] it was not, he was the [redacted]. Multiple policies in the MHCB refer to a "Clinical Director", yet lo and behold, nobody knew who that person was.

Finally, the [redacted] piped in and said that it was the previous Supervising Psychologist, [redacted], but unofficially. And currently? I guess there wasn't one. So here was a licensed inpatient psychiatric hospital that is solely run by psychologists, and has been for at least years. At the time of my departure, there was still no psychiatrist assigned as the clinical director. The ongoing rise in MHCB readmission rate of up to 40% did not surprise me one bit as psychologists were running an inpatient psychiatric hospital. Patients do not get admitted to psychiatric hospitals for acute therapy. No such therapy exists. The vast majority of these patients of stabilized via pharmacotherapy and a structured environment. Psychiatrists were never involved in the utilization management corrective action plan in addressing the high readmission rate—not once did anyone consider questions such as, did this patient stay compliant post transfer? If so, how many days before missing doses? Was this person's medications changed post discharge? Was this patient recently seen by a psychiatrist and denied a medication? These are all issues that we the psychiatrist knew were driving readmissions, but there was no psychiatrist involved in leading the MHCB, thus we played no role in addressing it's problems. I tried many times to highlight this, with [redacted] and [redacted], the [redacted] and [redacted]

respectively, in support, however it fell on deaf ears as the 'declared' [redacted] made no move to include psychiatry in the MHCB beyond having a staff psychiatrist.

To make this even more non-sensical, the "[redacted]" of the PIP, a psychologist, reports to the [redacted], also a psychologist as the supervising psychologist of the MHCB. Thus, the two licensed psychiatric hospitals are run completely by three psychologists. I had no role in either, except to fulfill the Clinical Director duties with [redacted] given her ongoing patient care duties. I was never informed of when the Coleman auditors were visiting. I was never sent the list of documents that they were requesting. When I did once request documentation for myself and [redacted] to review in advance of a meeting, it was denied by the PIP's [redacted], Program Director (a licensed psychiatric technician) and they indicated that they were told to deny us the documents by Dr. [redacted] (You have all the emails documenting this.)

I was not included in any emails about the PSH transfers that were to start last summer. In fact, [redacted] a Chief Psychologist and [redacted], a psychologist at headquarters were providing guidance on pc2602 to [redacted], who thankfully forwarded me the email, which is how I finally found out about the transfers and the comfort with which psychologists moved out of scope—into the pc2602 arena. They indeed provided inaccurate information which would have had detrimental effects without clarification.

The district [redacted] only included me in her weekly Chief's meeting once. I was not aware of the Sustainability audit, not invited to the entrance even and only found out after seeing [redacted] in an IDTT. When I asked about this, she responded that sustainable process was not related to psychiatrists, thus I was not informed.

I was not included in an important meeting regarding DPS use in the PIP. One of the psychologists from the district noted this and asked me if I had missed the meeting. I simply responded, as usual, that I was not invited.

I believe you have copies of emails of the dozens upon dozens of important meetings that [redacted], [redacted] and [redacted] excluded me from. I had to scavenge for information, even before a Coleman visit, on my own. Often, the only person I had to help me was the [redacted] or the [redacted] Otherwise, I truly was all on my own.

This withholding of information was key in keeping me from becoming involved, having an impact and perhaps showing that a psychiatrist has relevance and a place in leading the department.

EXHIBIT Q
(2018-05-23-2115hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Wednesday, May 23, 2018 9:15 PM
To: [redacted]@CDCR
Subject: Re: 30-Day Compliant Appointments

5/23/18 1
9:15 PM

Hi,
Thank you for your considering helping us get the data that we clinically need.
Best,
Michael

Sent from my iPhone

On May 23, 2018, at 8:58 PM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

> I agree data and information is important. We have much work to do to improve the system, which I've asked that we focus on. At the same time, we've already engaged, and will continue to engage, in a thoughtful open discussion of the data with all of the stakeholders.
>
> We have lots to discuss on June 5 when I get back to the office. I look forward to it.
>
> Sent from my iPhone
>
> On May 23, 2018, at 4:03 PM, Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov> wrote:
>
> > Hi,
> > Yes. I would add that it is important to know where the system is failing.
> >
> > For example, we don't know where appointments are not occurring on time in confidential spaces throughout our system.
> >
> > Not sure precisely what you mean by parsing data? But if appointments are 88% on time with a %-weeks compliance of 95%, that should provoke a radically different clinical and managerial response than if appointments are 95% weeks compliant and 20% on time. Do you see what I mean? The plan of correction would be utterly different.
> > And both are entirely possible.
> >
> > Furthermore all of the corrective action plans would *also* be entirely different if virtually every one of the appointments were in confidential spaces vs. if only 20% were or 0% were, in certain locations. Yes, there are units in which all patients are seen cell-side and not in offices. Data is invaluable to figuring out physically where the problems are with confidential appointments and on-time appointments. The absence of this information makes it hard to fix problems and that hurts our patients.
> >
> > So I think you can see that to make clinical decisions and implement the right corrective action plans, we need to know whether and where appointments are on

time and whether in confidential spaces — in at least most locations in our prison. 5/23/18 2

We have asked for that data for a long time and have not gotten it, as you know. I have now designed a way to get the data since the data team has apparently not had time to do it or perhaps for other reasons.

It is *clinically* necessary and my sense is that given your direction once again, this data will not be forthcoming or will be significantly delayed, but certainly I could be wrong.

I am hoping there can be a dual tract: 1. Fix what we can 2. Allow us the data we clinically need and have patiently asked for.

I want to note that several members of my team could easily have learned to write the queries to get the right information from our data bases, if the reason the data team did not look at the data is that they were too busy to help. Even I am now coding a bit.

But as you know, we were not permitted to learn to run queries because the HQ Psychiatry team was told that we did not do "QM". Thus valuable clinical information had been and has been denied to the HQ Psychiatry team.

Now, a psychiatrist has been hired to work for the psychologist's data team and he is allowed to run queries, unlike our team of psychiatrists. But it is not obvious that his supervisors will allow him to help us get the data we need, either.

But I must ask anyway: I am wondering whether he [redacted], a psychiatrist who now works for the HQ psychology/data team), might be allowed to write the code to get us access to on-time appointment %'s and % appointments and access to whether each of these appointments was in a confidential space?)

So I am hoping that in addition to your good suggestions, we also try to figure out the important clinical variables that I am mentioning.

And of course we can try to improve things as you ask and can work in a more general way, as well, and use the data we have. I will certainly try and do appreciate [redacted] help.

Please note, we were able to move people more quickly out of crisis beds in response to court orders because of the excellent work of many, but also because we had accurate knowledge of time lines. The data mattered there, too. We had to know when we were late and where the patients were! We need to similarly know for Psychiatry appointments whether they are late and where patients are being seen (Cell-Side or wherever).
The absence of this data really matters, now (obviously) in terms of trying to establish Psychiatry clinics, just like the correct data mattered when patients moved out of crisis beds.

Despite all this, your points are well taken and of course we will do our very best to get the right action taken, given what we know.

5/23/18 3

You are absolutely right that we can do better in a general sense. And thank you for involving [redacted], the regionals, and a whole team to try to make a difference.

Best,
Michael

Sent from my iPhone

On May 23, 2018, at 2:42 PM, [redacted]@CDCR [redacted]@cdcr.ca.gov> wrote:

> While I understand your questions about compliance, I'd like to spend some time trying to manage the system a little more actively. We can do more to get better results. I sent you a note directing you and [redacted] to immediately work on the actual management at our institutions. This needs to be a priority over trying to parse the data because today, I cant say we are managing our system in an optimal way. That should be our first priority.
>
> **From:** Golding, Michael@CDCR
> **Sent:** Wednesday, May 23, 2018 12:56 PM
> **To:** [redacted]@CDCR <[redacted]@cdcr.ca.gov>
> **Subject:** Fwd: 30-Day Compliant Appointments
>
> Hi,
> Just trying to see whether I have represented the way we currently calculate timely appointments accurately.
>
> One way to do that is look at the same data (just a few hypothetical patients and it should not take more than 20-minutes) and see if we get the same answer when we analyze.
>
> If we can get the same answer, then we can move forward since everyone will understand what we are doing.
>
> If I have made a mistake in rendering the way in which [redacted] and [redacted] and the team are representing things, I will change what I am doing immediately to make sure I get their answers.
>
> Best,
> Michael

5/23/18 4

Sent from my iPhone

Begin forwarded message:

From: "Golding, Michael@CDCR" <Michael.Golding@cdcr.ca.gov>
Date: May 23, 2018 at 11:41:27 AM PDT
To: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" [redacted]@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Subject: 30-Day Compliant Appointments

Hi,

Please consider the below as a representation of EOP appointments over nearly nine weeks, with patients becoming EOP at different times. I have also attached a word document, where it is much easier to see than in this message. There is an explanation below the box.

1. Please evaluate (if you have a moment) the weeks compliant divided by total weeks at the end of the box below and let me know whether the algorithm I am using is calculating those numbers correctly.

2. To calculate (a weighted average) of the whole table's appointments, one could add up all the numerators and divide by the sum of the denominators.

I am hoping that I can render your team's ideas about calculating % weeks-compliant as a measure of timely appointments. Then we

can compare the results to other ways looking at timely appointments like

5/23/18

5

1. %-on time appointments

2. %-days compliant

3. Any of the above with grace periods of varying lengths

Finally by varying the way the random appointments are generated, we can see when any of the 4-methods yield similar or different results. And we can think clinically about which measures relevant to psychiatric performance should be calculated as %-weeks compliant vs. %-on time appointments, and whether we should add grace periods

EXHIBIT R
(2018-06-01-1459hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Friday, June 01, 2018 2:59 PM
To: [redacted]@CDCR; [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Seclusion/Restraint Psychologist Role

Hi,

Title 22 refers to many different types of institutions..
Hospitalized patients are often medically sick.

Nurses are available in hospitals in an emergency.

It is not appropriate to place medically compromised patients in physical restraints without at least brief medical clearance by a nurse.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Friday, June 01, 2018 2:14 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; Golding, Michael@CDCR; [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Seclusion/Restraint Psychologist Role

We should use title 22 language

[redacted], PsyD, MBA, CCHP-MH
[redacted]
Statewide Mental Health Program

[redacted] IPhone
[redacted] Office
[redacted]@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Friday, June 01, 2018 1:16 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR [redacted]@cdcr.ca.gov>; Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Seclusion/Restraint Psychologist Role

Here is the relevant part of Title 22 § 79801 and the policy with revised language per your request.

Clinical restraint and clinical seclusion shall only be used on a written or verbal order of a psychiatrist or clinical psychologist. Clinical restraint shall additionally require a physician's or physician's assistant's or a nurse practitioner's (operating under the supervision of a physician) written or verbal approval. The order shall include the reason for restraint or seclusion and the types of restraints. Under emergency circumstances clinical restraint or clinical seclusion may be applied and then an approval and/or an order must be obtained as soon as possible, but at least within one hour of application. Emergency circumstances exist when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others, and it is impractical to first obtain an order and approval. Telephone orders and approvals for clinical restraint and clinical seclusion shall be received only by licensed medical and mental health care staff, shall be recorded immediately in the inmate-patient's health record, and shall be signed within twenty-four (24) hours.

From: [redacted]@CDCR
Sent: Friday, June 01, 2018 10:05 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Seclusion/Restraint Psychologist Role

I don't like the language for statewide policy. We should allow local PIPs to prioritize as they will but I am not comfortable with the language below.

[redacted], PsyD, MBA, CCHP-MH
[redacted]
Statewide Mental Health Program

[redacted] IPhone
[redacted] Office
[redacted]@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Friday, June 01, 2018 9:03 AM
To: Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Seclusion/Restraint Psychologist Role

There continues to be strong opinions and debate about the language in our draft policy regarding psychologist's ordering of seclusion/restraint. The issue is the balance between initiating restraint quickly to stop serious SIB and ensuring that medical issues are properly considered. The language in the draft policy is:

Clinical restraints or seclusion require an order from a Psychiatrist or licensed Clinical Psychologist with appropriate privileges to order restraints or seclusion. Clinical psychologists may write orders for clinical restraints only when a Psychiatrist is not available and only after a brief medical clearance has been obtained from a physician. Clinical psychologist orders for clinical restraints require cosignature prior to intiation of restraint, by a physician, physician assistant or nurse practitioner (i.e. those operating under the supervision of a physician) with privileges (CCR Title 22, Section 79801 (b). The Psychiatrist shall make the final medical decision after considering the physical and psychological risks versus benefits of using seclusion and restraints. In situations where the Psychiatrist did not initiate the restraints, and disagrees with the decision to do so, the patient shall be removed from restraints or seclusion as soon as possible, but no later than 15 minutes, following the psychiatrist's communication of the determination.

Would you be comfortable with the following edits?

Clinical restraints or seclusion require an order from a Psychiatrist or licensed Clinical Psychologist with appropriate privileges to order restraints or seclusion. Clinical psychologists may write orders for clinical restraints only when a Psychiatrist is not available and only after a brief verbal medical clearance has been obtained from a physician or qualified nurse. The clinical psychologist shall document the name of the physician or qualified nurse who provided medical clearance for restraints. Clinical psychologist orders for clinical restraints require cosignature ~~prior to~~ as soon as possible, and within 15 minutes of initiation of restraint, by a physician, physician assistant or nurse practitioner (i.e. those operating under the supervision of a physician) with privileges (CCR Title 22, Section 79801 (b). ~~The~~ A Psychiatrist shall make the final medical decision about continuing restraints or seclusion, after considering the physical and psychological risks versus benefits of using seclusion and restraints. In situations where the Psychiatrist did not initiate the restraints, and disagrees with the decision to do so, the patient shall be removed from restraints or seclusion as soon as possible, but no later than 15 minutes, following the psychiatrist's communication of the determination.

I set up time to discuss with you at 3pm today if you are available. I have not confirmed that this language would be acceptable to others, but I think it will resolve some of the concerns raised yesterday about possibly delaying initiation of restraints. It will be a very rare circumstance when a psychologist would be the only one available to enter the order.

[redacted], Ph.D., CCHP
Division of Health Care Services
[redacted] Office

[redacted] Cell
[redacted]@cdcr.ca.gov

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

EXHIBIT S
(2018-06-18-1359hrs)

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Monday, June 18, 2018 1:59 PM
To: [redacted] [redacted]@CDCR; [redacted] [redacted]@CDCR; Golding, Michael@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR
Subject: MH Change Management Committee - review process

Hello All,

We received some clarification regarding the change management committee, which I am passing along. Per [redacted] all change requests should come through the change management committee before we pursue an RFC. This helps ensure we make coordinated changes to the system. We are going to work hard to ensure that no changes or processes are slowed by the committee. If you have an RFC, all that is needed is to submit a solution center ticket with "MH EHRS" at the beginning of it, and that gets it tracked and routed straight to our MH team. If you find response times are slow or other performance issues, please notify John, and then me, immediately so we can ensure this doesn't occur.

Please let me know if you have any questions.

Thank You,

[redacted], cchp, Ph.D.
[redacted]
Statewide Mental Health Program
[redacted]

EXHIBIT T
(CHCF-2018-07-ASAS)

orts/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand

Report

Date Range: July

documents | Trendline: No

Colors: Green, Yellow, Red, Other

New page each group: No

6/01/18

Find | Next

Mental Health Screens

94% (18)

All MH Appointments at CHCF in month of July 98%

iatrist continuity of care

MH documentation of consultation from medical staff

0% (1)

Treatment plans with satisfactory documentation

67% (3)

Primary clinician continuity of care

Group tr... setting

ge PHQ-9 Score (Beta)

.0

nent Refused

Appointments Cancelled Due to Custody

1% (40,823)

Appointments seen as scheduled

98% (30,805)

clinical stays within ames

MHCB physical discharges within timeframes

95% (149)

ferral resolved before it eceived

Seen/Refused MH appointment duration greater than 4 hours

2 (2)

MH referral date(s) in the future

1 (1)

Data last refreshed: 8/14/2018 8:49:00 AM

Page 1 of 1

About - Report Viewer - Internet Explorer

Find | Next

Appointments seen as scheduled (ID: 204345)

DESCRIPTION	Percentage of all scheduled appointments that were seen.
DENOMINATOR	All scheduled appointments.
NUMERATOR	All apointments from the denominator that were completed as seen.
GREEN CUTOFF	0.85
RED CUTOFF	0.75
VALIDATION STATUS	Validated
SOURCE	EHRS

MentalHealthKpisPopup - Report Viewer - Internet Explorer

Find | Next

Quick List: CHCF
Appointments seen as scheduled from 7/01/18 thru 7/31/18
Placement: ALL
Data last refreshed 8/13/2018 8:37:00 PM

	Measurements	Appts Seen as Scheduled	Compliance
Appointments seen as scheduled	30805	30317	98%
ProviderUnavailable		0	0%
ModifiedProgram		0	0%
TechnicalDifficulties		0	0%
Seen		30317	98%

⊟ Details

Seen Reason	Placement	Inst	CDCR#	Name	Date	Appts Seen as Scheduled
⊟ ModifiedProgram (123)	ML EOP	CHCF	[redacted]		7/25/2018 1:00:00 PM	0
	ML EOP	CHCF	[redacted]		7/3/2018 12:00:00 PM	0
	ML EOP	CHCF	[redacted]		7/10/2018 12:00:00 PM	0
	ML EOP	CHCF	[redacted]		7/17/2018 12:00:00 PM	0
	ML EOP	CHCF	[redacted]		7/24/2018 12:00:00 PM	0
	ML EOP	CHCF	[redacted]		7/31/2018 12:00:00 PM	0

EXHIBIT U
(2018-07-02-1508hrs)

July 2, 2018 (1)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Monday, July 02, 2018 3:08 PM
To: [redacted]@CDCR
Subject: Power Plans EHRS

Hi,

You seemed to make a decision mandating that Power Plans be used for scheduling and approved a memo to that effect (but are now maybe possibly agreeing to more discussion), apparently with no understanding at all of the opinion of the psychiatry leadership team, the psychiatry leader on the EHRS project, and virtually every psychiatrist across the state who has spoken with us and been polled -- not to mention failing to take into account the historical process by which the EHRS was built.

Our team and psychiatrists across the state have repeatedly objected over years to the Power Plan design. Our medical colleagues obviously would not use it because of its inefficiency, and we repeatedly expressed our objections even to you.

As you may recall, our exec team (against the express and repeatedly stated opinion of HQ psychiatrists) designed the workflows in ways that psychiatrists vigorously objected to – including mandating powerplans -- which is why you could think that they would be considered standard, in some bizarre meaning of that word. It's our standard only because psychiatrists, for years, have been denied multiple chances to make the EHRS more efficient for them.

In terms of going down rabbit holes, which you accused me of doing, please note that your making decisions (without any apparent concern about what your psychiatry team thought, while fully listening to your psychology execs) is a very good way of beginning to dig that hole. This pattern has become far more serious, with patient care issues with far greater siginificance than EHRS issues.

Our psychiatry team briefly had hope for improvement earlier this year when the court staffing case began to get focus. You began to take an interest in certain psychiatry issues (including EHRS issues) and seemed to direct our psychology team to allow changes in the EHRS to help psychiatrists. And there was even a little bit of response.

For example the psychiatry team since 2017 begged our psychology team to enable those psychiatrists who had recently been hired to see patients when they started working, rather than to have to pay them a full salary for a month or more because of no access to the electronic record system. Psychiatrists can't see patients without the EHRS "provisioning" because they need to be able to individually find information on patients, schedule, and document their work. We begged for two years to create a simple fix for this problem, but were repeatedly thwarted by our fully non-medical exec team and admins who thought this psychiatry need was low priority. Furthermore, denying patients a month of care is also problematic, in addition to financial concerns.

The psychology team put the new psychiatrists in their queue, creating massive waste of time and resources. I note that this waste occurred, for one of the most expensive human resources in our system, our physician psychiatrist. Though we had argued for a couple of years for that change to no avail, you put a stop to their ignoring us on that one issue.

But do note that even still your psychology team did not quite follow your directive (unless you changed it when I was not aware). They did not build a provisioning resource for more than one new psychiatrist at a time, as you and we requested, but built the resource for just one! So if a second new psychiatrist comes to an institution, he or she is out in the cold and not allowed to see patients for several weeks or a month, while we pay him and patients are not seen. But even a little something is someting and we were grateful.

You say that you reported to the court that there has been a priority put on trying to improve the experience for the psychiatric physician with the EHRS, just last month. But this is just not true. Multiple projects requested by psychiatrists are not being done.

Physician [redacted] says ↓ July 12, 2018 (2)

[redacted] says the following:

We have had many instances of things not getting done, or occurring in a poor manner. This is nothing new.

1) When [redacted] asked us to go to CHCF PIP early after they started on the EHRS, [redacted] indicated he would be providing data flag data and other QM information for the discussion. Despite asking for that data, there was no response. The report was sent to [redacted] with clear indication that data was not made available to us.
2) A proposal for off-site telepsychiatry was advanced without thoughtful implementation, and sent out in announcements by the registry company to our telepsychiatry staff.
3) When I had asked [redacted] for data to better understand what Psychiatry is doing in the EHRS (orders fired, Order Rec completed, number of notes, etc), she facilitated a meeting with [redacted] me and her. It was agreed they could get the data and [redacted] was working on it. The data never came despite many asks. When discussed with [redacted] about 4 months later, she placed a request to CCHCS QM to compile the data. It sits in some queue somewhere, and no data has been made available.
4) We have had constant problems with psychiatrists sitting idle because MH Scheduling has not added them as a resource to be scheduled into. We were told there is a MH priority list, and this type of thing was not a priority. We were also told it takes on average 10 days to place someone as a scheduling resource. Just this morning I was asked by the MAT team why it has taken one month to get a new yard added for MAT scheduling at CIM.
    a. The "solution" was to have 2 or 3 people "share" a common schedule for a workday. This solution is confusing, as you can imagine.
    b. Although under the scrutiny of the court we were able to obtain the building of 1 generic scheduling resource per institution to avoid these resource delays, [redacted] and [redacted] agreed to build 4 additional generic resources. There is no timetable for that completion and it sits in another queue.
5) The recent (January 2018) survey to the field indicated a pervasive dissatisfaction with Powerplans and Powerforms. Scheduling complaints are extremely common. We have discussed in may forums, which have included [redacted] on the problems with powerplans and scheduling. Despite the concerns expressed for over 18 months, the relentless march toward powerplans and scheduling goes forward. I am not sure how many times it needs to be demonstrated this is a flawed approach, yet MH continues to double down on the process. This is not a scheduling process endorsed by Medical or Nursing.
    a. Although now fixed, we had problems with social workers and psychologists canceling out medical and lab order in powerplans.
    b. We continue to have problems with multiple open powerplans, and multiple open phases.
    c. It has been demonstrated an innumerable amount of times the number of clicks required to work with powerplans is inefficient relative to one-off orders.
6) When Psychiatry change requests were placed in the MH Solution Center ticket queue, they languished and were not addressed. It was promised they would be built by MH, but that never happened. Finally, in around late fall 2017 MH released the change requests to CERNER, who has been building them out. This in the context of MH somehow able to build items that were of interest and important to them.
7) The consolidation of power continues with the MH Change Management Committee, which has moved from a place to discuss changes to the MH EHRS process, to a group that votes whether to allow changes to move forward to be heard at CLAC in the form of an RFC. It is a committee that has a deficit of voting psychiatrists relative to psychologists. It is now impossible for psychiatry to advance something to CLAC (and heard by all the CCHCS disciplines) that would be unpopular with psychology.
    a. We witnessed this exact situation last week when in the MH QM meeting the two psychiatry voting members were outvoted in the agreement to disregard scheduling orders written by psychiatrists in the interest of the patient, over the interest of the program and data.

We have surveyed the psychiatrists and know how they want to work in the EHRS. It is not how they work currently. Given the continuing push for control, it would seem clear the intent is to engage psychiatrists when the court is looking,

July 12, 2018 ③

but otherwise disregard as has been the case for the last 2 decades. It has been very unsatisfying for psychiatry at all levels.

HQ Physician-Psychiatrist [redacted] says

I can Help

Of interest recently, perhaps to counteract the tiny bit of pressure you placed on our psychologist/admin exec team a three or four months ago, they designed a committee composed exclusively of psychologists and admins (and one psychiatrist, [redacted] to prevent what used to occur: Though our psychology team blocked virtually every (but not all) EHRS project that our psychiatrists have wanted, the psychiatrist [redacted] used to be able to appeal to his nursing, medical, and administrative colleagues at CLAC (nursing and medical representatives). Sometimes as fellow medical providers, they could (with their political force) get some of the psychiatrist's EHRS needs met by our colleagues

But that loophole in which psychiatrists could sometimes make some progress was shot down by our exec psychologists. The completely non-medical exec team/administrative team easily outvotes the one physician (Dr. [redacted]) on the panel, which means that those who have historically and continually blocked progress with the EHRS -- making disastrous and inefficient design decisions for psychiatrists -- now fully control any attempt by psychiatric physicians to make a difference. We are no longer allowed to appeal to our CLAC (medical and nursing) colleagues, but cannot ask for anything unless our psychologists, with their proven hostility to medical workflows, first approve.

So psychiatrists continue to suffer from the incredible inefficiencies of the EHRS (some of which due to the CERNER design,,,, eg med reconcilliation) but much also due to the enforcement of exec psychology mandates on our physicians in mental health. It's been disastrous and that is perhaps one of the smaller of our problems (virtually all other avenues to improve psychiatric medical care of patients are also being currently thwarted, probably since the incident at the end of April which seemed to have inspired the exec psychology team to prevent the psychiatrists from caring for patients even more.)

I actually can give you several examples where your psychology team has voted to maintain and extend their right to specifically overrule direct medical orders for specific patient care written directly and explicitly in the chart. In discussion with very high ranking physicians in CCHCS, they claim what you are allowing and have for years (overruling physician's direct orders in the chart) is probably illegal (?) This too must stop.

Finally, you say that we are following what the psychiatry experts said. Obviously you either did not allow or did not encourage the psychiatry experts to ask your psychiatry team's opinion about essentially anything related to how psychiatry is practiced in CDCR (The [redacted] was asked to give them a brief tour of a telepsych facility in which the purpose was to show them the facilities). The opinion of the experts therefore cannot take into account the information that the psychiatry leadership team knows about CDCR and its treatment of psychiatric patients.

You are fond of saying that we should discuss more in person what is said in e-mail messages. But I can point out to you that the topics we are supposed to discuss in e-mail, only occasionally get actually discussed. Perhaps that's why it is not in the front of your mind the very significant issues that are right now adversely affecting patient care, including perhaps the above-mentioned less important issues (??) that merely make psychiatrists miserable and inefficient in utilizing aspects of the EHRS.

And my concerns are at this point far deeper than power plans, as are the concerns of our leadership team in psychiatry. I believe our concerns would be shared by many.

With Concern,
Michael

July 12, 2018
(4)

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

EXHIBIT V
(2018-07-03-m)

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date	:	July 3, 2018
To	:	All Healthcare Staff
From	:	Headquarters Mental Health
Subject	:	CCHCS Healthcare Dashboard Diagnostic Monitoring Methodology Change and Mental Health Registry Enhancements

Beginning June 2018, the Diagnostic Monitoring measures on the Statewide Dashboard will adopt the new performance measurement methodology included in the new MAPIP Measure Summary. This update also aligns the Dashboard methodology with the current Psychotropic Medication Monitoring Requirements adopted by Mental Health in September 2015 (memo). Various additions and enhancements were also made to the Mental Health Registries to support Institutions in improving patient care following this performance measurement overhaul.

Dashboard Methodology Explained

The new dashboard specification documents can be found here and will be added to the PDF version of the dashboard specifications in July. The old specification documents will be stored here for comparison purposes. Although there is some variation between each of the 41 dashboard measures, the table below gives a general overview of how the methodologies differ across most of these measures. As you will see, the new methodology will require a greater level of diligence to achieve higher performance scores on the dashboard.

	Old Methodology	New Methodology
Numerator	All patients who received appropriate psychotropic monitoring screening / test within the past 12 months.	Received appropriate psychotropic monitoring screening / test within the compliance timeframe*: **Baseline*: Completed within 90 days before the medication start date and 14 days after* **3 Month*: Completed between 15 and 90 days after the start date* **Annual*: Completed between 91 and 365 days after the start date*
Denominator	Only Patients prescribed the same psychotropic class of medication every month for the past 12 months.	Patients prescribed a psychotropic class of medication with a compliance date that came due* during the measurement period. **Baseline*: 14 days after the medication start date* **3 Month*: 90 days after the medication start date* **Annual*: 365 days after the medication start date*

Patients are considered to be consistently on a psychotropic medication class (i.e. Antipsychotics, Lithium, etc.) as long as they do not have a gap of more than 45 days between prescriptions. Switching between different antipsychotic medications does not impact the medication start date.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Enhancements to the Mental Health Registries

In order to support improvement efforts in these new dashboard performance measures, the Mental Health registries have been updated with new fields, filter options, and alert rules. Institutions can now use these registries to proactively track and monitor patients with labs or charting requirements that are due soon and take action before falling out of compliance, effectively improving future performance.

MENTAL HEALTH – MASTER REGISTRY

PSYCHOTROPIC MEDICATION MONITORING REGISTRY

The Mental Health Master Registry still exists as a tool for users to quickly find all patients in the Mental Health program at any institution. Users can then navigate to any Sub-Registry (i.e. Anti-Depressants, Clozapine, etc.) by simply clicking on the column header (outlined in yellow above). Three new data points were also added to the report (outlined in red above):

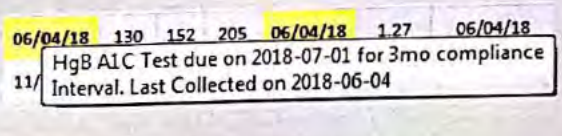
- Expired Psych Meds: Shows the count of a patient's psychotropic medication expired in the past 3 days or expiring in the next 3 days (hover for details).
- Psych Med Admin Alert: Displays a check mark if a patient missed any High Alert or PC2602 medication, 50% or more of administrations within the past 7 days, or 3 consecutive days of any one medication (Psychotropic Medications only- hover for details).
- Psych Drug-Drug Alerts: Displays the highest level of drug interaction, if one exists, between active psychotropic medications and any other active prescription. Users can hover over the interaction for more details or click to access the Drug-Drug Alerts report.

MENTAL HEALTH – SUB-REGISTRIES

PSYCHOTROPIC MEDICATION MONITORING REGISTRY

All 6 of the Mental Health Sub-Registries will look and act similar to their prior versions but have significantly enhanced functionality outlined below. In addition, all flagging rules have been updated to match the new Diagnostic Monitoring performance measurement methodology.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Description	Example
All Sub-Registries now include each patient's most recent Height, Weight, and Blood pressure	
Hovering over any flag in the registries will show the reason for the flag, the compliance interval (i.e. baseline, 3 month, annual), and the last date the lab / charting was completed.	
New filter options allow users to quickly find all patients with a lab or charting requirement due within the next 30 days.	

ACCESS AND TRAINING

REPORT ACCESS

Click *here* to access the QM Portal Care Team Tools & Operational Reports page; you will find the enhanced Mental Health Registries under the "Behavioral Health" section. A Definitions document that provides detailed information about report features and data sources is linked on the top right corner of each registry.

TRAINING

Quality Management will hold a training on the MAPIP Measure Summary and Mental health Registry updates at the next two QM Webinars (July 11th and 18th), held every Wednesday from 1-3 pm. Please click here for more details.

Questions?

Please direct any questions to the appropriate group below:

Mental Health Policies and Procedures: MHPolicyUnit@cdcr.ca.gov
Data Issues: QMStaff@cdcr.ca.gov

EXHIBIT W
(2018-07-06-1016hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Friday, July 06, 2018 10:16 AM
To: [redacted]@CDCR
Subject: Resolving the "Clearance" Issue

Why a psychiatric medical clearance order is needed,

~~7/6/18~~ 7/6/18 ;

Hi,

Please don't feel that the issue of needing psychiatric/medical clearance (some prefer the words "risk benefit analysis") for discharge from licensed facilities would be resolved by mandating that psychiatrists fill out some new form in . treatment team or some new part of a treatment plan.

That understanding would misunderstand the problem.

The problem is that the incentive of the psychologist needs to change. That is what is different between our system and perhaps any other system. The psychologist has no incentive in our system to make sure the psychiatrist is involved in discharge decisions, other than to successfully mouth the words,

"It is a treatment team decision. The psychiatrist must be involved in discharge decisions".

Such words are cheap and meaningless as [redacted] review shows, even though these words have been mouthed repeatedly. Yes these words have been mouthed, even by very powerful people in the mental health chain. But they have accomplished noting and would not be expected to accomplish anything, because they do not change the ***incentive*** for the psychologist, who currently have an incentive to discharge the patient frequently, without including the psychiatrist, unless they think that there is a psychiatric issue that should be addressed by the psychiatrist. You speak frequently about including psychiatrists, but that did not change that every single HQ psychologist in the room at a meeting voted on a recent issue that it was OK to countermand a physician's order about when a patient needs to be seen.

Whatever new "form" or new part of a treatment plan that you or I might mandate that the psychiatrist fill-out that would indicate medical clearance will not help. Because to be effective, that "form" must actually be tied to ***an order*** to nursing that gets the patient ready to go. [redacted] **solution is a form that actually is an order to nursing that it is OK to get the patient ready to go**. That actually would work! If psychologists (essentially in charge of our patients in our program) needed the psychiatrist to evaluate a patient for medical clearance, before the order preparing the patient to leave went to nursing, that would in fact solve the problem.

Otherwise the psychologist will write the order that goes to nursing that gets the patient ready to go. Whatever we mandate that the psychiatrist fills out will not be filled *before the psychologist sends the order to nursing that gets the patient ready to leave*. Attempts to mandate that psychologists not send the order prior to the psychiatrist clearing the patient are equivalent to telling psychologists to include psychiatrists in discharge planning. The [redacted] problem (psychiatrists not involved in discharge decisions) will persist. But, there will now just be some new mandate for the psychiatrist to fill out some new form.

Do you see that creating new mandatory forms does not change the incentive for the psychologist to include the psychiatrist? Yhat has lead and continues to lead to medical disaster.....

New mandatory forms (eg psychiatrist should write more in treatment plan) just kicks the "can" down the road. Actually much worse. (And it is a fascinating theoretical story about what can make government ineffective, which is being replayed with this very issue)

The leaders who mandate these paper solutions, without dealing with the underlying incentives, feel they have solved the problem and so no more work needs to be done. But the incentive (power) structure is the same so people (psychiatrists and psychologists) effectively do the same things.

Only the words have changed. 7/6/18 2

But far worse, the leaders consider the problem solved. What actually happens then becomes the opposite of what the leader says, because the incentive does not change. So the leader has said, "I mandate X instead of Y". But what happens is "Y instead of X". And so those who report to the leader notice that the opposite of what the leader says should happens in fact happens, which has its own bad implications.

In this case -- because the incentive of the psychologist to include the psychiatrist in discharge decisions does not change -- mandating that psychiatrists fill out new forms now clearing patients, helps not at all in addressing the underlying problem. The underlying problem is that psychologists receive tremendous succor and support from their leadership in their belief that they should determine what is a medical issue; that is in this case, they are supported culturally in speaking with psychiatrists about discharge only when they decide that a medical issue is present. The record is very clear, regardless of what people say.

So the problem goes on and on and on, regardless of the leaders' pronouncements. Worse, the consequences of the problem go on and on. Until someone finally decides to do something more definitive.

Allow the psychiatrist's clearance note to be an order that notifies nursing that the patient is ready to go.

Then the psychologists will include the psychiatrists in discharged decisions. They will do so because their incentives have changed, not just because a pronouncement has been made.

Does this make sense at all to you? Perhaps I have not expressed this clearly.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Save Our Water

Learn easy ways to save water during California's drought at SaveOurWater.com

EXHIBIT X
(2018-07-12-1000hrs)

% weeks Clinical Management EHRS committee
Compliance does not take MH account EOP timelines
July 12, 2018 July 17 2018

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES
MH CHANGE MANAGEMENT COMMITTEE

Meeting Date: July 12, 2018
Meeting Time: 10:00 a.m. – 11:00 a.m.
Location(s): Building G, G2-332
Dial-In Number: 877-402-9753
Participant Code: 7304543

	INVITEES	WORKING TITLE	AREA/DISCIPLINE
☐	[redacted]	[redacted]	Mental Health – Executive
☐	[redacted]	[redacted]	Mental Health – Executive
☐	[redacted]	[redacted]	MH – Program Support
☐	[redacted]	Administrator	MH – Quality Management
☐	[redacted]	Administrator	MH – Region III
☐	[redacted]	Administrator	MH – Clinical Support
☐	[redacted]	Administrator	MH – Region II
☐	[redacted]	Administrator	MH – Region IV
☐	[redacted]	Administrator	MH – Region I
☐	[redacted]	Administrator	MH – Training & Operations
☐	[redacted]	Special Asst. to the [redacted]	Mental Health – Executive
☐	Michael Golding	Chief Psychiatrist	MH – Psychiatry
☐	[redacted]	Chief Psychiatrist	[redacted]
☐	[redacted]	Chief Psychologist	[redacted]
☐	[redacted]	Chief Psychologist	[redacted]
☐	[redacted]	Chief Psychologist	[redacted]
☐	[redacted]	Sr. Psychologist Specialist	[redacted]
☐	[redacted]	SSM II	MH – Program Support
☐	[redacted]	SSM I	MH – Quality Management, IRU
☐	[redacted]	SSM I	MH – Program Support
☐	[redacted]	SSM I	MH – Program Support
☐	[redacted]	SSM I	MH – Program Support
☐	[redacted]	HPS I	MH – Quality Management
☐	[redacted]	SSA	MH – Quality Management, EHRS

Agenda #	Topic	Presenter
1.	Ticket #N/A – MH Notify HCPOP Send Order • Request: "Add two fields to order: reason for referral and prior MHI."	[redacted]
2.	Ticket #993983 – Add "UM Review" as reason option to the 7 and 30 day ICF/ACUTE MTP • Request: "Add "UM Review" as reason option to the 7 and 30 day ICF/ACUTE MTP"	[redacted]

EXHIBIT Y
(2018-07-12-1442hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Thursday, July 12, 2018 2:42 PM
To: [redacted]@CDCR
Subject: SAC Problems vs. Telepsych Cellside

7/12/18 1

Hi,

We were hoping to expand the use of camera equipment to use cell-side to improve the safety of patient visits on-site, where much of the care is unsafe in multiple locations. Remarkably enough, cell side visits on-site are often worse than cell-side visits when organized by telepsychiatry. Let me explain

Telepsychiatrists currently are making several cell-front visits using laptops and cameras to see patients who will not leave their cell or if custody is unable to bring them. That is going on right now and is often an improvement over the conditions that on-site psychiatrists face. Dr. [redacted] should be told that we are using cell-front psychiatry. He asked whether we were using the specific camera we showed him yesterday and [redacted] answered truthfully "No" (we are not using that set-up). But we are doing cell-front telepsychiatry using just the cameras that are attached to laptop computers in multiple settings. If we need to stop doing that, please let us know although I think in many circumstances it can improve patient safety given the context in which our psychiatrists practice.

Telepsychiatrists don't like doing cell-front telepsychiatry, but they do it to try to take care of the patient. Better camera equipment and microphones, portable and stationary, would improve the experience in the future. The excellent camera and reasonable microphone used in the crisis bed (that could be used elsewhere) can only be considered a "bad" or "worse" solution in the context of knowing what other alternatives there are. If it is bad, it is bad relative to what? Let me explain why even the laptop camera and cell-side visit can be much better for patient care than many of our [redacted]site cell-side visits for psychiatrists.

My visit at SAC was interesting. Telepsych had to pull out of SAC a few years ago because we could not force the changes needed to make cell-side telepsychiatry even minimally safe there and we could not get patients brought to appointments. Normally we can force the changes so even cell-side telepsychiatry can sometimes be preferred, because we make the context of the cell-side visit safer. But we could not do that at SAC and so telepsych left.

On-site psychiatry at SAC, however, is also not practiced safely there. If we could divert patients from EOP there to a different institution, we really should. I understand if there is no alternative. We have to do the best we can. But current psychiatric care there is just not acceptable at all. So I would much rather have a set-up like we had with the camera in the crisis bed at CHCF, than on-site care at SAC. Given the conditions at SAC, I don't believe that even our telepsych team could enforce a measure of safety at the institution. We tried before and failed.

The basic reason why telepsychiatry (even cell-side telepsychiatry) can often be better than onsite cell-side psychiatry – but certainly is not always or even most of the time better-- is this: In other institutions in which cell-side visits occur telepsychiatrically, our telepsychiatry managers fight to get patients seen in an office and not cell-side. And if the telepsychiatrists do have to go cell-side,
we

1. insist on quiet conditions,

that

2. the patient be found ahead of time (no searching around yards),
3. an MA is there,
4. a custody officer can open the food port for visualization if necessary with the camera, etc. and etc.

[redacted]e were unable (and I suspect are) unable to insist that that occurs at SAC now and so telepsych left and should not come back unless drastic changes occur in the culture.

7/12/18 2

The SAC on-site psychiatrists schedule around 11-16 appointments *in the morning* hoping that a few patients will come to their clinic. When I was there two days ago, 3 of 11 patients showed up for one of the psychiatrists in the morning and 4/16 showed up for the other psychiatrist we shadowed. They are told by their administration to cancel out all appointments that don't come, which has the effect of not allowing a no-show rate to be calculated or known. So their numbers look like they're doing far better than they are.

After all, if 3/11 patients show up, but you cancel out the appointments for eight, then you record that 3/3 scheduled appointments came and your refusal rate is zero! If you investigate the data, it looks like the psychiatrist is not scheduling enough. LOL. The schedulers also reschedule the no shows, so it doesn't look like a cancellation or a no-show! The patient is seen "cell-side" so there is no record of the very low % of patients who did not come to clinic!! Makes it look far better than it is. Hmmm.

And we also can't calculate what must be a huge cell-side non-confidential rate given the QM team won't calculate that for us and the psychiatry team is not allowed to send (even read only) queries to the data base. So QM does not capture this horrible "no-show" rate at the clinic and we can't tell that most of the visits are cell-side! Hmmmm.

You have to be there to see it with your own eyes. You should go undercover with me!

The actual reality is that 65% to 80% of patients don't show and the psychiatrist's time is utterly wasted in the morning waiting for large numbers of patient who never come. Their time is also utterly wasted in the afternoon.

Keep reading.

At SAC after the morning, we spent maybe an hour running around the yard in (I believe) about 100- degree heat trying to find patients, with other patients/inmates running up to the doctor (closer to the door to the block) and with him sweating profusely with his heavy stab-vest on. I think the stab vest is critical. He and I were surrounded by inmates on the yard and toward the doorway with no custodial officer anywhere near us and multiple patients coming up to him.

As Dr. [redacted] says,
"Nothing has changed in 4-years".

She left SAC because of trying to find patients on the yard and being surrounded by inmates and it was unsafe. It was clearly very dangerous for the psychiatrist who tells me (modestly) that these conditions will affect psychiatry retention!!

For those appointments that occurred in the doorway (non-scheduled), the doc had no health history about them and tried to provide a medical intervention in 100 degree heat (actually just inside the cell-block door with many inmates around) for about 90-seconds in a patient he did not know and had no information about! Wow.

This type of on-site visit is the proper comparison in CDCR to a cell-side camera visit that is orchestrated by the telepsychiatry team. Our telepsychiatirst is in a comfortable location, has a patient in a fixed location, can see and hear the patient in the cell with a camera, can speak for 30-minutes, and has the patient's records. Cell side cameras, in the context of a telepsych team that is trying to protect the patient and improve the communication is far far better than what happens in-person at SAC, for example, as I think you can see.

Other cell-side interactions that occurred in person at SAC were actually *worse* as the day went on. We found no patients whom we were looking for on the yard, although the doc says he's learning where the patients hang out to better locate them in the future. But we looked at several locations around the yard and were unsuccessful. Then we went cell-side to try to see patients, but the conditions were much worse than the minute-appointments in the doorway between the block and the yard in which patients came up to the doctor. Many of the patients were not in their cells, either.

7/10/18 3

We were in a block with an incredibly loud air conditioner and the TV volume incredibly loud. Inmates were milling about wearing only a towel and yes I could see what the doctor meant about how easy it would be for an inmate to throw him off the upper tier. It would be utterly inappropriate for a female psychiatrist to have been there. Our female psychiatrist says that she is given 10-15 minutes to try to see her (she recalled) 7-cellside patients before shower time (between 12:45 and 1:00). SO she is only guaranteed 15-minutes in the afternoon to see the patients before the showers begin. (It is not safe for any female non-custodial officer to be there with half-naked men wearing only a towel while the woman is easily surrounded. So I support her not going into the blocks with the nearly naked men.)Unfortunately, I thought I saw some inappropriate public activity going on when we arrived, given what I could visualize.

Our female doc doesn't go there during shower time and she shouldn't to protect her life, but her patients can't get care. As stated, she reports that she is given 15-minutes (between 12:45 and 1:00) to see her patients cell-side before the showering and she finds that ridiculous (I find it ridiculous and highly dangerous).

It's not much better for the patients of male psychiatric patients. When we went cell-side, multiple of the patients were not there and no one knew where they were. Because of the loud conditions (air conditioner and TV), the psychiatrist had to (almost) scream through the door so that the patients cellmate, and everyone around could clearly here. The questions could be no more psychiatric than "Are you going to kill yourself?", "Any side effects?" , "Do you want more of the depression med or the voices med?"

To add to the experience, there was an "agitated" inmate on one of the blocks, so they (appropriately) forbade us from seeing all other patients housed on the block. The psychiatrist asks me what I would think if we had been there when the inmate became "agitated". I paused and considered.

What I saw at SAC was not even a primitive psychiatric interview nor was it psychiatric care. Our physicians were struggling. Their goal can only be to try to prevent the patient from toxic reactions to meds, and try to stop suicidality, while making the best guess they can about medications..

No amount of QM number manipulations (%-weeks compliant vs on-time appointments, cancelling out appointments so they are not recorded as no-shows, the QM team refusing to allow us to calculate % of visits that are cell-side, 30-50 IDTT's scheduled in 3-4 hours [and not allowing us to calculate how often that occurs], making it challenging to record and calculate non-confidential visits, etc.) can obscure what is straightforward and easy to see.

You can't provide medical care with no little to information standing cellside, and virtually screaming through a cell-door, no matter how many EOP reviews we are said to pass. If we pass when this is occurring, passing means nothing in terms of medical care.

Our number crunching is also bizarre and poorly done. The CCC psychiatrist was seeing patients cell-side frequently and never once (he said) recorded the visits as in non-confidential spaces (though we would not be allowed access to the data even if he did). The system defaults to recording visits as confidential so all his cell-side visits were recorded as confidential (even if we were allowed to make these calculations system-wide and investigate psychiatrist by psychiatrist, which we are not)

So even if we were allowed to know what the system calculates as the % of non-confidential appointments and no-show rates in clinics (not "cancellations"), we still would not have accurate data. The psychology EHRS-designers-for-psychiatrists will not allow us to create separate note "types" for confidential vs. non-confidential appointments, for example. That would be a straightforward solution (per Dr. [redacted]

Relative to the cart with the camera at CHCF, SAC with live psychiatrists is not a safe place for patients in the EOP setting. I recommend that the EOP patients be moved. If there is no alternative (no place for them to go), then we can only hope that very rapid changes occur. There are reasonable numbers of psychiatrists working there and the [redacted]

7/12/18 4

[redacted] seems reasonable. Furthermore the psychiatrists are reasonably organized. They just don't have the executive might to force the type of changes that would allow them to practice medicine. It really would require a custodial solution (read below)

The problem is that custody is not moving patients to the appropriate psychiatric clinic in the morning at SAC, virtually at [redacted], and it is very convenient to say the patient refuses (although even that is recorded as a "cancellation" or a "rescheduled appointment"). Somehow they refuse ("Cancel") so much more at SACI Patients are brought in batches rather than individually.

Solution:
The cultural incentives need to change.
If patients were

1. brought to appointments

and

2. If no-shows were tracked by custody

and

3. If custody had to work with the physician on the cell-block to find and track patients who did not make it to clinic (so docs would not be trying to find paitents)

and

4. If custody opened food ports (so docs don't spend their time virtually screaming through cracks in a door

that might be the beginning of a solution.

To get patients to appointments

A. Custody should get to know the patients better who refuse to come to appointments (that are recorded as "cancelled" [or are rescheduled so not even reported as "cancelled"]).
B. It should be imperative at SAC (probably system-wide) that the officer recording the refusal fills out a relatively detailed report about the condition of the cell and the condition of the patient in the cell.
C. For each patient that does not come, the custody officer should sit with the psychiatrist in the clinic area and review the patient with the psychiatrist, so the psychiatrist could learn more about the patient and his refusal.
D. My guess is that as the custodial officer pays closer attention to the details of the mental health patient's confinement, by documenting about it and speaking to the psychiatrist, the custody officer will understand the patient.
E. A far higher % of patients will come to appointments as soon as custody officers begin noticing the problem and having to carefully document about it each and every time patients do not come. If patients come, no documentation would be required because they could get care by the physician.

When cell-side visits must occur -- these are currently the norm at SAC

A. A custody officer should be assigned to the psychiatrist on the ward and responsible for finding the patients that need to be seen in the afternoon.
B. The custodial officers should be willing (if safe) to open food ports if the psychiatrist asks in the cell.
C. For a few patients in the afternoon, (maybe 2-3 per day, the custodial officer should be able to open the cell and bring the patient to the block. I recommend a treatment module on each block. Since the patients will not come to the clinic, the custodial officer can help encourage the patient to see the psychiatrist in the TTM.
D. The key is that the healthcare access officer needs heavy involvement in an utterly unacceptable situation.

When we have 25-minute treatment teams that Coleman observes, with select patients for the day of their arrival, of course the care looks reasonable. If you actually follow a real psychiatrist throughout the day (and we followed two), you understand quickly what medical danger is.

EXHIBIT Z
(2018-07-17-1703hrs)

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Tuesday, July 17, 2018 5:03 PM
To: Golding, Michael@CDCR
Subject: hi from CHCF

July 17, 2018

Dr. Golding,

Nice to speak with you today. You asked me to write you regarding some specific comments I made today, so here is that:

It seems that certain types of decisions, including level-of-care changes, are made by the supervising psychologist in consult with the clinician (psychologist or social worker). In a setting like this, you must choose your battles, so I don't say anything. On a few occasions I did get frustrated because I felt strongly about certain cases and spoke up, expecting people to respect my view, but certain staff just argued against me. If I really felt I wasn't being heard, I could have just contacted the other facility involved to say that I disagreed with the team, but I would never do that. Even weirder is when they answer questions for custody regarding whether mental illness played a role in some infraction when going in front of a disciplinary board. This question almost always seems to involve a deep understanding of the role of medications in relation to their illness, and I'm trained in forensics and have been involved in answering questions like these for courts in several locations and internationally.

I've just gotten very good at biting my tongue for 90% of our meetings that are dominated by psychologists. It helps keep me humble, because in reality I'm trained in Johns Hopkins and Yale and have often had high level experiences or been directly involved in research related to the matter at hand. So if a social worker with no real mental health training is asked their opinion over mine, it just tells me that the system is more interested in other things than truth. Hope that's not too cynical or going to get me into trouble. I'm always interested in big picture and systems level thinking, so please let me know if I can be of service or if there are any unique opportunities in the future. Thank you.

Psychiatrist at CHCF opines that his medical opinion seems less valuable than that of a social worker or psychologist.

EXHIBIT AA
(2018-07-17-1722hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Tuesday, July 17, 2018 5:22 PM
To: [redacted]@CDCR
Subject: FW: CHCF Clinic Model

7/17/18 ①

Slight edit

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: Golding, Michael@CDCR
Sent: Tuesday, July 17, 2018 5:17 PM
To: [redacted]@CDCR
Subject: CHCF Clinic Model

Hi,

Visit to CHCF on Tues 17th

[redacted], MD (Statewide [redacted] and I (Michael Golding, MD Statewide Chief Psychiatrist CDCR) went to CHCF on Tuesday the 17th of July. We visited all yards and spoke with the 3-on site psychiatrists who were there today. Two of them work in the crisis bed and one works in Ad Seg EOP. We also spoke at length with [redacted] The CHCF [redacted]

Clinic model:
Crisis Bed
There is no clinic model in the crisis unit hospital beds. Custody will bring patients to seated psychiatrists for initial psychiatric appointments, but not follow-up visits which are all cell-side. There are 3 rooms which all the psychologists, social workers, and Rec Therapists compete for in order to have the privilege of being able to see patients confidentially. The two physicians in the crisis bed were clear that there was no pecking order for these room assignments. Rec therapists have as much priority as physician psychiatrists in claiming the rooms or claiming the custody officer's time. We confirmed the "first come first serve" model with custody.

7/17/18 ②

Practically, the absence of clinic space or a clinic model means that psychiatrists will attempt to see crisis bed patients for their initial appointment in a confidential space, but they attempt no follow-up appointments in a confidential setting given the office shortages.

Instead all follow-up appointments are cell-side. Given time constraints, Dr. [redacted] cannot use the shared room (that the Psychologists, Rec Therapists, and Psychiatrists compete for) in order to dictate notes. He says he needs to use Dragon (to dictate his notes), but he has no office and therefore when he leaves the competed-for-space there then is no quiet space where the computer can accurately process his voice. He notes that the occupational therapy supervisor has an office but thinks he should have one to be able to dictate his notes.

If he returns to his "office" (a chair at a table in an open room with many people seated and walking about), he does not have the quiet to dictate. Lack of office space is a constant.

Both psychiatrists said that their decision making was not adequately considered. Dr. [redacted] and Dr. [redacted] both expressed that often when they go to treatment teams, they find out that their patients are going to be discharged during treatment team, sometimes in the beginning of the team when it is announced or sometimes when the patient is told. Effectively the psychiatrists opinion is not considered in making many of the decisions for discharge and both psychiatrists say that their opinion has been overruled. Both asked who is ultimately in charge when discharge decisions are made. They both said that it seemed that the psychologists who made the discharge decisions were in charge and did not need to consider their medical opinion.

On the other hand, they said that if they vigorously objected, often but not always, the psychologists running the treatment team (and making the decisions) would change his or her mind. Nonetheless it was clear that many or most of the decisions about discharge were made by psychologists without consulting the psychiatrist and the decision was a *fait accompli* when the psychiatrist first heard about it in the treatment team.

The psychiatrists also thought that having just psychologists determine that a patient is medically appropriate for admission to the crisis bed hospital is problematic and dangerous. They say that the psychologists determine that it is OK for the patient to come to their hospital and the physician psychiatrist is not consulted. Dr. [redacted] (the [redacted] said the admission team used to consult with her, but not anymore. She says that many patients are medically compromised and they hear about the problems after the patient has arrived, when some preparation would have been better.

Huddle in the AM takes about ½ hour. There are about two hours per day of treatment team meetings. Shower time is between 2:30 to 4:30. There is about an hour per day of groups that take the patient away. Huddle plus IDTT plus group takes between 8:00-11:00. Psychiatrists have between 11:00-2:30 to compete for the available rooms for the privilege of having confidential appointments with the patients. After 4:30 custody is usually not available so patients can only be seen cell-side. Psychiatrists usually use the time after 2:30 to do documentation.

AdSeg EOP

We visited Ad Seg EOP. There is no clinic model present. The psychiatrist (Dr. [redacted] says that he is competing with the patients who are on grounds or in groups. Patients will not be brought to him in general but he says he has worked out how to see patients in the yard (standing up) and interacts with many of his patients that way. He also sees them cell-side. In terms of his ability to be involved with decisions about level of care change, he says that he tries to just agree with the decisions that the psychology leaders make (and they usually do not consult him). He says that he has hoped that when he does have a strong medical opinion about a particular patient (because of medication changes or instability) that at least at that point the psychology leadership would hear him out. But he says that the few times he has tried to change a level of care decision, the psychologist simply said, "No."

The AdSeg psychiatrist frequently sees patients cell-side, but does not know how to record these appointments as non-confidential. The EHRS default-setting is that the appointment is confidential, so even if the psychiatry team were allowed to know the EHRS %'s of patients that are documented as being seen cell-side, since many of our psychiatrists

(including this one) do not know how to use the EHRS to record that, the appointments are recorded as confidential though they are not (there are simple fixes to make it easy to record this but these have not been allowed).

7/17/18 3

-yard
No one shows up" ([redacted] Dr. [redacted]. Doctors have to find the patients to treat them.

C-Yard: Dr. [redacted] noted that the general medical physician has a large independent office and then a room right next to it (a large exam room). Dr. [redacted] points out that none of the psychiatric physicians have anything like that. There are two spaces in which patients can be seen (if they were brought). Social Workers, Psychiatrists, and Psychologists compete to use those rooms, but Dr. [redacted] said that in general it has not been hard for the psychiatrist to gain access to these confidential spaces. Indeed when we were there, no one was in either of the spaces, so there appears to be space available. But per Dr. [redacted] the hard part on "C-yard" is "finding the patient" to be able to complete an appointment.

Some of the medical yards have 4-beds per dorm. It is hard for the psychiatrist to either get the patient to a room and the room itself is not confidential because of three other medical patients who are there.

Dr. [redacted] herself does have an MA assigned to her who helps her to accomplish her tasks. None of the admins assigned to the CMH in general are able to help her but she is very happy about the MA (we explained to her that MA's are not supposed to be used that way, but to assist the clinical staff. Instead, the admins helping the CMH are supposed to be shared with her which they are not.

Dr. [redacted] fills in for her psychiatrists and sees patients, like more than half (about 60%) of the Chiefs and Senior Supervisors across the state. There certainly is no clinic manager in any setting nor is there time or personnel available for Dr. [redacted] to try to arrange that coverage.

In short, there is no clinic structure at CHCF, psychiatrists struggle for confidential spaces which are frequently absent, and finding patients is a daily struggle. There is not much respect for medical decision-making by physician psychiatrists, but psychologists fill in with medically involved decisions by determining whether the medical context is safe for patients to be admitted in crisis beds hospitals, when medications are titrated sufficiently for patients to leave crisis bed hospitals, when levels of care should be changed in AdSeg. and throughout the hospital etc.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Save Our Water

Learn easy ways to save water during California's drought at SaveOurWater.com

7/17/18
(4)

EXHIBIT BB
(2018-07-18-R)

Mid July 2018 Dr. [redacted]

The medical danger at SAC is bad.

The below is the psychiatrists description of his day I spend with him. I eliminated the description of the previous day (much like the first) but I did not observe it so could not fill in details, like above.

Dr. [redacted] says,

Of note in the last year time there has been a stabbing on the yard, fights on the yard, and it is not uncommon for inmate patients to have manufactured weapons in their cells. Also on the prison block some inmate patients likely are walking around as they await their turn to use the shower, waiting to be escorted by custody, working as porters, etc. The blocks are also two tiered so there is always a risk that an inmate patient might throw a provider off the highest tier severe injuring or even killing a provider.

On Tuesday 07/10/2018 there were a total of 11 entirely different patients scheduled however 2 were moved to a different block and thus the actual patients scheduled to my care were 9 as the other 2 were now under the care of a different psychiatrist given the movement. Only 3 of the 9 came and were interviewed in the safety of the EOP clinic. The remaining 6 were attempted to be seen on the block in addition to the 6 remaining patients to be seen on the block from the previous day making the total of 12 cell side interviews. 5 (Five) [redacted] of the 12 inmate patients on the C section of the block could not be interviewed because custody informed us that an agitated inmate patient [redacted] was in section C and it would not be safe to enter as the door to section C was closed. The following is regarding the A and B section of the block. 1 (One) [redacted] was not in his cell to do the cell side interview. His cellmate reported that inmate [redacted] was somewhere on the yard.

4 (Four) [redacted] of the remaining 6 were interviewed cell side and 1 (One) [redacted] of the 6 was interviewed in the hallways as inmate patient called to me appearing mildly agitated requesting to be taken off his heat medications. Of note the patient was also refusing his other psychiatric medications as well. A brief interview was done in the hallway of the block. Of note, [redacted] reported the he left the EOP clinic this morning before his psychiatry appointment because he had a Telemedicine appointment at the same time. 1 (One) [redacted] of the remaining 6 was spoken to in the open section as he had finished showering and was walking back to his cell. [redacted] reported that he did not come to his EOP clinic appointment because he was in severe pain secondary to his complications from his end stage liver disease and bilateral severe leg edema.

[redacted] reported that he did not come to his EOP clinic appointment because he just recently saw his clinician (psychologist or social worker) and that the ducat he received must have been an error [redacted] reported and showed us that he only receive a single ducat for group noting "A EOP Trt Cntr Grp RM 2 MH" but did not receive a ducat for his psychiatry 1:1 appointment [redacted] reported that he had a legal visit at 7:30am that lasted approximately 45 minutes. He reports returning to the block but by this time the second group was already likely brought to the EOP clinic.

[redacted] is prescribed involuntary psychiatric medications under an active PC 2602 court order and was not able to articulate a clear reason why he did not come to his EOP clinic appointment. When pressured to clarify further the patient then reported that he thinks his cell door was not opened.

Of note, two other inmate patients who were not scheduled for today or yesterday [redacted] in different cells requested to speak to me to address their questions and needs. [redacted] seemed to commute better in Spanish but spoke some broken English.

EXHIBIT CC
(2018-07-26-1053hrs)

7_26_18_1053hrs_pg 1 pg 1

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Thursday, July 26, 2018 10:53 AM
To: Golding, Michael@CDCR
Subject: Performance Report
Attachments: Performance Report 2.PNG; Performance Report on 7.26.18 no longer has Placement option.JPG; Timely Psychiatry Contacts 7.26.18.JPG

Hi Michael,

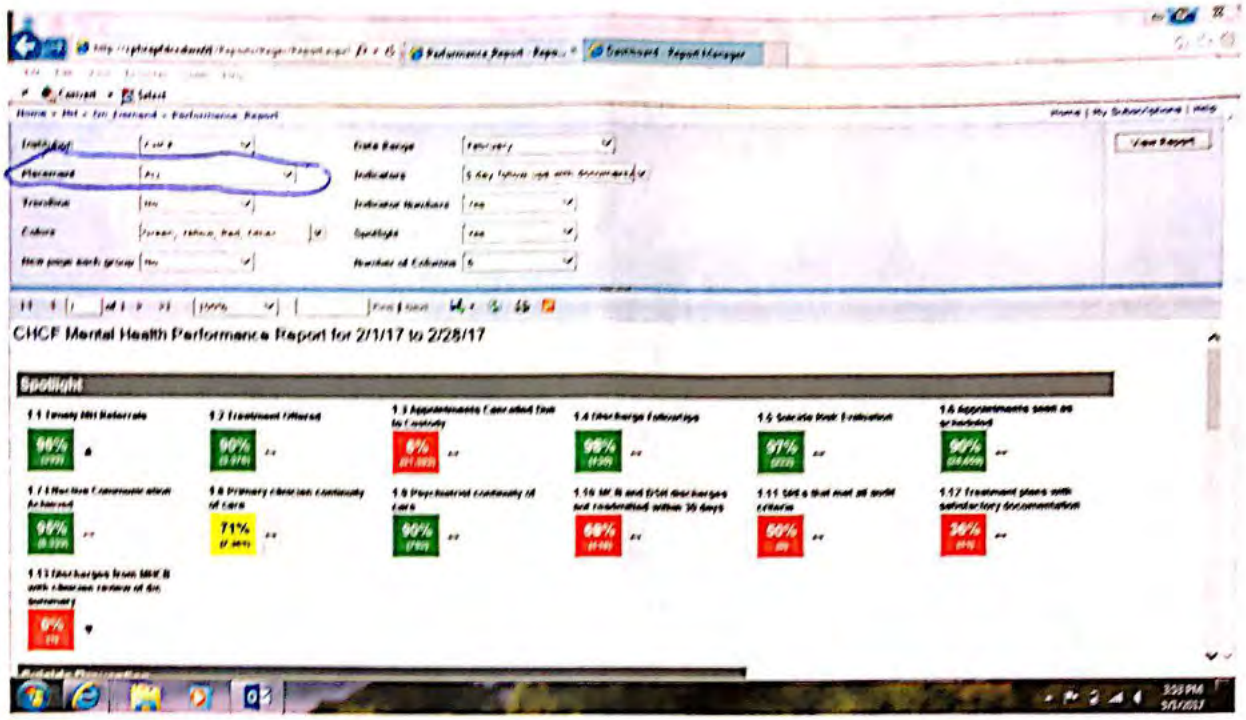
I have attached a screenshot of the Performance Report from 5/2017, showing that 'Placement' (EOP, CCCMS, etc) used to be included in the filter options, and a screenshot of the Performance Report from 7/26/18, showing that 'Placement' is no longer an option. Placement options were ML EOP, CCCMS, ASU EOP, MHCB, etc, but I don't have an old screenshot showing these options. Now that 'Placement' is no longer an option, the 'Timely Psychiatry Contacts' indicator returns one percentage for the entire institution, making it impossible to determine what the percentage is for EOP versus CCCMS. Previously you could select 'EOP' under 'Placement', for example, and get the percentage specifically for EOP timely psychiatry contacts. In order to obtain this data now, the user would have to drilldown in Timely Psychiatry Contacts, and manually sort through the list of all appointments, week by week, to total up the compliance percentage for a particular level of care. I have attached a screenshot to try to explain this better, but please ask me to explain it if this doesn't make sense.

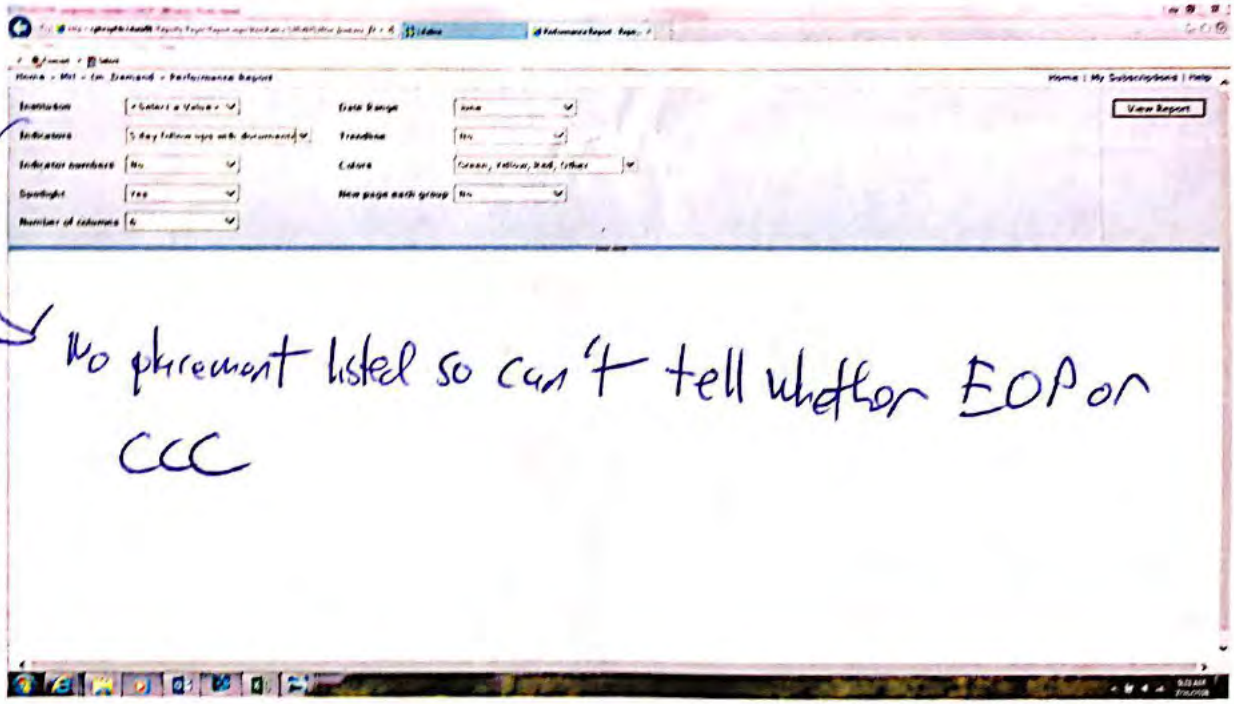
[redacted]

[redacted] **MD**
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

Pg 2

old rep 5/11/17





New report from this

No placement listed so can't tell whether EOP or CCC

EXHIBIT DD
(2018-07-27-0926hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 9:26 AM
To: [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: RE: Compliant Appointments

July 27, 2018
9:26 AM

Yes.
Thank you.
That's what I thought.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 8:45 AM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR
Subject: RE: Compliant Appointments

Exactly. The definition of Timely Psychiatry Contacts numerator is "*Number of patient-weeks included in denominator during which the patient was up-to-date on their required Psychiatrist contact. Contact requirements delineated in the Compliance Rules grid*".

The Compliance Rules grid lists the program guide limits, so that CCC patient's appointments are compliant if they occur within 90 days (or even a little longer because of the way of checking by weeks), no matter when the psychiatrist scheduled them.

Yes, the scheduling order could be cancelled with no reason given and although there would still be a cancelled scheduling order visible in EHRS, it would not show up in any of QM's indicators (unless they decided to start looking at the number of cancelled scheduling orders). If the appointment was closed without the patient being seen, it would

reason – not brought by custody, patient refused, provider not available, etc – but you're right that this would whether the psychiatry contact is timely.

. Golding, Michael@CDCR
nt: Friday, July 27, 2018 8:12 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Compliant Appointments

Hi,
Let's say a patient arrives at CCC and is referred to the psychiatric physician and seen on the day of arrival to CCC. The psychiatrist sees the patient and then schedules an appointment back in 10-days. Imagine that the appointment does not occur for some reason.

I don't think that missed appointment would not lower the %-weeks compliant number; that is it would not lower the "timely appointment" number, right?

So if the physician scheduled a patient who just arrived at CCC to be seen 10-days later, but the patient was not seen, the next appointment (say 80 days after the missed appointment) would not be considered lat (though it was 75-days late) because it is within program guide timelines (90 days from the last appointment).

Indeed, the 80 day later appointment would be considered "timely", because the patient was seen at least once within 90-days of their last appointment at a CCC level of care. So "timely appointments" does not in any way count missed appointments that are scheduled by physicians, if earlier than maximum program guide limits.

All appointments are considered timely, regardless of when the physician orders to see the person, as long as they are within maximum program guide time frames. Right?

So timely appointments have nothing to do with when physicians order patients to be seen, only whether we are following program guide timelines (and even then, it can be over and still be perfectly compliant in many scenarios, as I have illustrated elsewhere.)

So in those patients who are most likely to need to be seen (those who are scheduled earlier than mandated timelines), if the appointment was missed, "timely appointments" would not be changed.

If true, they are

1. Again ignoring the importance of a patient being seen on time when a physician orders that a patient be seen on time.
2. Creating a situation in which the reports of timely appointments are very likely falsely elevated, because all appointments scheduled before the maximum program guide timeframes cannot be considered non-compliant, so no missed appointments can be counted. There is a built in grace period for every physician scheduled appointment, because violating the maximum program guide timeframe is the only way of having the appointment count as "non-timely." At a CCC level of care, an appointment could be even 80 days late (after the scheduled appointment) and still be considered on time!

Here is a slightly different question:

Let's say the appointment is not seen that was scheduled to be seen by a psychiatric physician (in 10-days after arrival at CCC). If the appointments was closed out, presumably a reason would have to be given (or they cancel out the scheduled appointment and no reason need be given, right?) Cancelling out the appointment is possible and the worst option, because then *no record* is really visibly left of any error.

's say a reason is given (say, "not brought by custody"). This would be recorded merely as a failure to bring the would not be reported that the patient's appointment was not on time, despite the physicians order. Right? tient's appointments would still be recorded as "timely" despite missing the appointments that are the most rtant to make, the ones that are scheduled earlier than normal because there is a problem.

Thank you for thinking about this for me.
:-)

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

EXHIBIT EE
(2018-07-27-1634hrs)

7/27/18 1

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: 7/27/18 Friday, July 27, 2018 4:34 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

Yes. As I suspected, this patient according to the interpretation of a QM committee vote, did not need to be seen sooner. The psychiatrist is scheduled to see the patient 3-months after his arrival in May at SATF, which would be some time in August, which has not yet passed.

Our two psychiatrists on the committee voted against this but there are 17 psychologists on the QM committee and there were about 8 there during this vote and they (and several administrators and the [redacted] and [redacted] voted that against what our psychiatrists wanted

1. Patients transferred to new institutions should be seen within 14-days

Or

2. If they would not allow that, they should be seen at a minimum when the physician ordered that they be seen next.

The psychiatrists clearly favored number "1", but we could not get "1" or "2".

Two [redacted] (the [redacted] and [redacted]) also voted that it would be OK to override the physicians order when patients transfer.

I will ask Dr. [redacted] to find out when the last visit was at Wasco by a psychiatrist and what he ordered in terms of when the patient should be seen next..

Unfortunately, our psychologists voted that they can override when the physician psychiatrist says the patient needs to be seen next if the patient switches institutions. The reasoning is that we have a "referral based system."

That means that the psychologist decides when to refer a patient to see a psychiatrist, even if the previous psychiatrist made a determination that the patient needs to be seen earlier than the psychologist determines.

It's even a little worse than all that. Let's say a patient DOES NOT switch institutions and a psychiatrist orders that a patient be seen in 10-days. If the program guide would say that the maximal amount of time that the patient should be seen in is 70-days later (not 10 days later), then missing the physician-ordered time frame is NOT COUNTED AS LATE.

In other words, the physicians order in no way determines whether patients are considered to have been seen late or not! And when patients transfer institutions, they voted that they do not have to follow the physician's order. So those who need to be seen early and are most at risk, can be seen weeks later and still be thought to have a timely appointment.

Yes remarkable. Let's find out what the physician's order said for when the patient should be seen next if he had not transferred institutions. Given that he transferred institutions, I think he should have been seen within 14-days.

Best,
Michael

7/27/18 2

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

---

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:34 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

Hi Michael,

He came from Wasco Reception Center to our CCCMS but the SATF nurse practitioner assigned to him in CCCMS is also assigned to cover EOP. The psychiatric coverage is therefore stretched thin.

[redacted] MD
[redacted]
CSATF/SP Corcoran
Tel: 559-992-7100 Ext 7248
Cell 559-670-8029

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 3:27 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: Pt not seen by our MHMD since arrival in May

Hi,
Is the patient in CCC or EOP?
There is a reason for my request and then I will answer.
Yes I am concerned.
Michael

7/27/18 3

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

---

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:14 PM
To: Golding, Michael@CDCR
Subject: Fwd: Pt not seen by our MHMD since arrival in May

[redacted], M.D.
[redacted]
[redacted] mobile

Sent from my iPhone
Kindly excuse any errant autocorrections and spelling errors.

Begin forwarded message:

> **From:** "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
> **Date:** July 27, 2018 at 12:04:01 PM PDT
> **To:** "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
> **Cc:** "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]" <[redacted]@cdcr.ca.gov>, CDCR CCHCS TelePsych Admin <TelePsych.Admin@cdcr.ca.gov>
> **Subject: Pt not seen by our MHMD since arrival in May**
>
> Hello Everyone,
>
> This patient has not been seen since his arrival in May by one of our psychiatrists?
>
> He has had a major incident that could be related to psychosis- he is currently not on an antipsychotic?
>
> Why was this patient not seen?

7b7/18 4

7B 7/18 S

[redacted] Opened by [redacted]

Task Edit View Patient Chart Links Notifications Documentation Help

Ambulatory Organizer | Message Center | Patient List | Therapeutic Notes | MyExperience User Console | Ph

Uptodate

Links

Propo:: 1

Tear Off | Suspend | Exit | Calculator | AdHoc | Communicate | Patient Education | Medical Record

[redacted]

CDC[redacted] PCP[redacted] PS

DOB[redacted] NCM:[redacted] RN/__MHPC:[redacted]

MHMD:[redacted] Psychiatrist/__DEN:H

Menu

- Psychiatry Workflow
- Mental Health Summary
- Results Review
- Diagnosis & Problems
- Orders + Add
- Documentation + Add
- MAR Summary
- Medication List + Add
- Allergies + Add
- Histories
- Appointments
- Patient Information
- Notes
- Form Browser
- MultiMedia Manager + Add
- eUHR
- Plan of Care Summary
- LearningLIVE
- Interactive View

Documentation

Add | Sign | Forward | Message | Modify

List

Display : All Physician Notes ...

Arranged By: Date	Newest At Top
Effective Communication...	**7/11/2018 14:46:00 PDT**
Effective Communication [redacted]	Psychologist
IDST -Text	**7/11/2018 14:41:00 PDT**
IDST [redacted]	Psychologist
Outpatient Progress Note	**6/27/2018 12:52:00 PDT**
Office Visit Note: CCP [redacted]	P&S
Vital Signs - Text	**6/14/2018 09:40:00 PDT**
Dental Vital Signs [redacted]	Dentist
Effective Communication...	**6/13/2018 09:35:00 PDT**
Effective Communication [redacted]	Psychologist
IDTT Progress Note	**6/13/2018 09:34:00 PDT**
Free Text Note [redacted]	Psychologist
Effective Communication...	**6/5/2018 12:57:00 PDT**
Effective Communication [redacted]	Psychologist
IDST -Text	**6/5/2018 12:52:00 PDT**
IDST [redacted]	Psychologist
Effective Communication...	**6/1/2018 14:04:00 PDT**
Effective Communication [redacted]	Psychologist
MHPC Progress Note	**6/1/2018 14:01:00 PDT**
Free Text Note [redacted]	Psychologist
7410	**5/31/2018 11:24:00 PDT**
7410 [redacted]	P&S
7410	**5/31/2018 11:24:00 PDT**
7410 [redacted]	P&S
Effective Communication...	**5/30/2018 12:28:00 PDT**
Effective Communication [redacted]	Psychologist
Developmental Disability...	**5/30/2018 12:16:00 PDT**
MH DDP Note [redacted]	Psychologist
MHMD Progress Note	**5/25/2018 10:47:00 PDT**

Patient seen for an i

S: Patient entered th
the patient's request

O: Fully oriented. Ad

A: Patient was not in

P: Schedule for IDTT

Result type:
Result date:
Result status:
Result title:
Performed by:
Verified by:
Encounter info:

EXHIBIT FF
(2018-07-30-0925hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Monday, July 30, 2018 9:25 AM
To: [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

Yes.
Exactly.
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

---

From: [redacted]@CDCR
Sent: Monday, July 30, 2018 9:23 AM
To: Golding, Michael@CDCR; [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

[redacted] was scheduled for an appointment at Wasco on 5/25/18, but refused to see the psychiatrist when he came to the clinic. The psychiatrist's note is a single line: "inmate was placed on my schedule since he wanted to talk to the psychiatrist and after coming to the clinic he refused to see the psychiatrist , and went back , will need to be rescheduled again". His most recent completed psychiatry appointment was on 4/25/18, at which time the psychiatrist wrote "Return to clinic per CDCR guidelines for CCCMS level of care of 60 days." So if the psychiatrist's order had been followed, the patient would have required an appointment by 6/24/18, about a month after transferring to SATF.

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 4:35 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Pt not seen by our MHMD since arrival in May

Yes. As I suspected, this patient according to the interpretation of a QM committee vote, did not need to be seen sooner. The psychiatrist is scheduled to see the patient 3-months after his arrival in May at SATF, which would be some time in August, which has not yet passed.

Our two psychiatrists on the committee voted against this but there are 17 psychologists on the QM committee and there were about 8 there during this vote and they (and several administrators and the [redacted] and [redacted] voted that against what our psychiatrists wanted

1. Patients transferred to new institutions should be seen within 14-days

Or

2. If they would not allow that, they should be seen at a minimum when the physician ordered that they be seen next,

The psychiatrists clearly favored number "1", but we could not get "1" or "2".

Two [redacted] (the [redacted] and [redacted] also voted that it would be OK to override the physicians order when patients transfer.

I will ask Dr. [redacted] to find out when the last visit was at Wasco by a psychiatrist and what he ordered in terms of when the patient should be seen next..

Unfortunately, our psychologists voted that they can override when the physician psychiatrist says the patient needs to be seen next if the patient switches institutions. The reasoning is that we have a "referral based system."

That means that the psychologist decides when to refer a patient to see a psychiatrist, even if the previous psychiatrist made a determination that the patient needs to be seen earlier than the psychologist determines.

It's even a little worse than all that. Let's say a patient DOES NOT switch institutions and a psychiatrist orders that a patient be seen in 10-days. If the program guide would say that the maximal amount of time that the patient should be seen in is 70-days later (not 10 days later), then missing the physician-ordered time frame is NOT COUNTED AS LATE.

In other words, the physicians order in no way determines whether patients are considered to have been seen late or notl And when patients transfer institutions, they voted that they do not have to follow the physician's order. So those who need to be seen early and are most at risk, can be seen weeks later and still be thought to have a timely appointment.

Yes remarkable. Let's find out what the physician's order said for when the patient should be seen next if he had not transferred institutions. Given that he transferred institutions, I think he should have been seen within 14-days.

Best,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Save Our Water

Learn easy ways to save water during California's drought at SaveOurWater.com

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:34 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

Hi Michael,

He came from Wasco Reception Center to our CCCMS but the SATF nurse practitioner assigned to him in CCCMS is also assigned to cover EOP. The psychiatric coverage is therefore stretched thin.

[redacted] MD
[redacted]
CSATF/SP Corcoran
Tel: [redacted]
Cell [redacted]

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 3:27 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: Pt not seen by our MHMD since arrival in May

Hi,
Is the patient in CCC or EOP?
There is a reason for my request and then I will answer.
Yes I am concerned.
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:14 PM
To: Golding, Michael@CDCR
Subject: Fwd: Pt not seen by our MHMD since arrival in May

[redacted], M.D.
[redacted]
[redacted]mobile

Sent from my iPhone
Kindly excuse any errant autocorrections and spelling errors.

Begin forwarded message:

From: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Date: July 27, 2018 at 12:04:01 PM PDT
To: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]" <[redacted]@cdcr.ca.gov>, CDCR CCHCS TelePsych Admin <TelePsych.Admin@cdcr.ca.gov>
Subject: Pt not seen by our MHMD since arrival in May

Hello Everyone,

This patient has not been seen since his arrival in May by one of our psychiatrists?

He has had a major incident that could be related to psychosis- he is currently not on an antipsychotic?

Why was this patient not seen?

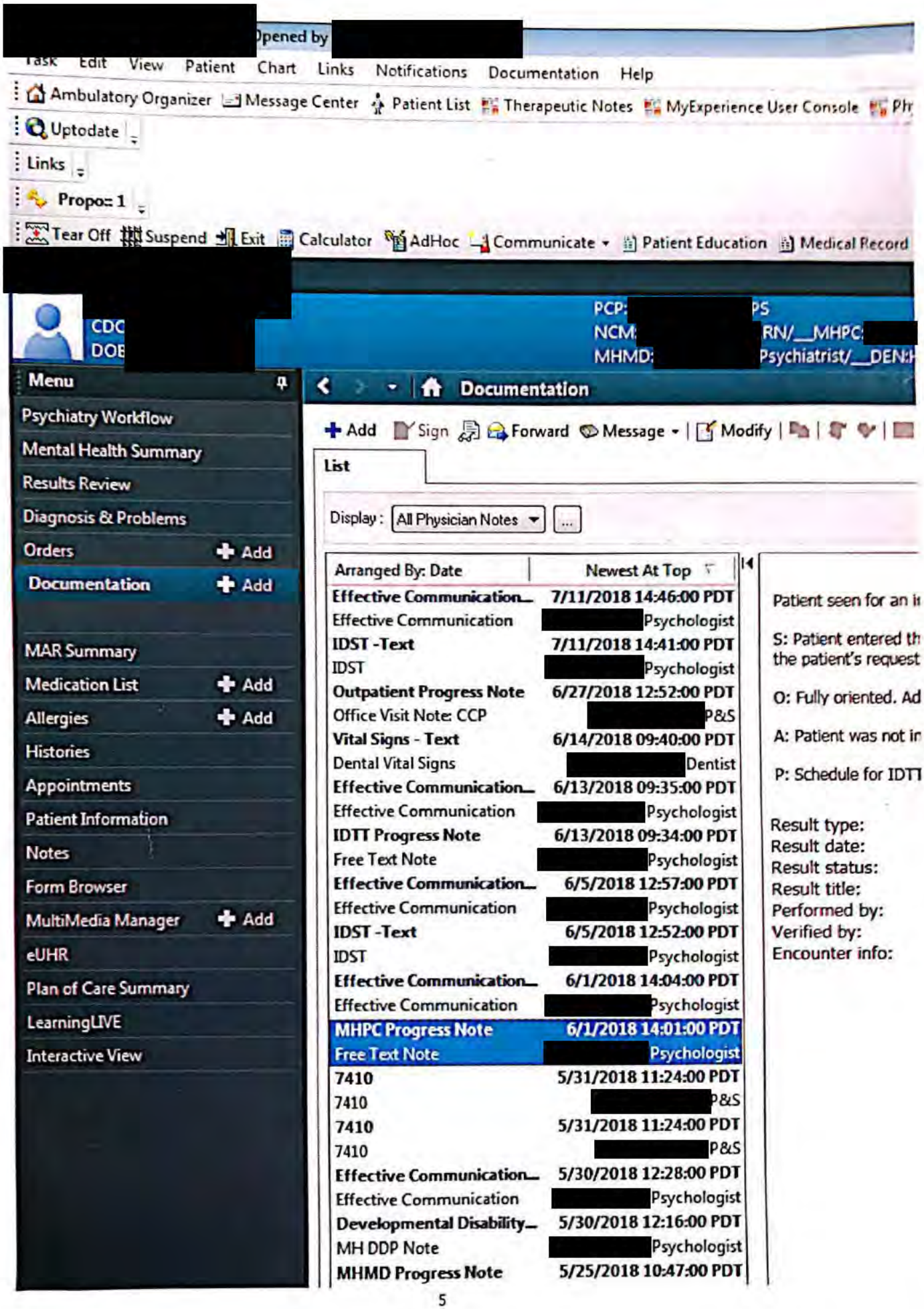

[redacted] Opened by [redacted]
Task Edit View Patient Chart Links Notifications Documentation Help
Ambulatory Organizer Message Center Patient List Therapeutic Notes MyExperience User Console Ph
Uptodate
Links
Propo= 1
Tear Off Suspend Exit Calculator AdHoc Communicate Patient Education Medical Record
[redacted]
CDC
DOB
PCP: [redacted] PS
NCM: [redacted] RN/__MHPC: [redacted]
MHMD: [redacted] Psychiatrist/__DEN:H
Menu
Psychiatry Workflow
Mental Health Summary
Results Review
Diagnosis & Problems
Orders Add
Documentation Add
MAR Summary
Medication List Add
Allergies Add
Histories
Appointments
Patient Information
Notes
Form Browser
MultiMedia Manager Add
eUHR
Plan of Care Summary
LearningLIVE
Interactive View
Documentation
Add Sign Forward Message Modify
List
Display: All Physician Notes ...
Arranged By: Date | Newest At Top
Effective Communication... 7/11/2018 14:46:00 PDT
Effective Communication [redacted] Psychologist
IDST -Text 7/11/2018 14:41:00 PDT
IDST [redacted] Psychologist
Outpatient Progress Note 6/27/2018 12:52:00 PDT
Office Visit Note: CCP [redacted] P&S
Vital Signs - Text 6/14/2018 09:40:00 PDT
Dental Vital Signs [redacted] Dentist
Effective Communication... 6/13/2018 09:35:00 PDT
Effective Communication [redacted] Psychologist
IDTT Progress Note 6/13/2018 09:34:00 PDT
Free Text Note [redacted] Psychologist
Effective Communication... 6/5/2018 12:57:00 PDT
Effective Communication [redacted] Psychologist
IDST -Text 6/5/2018 12:52:00 PDT
IDST [redacted] Psychologist
Effective Communication... 6/1/2018 14:04:00 PDT
Effective Communication [redacted] Psychologist
MHPC Progress Note 6/1/2018 14:01:00 PDT
Free Text Note [redacted] Psychologist
7410 5/31/2018 11:24:00 PDT
7410 [redacted] P&S
7410 5/31/2018 11:24:00 PDT
7410 [redacted] P&S
Effective Communication... 5/30/2018 12:28:00 PDT
Effective Communication [redacted] Psychologist
Developmental Disability... 5/30/2018 12:16:00 PDT
MH DDP Note [redacted] Psychologist
MHMD Progress Note 5/25/2018 10:47:00 PDT
Patient seen for an i
S: Patient entered th
the patient's request
O: Fully oriented. Ad
A: Patient was not ir
P: Schedule for IDTT
Result type:
Result date:
Result status:
Result title:
Performed by:
Verified by:
Encounter info:

EXHIBIT GG
(2018-07-30-1002hrs)

7/30/18 1

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Monday, July 30, 2018 10:02 AM
To: Golding, Michael@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

[redacted] is a [redacted] year old [redacted] male with schizophrenia and PTSD who was transferred to Wasco on 3/26/18 from Los Angeles County jail, and then transferred from Wasco to SATF on 5/29/18. He has a history of CCCMS, EOP, MHCB (11/3/10, 4/12/01), and DSH (12/29/15) levels of care during a previous incarceration, and reportedly attempted suicide by shooting himself in the chest approximately 15 years ago. He was prescribed Zyprexa while in jail, but this was discontinued on 3/29/18 shortly after arriving at Wasco per patient request. On 7/26/18 he assaulted another inmate resulting in a serious eye injury that necessitated sending the inmate to an outside hospital, and reported he had command auditory hallucinations to hit the inmate. Per Dr. [redacted] 7/27/18 note, the inmate reported "there is a conspiracy by the CO's to have the other inmates go at him. He felt that the peer that he attacked was part of this plan to harm him." Dr. [redacted] also noted "he became increasingly agitated while discussing this and refused to consider taking an antipsychotic medication". He has been prescribed Remeron and Vistaril since 3/29/18, and per the MAR he was compliant with them until 6/30/19, at which time he became intermittently compliant.

His history of EOP, MHCB and DSH suggest a patient who requires more frequent psychiatric intervention. Also concerning is the discontinuation of Zyprexa without regular follow-ups to evaluate for decompensation. He was seen by psychiatry on 3/29/18, 4/25/18, and 7/27/18.

From: Golding, Michael@CDCR
Sent: Monday, July 30, 2018 9:26 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Pt not seen by our MHMD since arrival in May

Yes.
Exactly.
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

7/30/18 2

From: Gonzalez, Melanie@CDCR
Sent: Monday, July 30, 2018 9:23 AM
To: Golding, Michael@CDCR; [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

[redacted] was scheduled for an appointment at Wasco on 5/25/18, but refused to see the psychiatrist when he came to the clinic. The psychiatrist's note is a single line: "inmate was placed on my schedule since he wanted to talk to the psychiatrist and after coming to the clinic he refused to see the psychiatrist , and went back , will need to be rescheduled again". His most recent completed psychiatry appointment was on 4/25/18, at which time the psychiatrist wrote "Return to clinic per CDCR guidelines for CCCMS level of care of 60 days." So if the psychiatrist's order had been followed, the patient would have required an appointment by 6/24/18, about a month after transferring to SATF.

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 4:35 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: Pt not seen by our MHMD since arrival in May

Yes. As I suspected, this patient according to the interpretation of a QM committee vote, did not need to be seen sooner. The psychiatrist is scheduled to see the patient 3-months after his arrival in May at SATF, which would be some time in August, which has not yet passed.

Our two psychiatrists on the committee voted against this but there are 17 psychologists on the QM committee and there were about 8 there during this vote and they (and several administrators and the [redacted] and [redacted]) voted that against what our psychiatrists wanted

1. Patients transferred to new institutions should be seen within 14-days

Or

2. If they would not allow that, they should be seen at a minimum when the physician ordered that they be seen next.

The psychiatrists clearly favored number "1", but we could not get "1" or "2".

Two [redacted] (the [redacted] and [redacted] also voted that it would be OK to override the physicians order when patients transfer.

I will ask Dr. [redacted] to find out when the last visit was at Wasco by a psychiatrist and what he ordered in terms of when the patient should be seen next..

Unfortunately, our psychologists voted that they can override when the physician psychiatrist says the patient needs to be seen next if the patient switches institutions. The reasoning is that we have a "referral based system."

That means that the psychologist decides when to refer a patient to see a psychiatrist, even if the previous psychiatrist made a determination that the patient needs to be seen earlier than the psychologist determines.

It's even a little worse than all that. Let's say a patient DOES NOT switch institutions and a psychiatrist orders that a patient be seen in 10-days. If the program guide would say that the maximal amount of time that the patient should be seen in is 70-days later (not 10 days later), then missing the physician-ordered time frame is NOT COUNTED AS LATE.

In other words, the physicians order in no way determines whether patients are considered to have been seen late or notl And when patients transfer institutions, they voted that they do not have to follow the physician's order. So those who need to be seen early and are most at risk, can be seen weeks later and still be thought to have a timely appointment.

Yes remarkable. Let's find out what the physician's order said for when the patient should be seen next if he had not transferred institutions. Given that he transferred institutions, I think he should have been seen within 14-days.

Best,
Michael

7/30/18 3

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:34 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Pt not seen by our MHMD since arrival in May

Hi Michael,

He came from Wasco Reception Center to our CCCMS but the SATF nurse practitioner assigned to him in CCCMS is also assigned to cover EOP. The psychiatric coverage is therefore stretched thin.

[redacted]MD
[redacted]
CSATF/SP Corcoran
Tel: [redacted]
Cell [redacted]

7/30/18 4

From: Golding, Michael@CDCR
Sent: Friday, July 27, 2018 3:27 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: Pt not seen by our MHMD since arrival in May

Hi,
Is the patient in CCC or EOP?
There is a reason for my request and then I will answer.
Yes I am concerned.
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

Learn easy ways to save water during California's drought at SaveOurWater.com

---

From: [redacted]@CDCR
Sent: Friday, July 27, 2018 3:14 PM
To: Golding, Michael@CDCR
Subject: Fwd: Pt not seen by our MHMD since arrival in May

[redacted] M.D.
[redacted]
[redacted] mobile

Sent from my iPhone
Kindly excuse any errant autocorrections and spelling errors.

Begin forwarded message:

From: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Date: July 27, 2018 at 12:04:01 PM PDT
To: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>

Cc: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, "[redacted]" <[redacted]@cdcr.ca.gov>, CDCR CCHCS TelePsych Admin <TelePsych.Admin@cdcr.ca.gov>
Subject: Pt not seen by our MHMD since arrival in May

Hello Everyone,

This patient has not been seen since his arrival in May by one of our psychiatrists?

He has had a major incident that could be related to psychosis- he is currently not on an antipsychotic?

Why was this patient not seen?

7/30/18 5

7/30/18 6

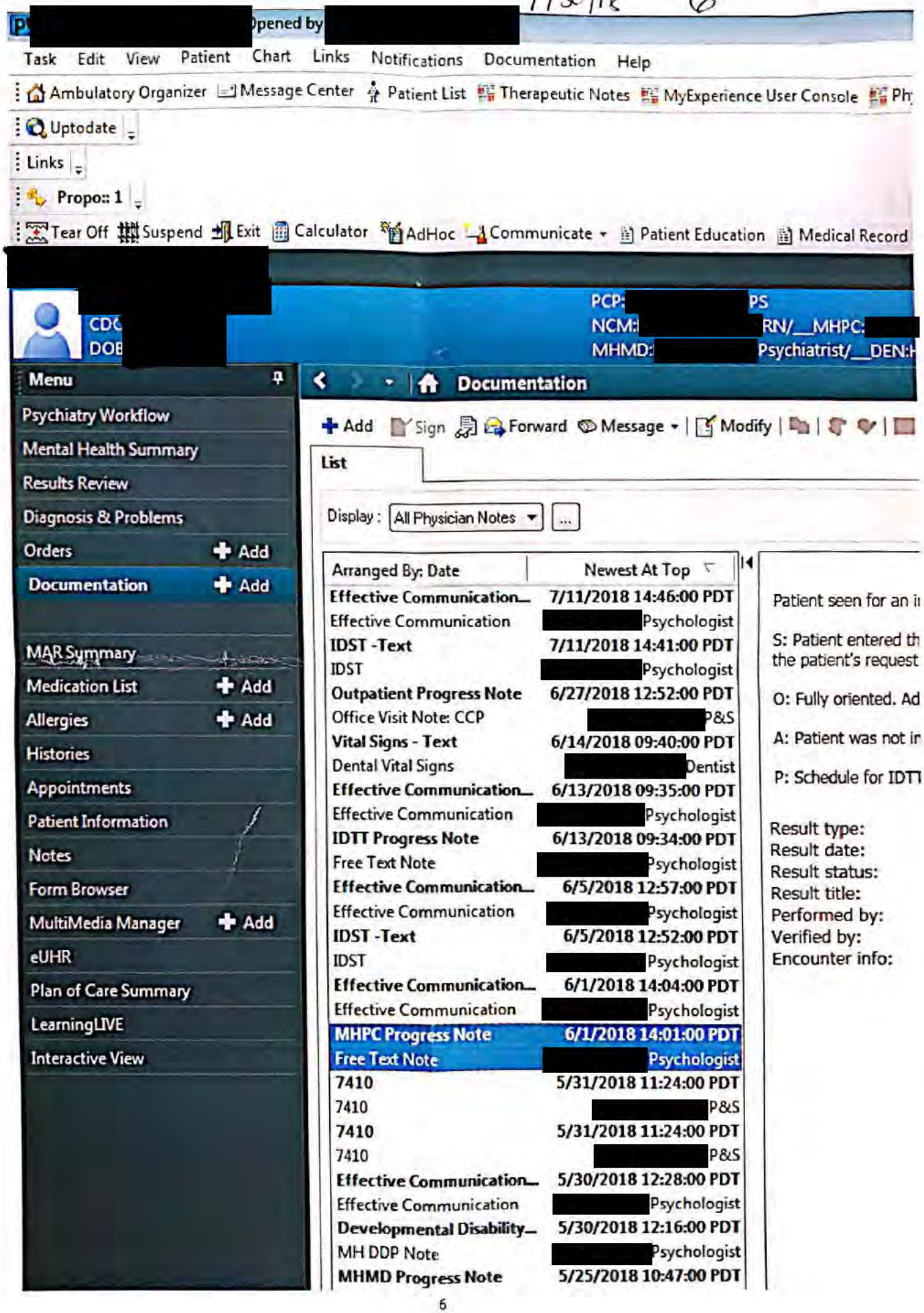

[redacted] Opened by [redacted]
Task Edit View Patient Chart Links Notifications Documentation Help
Ambulatory Organizer Message Center Patient List Therapeutic Notes MyExperience User Console Ph
Uptodate
Links
Propo:: 1
Tear Off Suspend Exit Calculator AdHoc Communicate Patient Education Medical Record
[redacted]
CDC
DOB
PCP: [redacted] PS
NCM: [redacted] RN/__MHPC: [redacted]
MHMD: [redacted] Psychiatrist/__DEN:H
Menu
Psychiatry Workflow
Mental Health Summary
Results Review
Diagnosis & Problems
Orders Add
Documentation Add
MAR Summary
Medication List Add
Allergies Add
Histories
Appointments
Patient Information
Notes
Form Browser
MultiMedia Manager Add
eUHR
Plan of Care Summary
LearningLIVE
Interactive View
Documentation
Add Sign Forward Message Modify
List
Display : All Physician Notes ...
Arranged By: Date | Newest At Top
Effective Communication... 7/11/2018 14:46:00 PDT
Effective Communication [redacted] Psychologist
IDST -Text 7/11/2018 14:41:00 PDT
IDST [redacted] Psychologist
Outpatient Progress Note 6/27/2018 12:52:00 PDT
Office Visit Note: CCP [redacted] P&S
Vital Signs - Text 6/14/2018 09:40:00 PDT
Dental Vital Signs [redacted] Dentist
Effective Communication... 6/13/2018 09:35:00 PDT
Effective Communication [redacted] Psychologist
IDTT Progress Note 6/13/2018 09:34:00 PDT
Free Text Note [redacted] Psychologist
Effective Communication... 6/5/2018 12:57:00 PDT
Effective Communication [redacted] Psychologist
IDST -Text 6/5/2018 12:52:00 PDT
IDST [redacted] Psychologist
Effective Communication... 6/1/2018 14:04:00 PDT
Effective Communication [redacted] Psychologist
MHPC Progress Note 6/1/2018 14:01:00 PDT
Free Text Note [redacted] Psychologist
7410 5/31/2018 11:24:00 PDT
7410 [redacted] P&S
7410 5/31/2018 11:24:00 PDT
7410 [redacted] P&S
Effective Communication... 5/30/2018 12:28:00 PDT
Effective Communication [redacted] Psychologist
Developmental Disability... 5/30/2018 12:16:00 PDT
MH DDP Note [redacted] Psychologist
MHMD Progress Note 5/25/2018 10:47:00 PDT
Patient seen for an i
S: Patient entered th
the patient's request
O: Fully oriented. Ad
A: Patient was not ir
P: Schedule for IDTT
Result type:
Result date:
Result status:
Result title:
Performed by:
Verified by:
Encounter info:

EXHIBIT HH
(2018-07-30-2057hrs)

1 of 1 100% Find | Next

7/20/18 8:57 PM

Quick List: SAC
Appointments seen as scheduled from 2/01/18 thru 2/28/18
Placement: ALL
Data last refreshed 7/30/2018 8:57:00 PM

	Measurements	Appts Seen as Scheduled	Compliance
Appointments seen as scheduled	745319	678395	91%
ProviderUnavailable		0	0%
ModifiedProgram		0	0%
TechnicalDifficulties		0	0%
Seen		678395	91%

⊞ Details

Seen Reason	Placement	Inst	CDCR#	Name	Date	Appts Seen as Scheduled
⊞ ModifiedProgram (2444)						
⊞ ProviderUnavailable (63544)						
⊞ TechnicalDifficulties (936)						

EXHIBIT II
(2018-07-31-1346hrs)

From: [redacted]@CDCR
Sent: Tuesday, July 31, 2018 1:46 PM
To: Golding, Michael@CDCR
Subject: RE: SAC scheduling

It is odd, and I don't understand why Appointments seen as scheduled is so high. When I drill down on Appointments seen as scheduled, the only options it shows are Seen, ProviderUnavailable, ModifiedProgram, and TechnicalDifficulties (I have attached a screenshot). There are several other options to choose from when cancelling an appointment, including IP No Showed, IP Refused, Scheduling Error, etc, so it appears they do not include any appointments with those outcomes in the denominator. But that is so illogical that I'm doubting myself.

EXHIBIT JJ
(2018-08-01)

Aug 1 2018 1

Psychiatry QM

Timely Psychiatry Contacts – measured in weeks, only checked once a week on Sunday, clock resets when patient transfers, physician orders for follow-ups prior to maximum time per program guide are often ignored (especially if the patient transfers institutions).

Routine

Initial

After transfer

After leaving MHCB/PIP

Medication non-compliance – these appointments are only measured if the physician puts in a scheduling order for a medication non-compliance appointment. The appointments that are ordered are *far* more likely to be completed. To accurately capture the percentage of medication non-compliance appointments that are occurring when they should, the denominator needs to be the number of patients who are flagged as medication non-compliant, and the numerator needs to be the number of medication non-compliant patients who are seen within the specified program guide timeframe.

Timely MH Referrals: Denominator = Number of Routine, Urgent, Emergent, Med Refusal, and RVR MHA referrals that either came due or were completed during the reporting period. Due dates determined using the timeframes delineated in the Compliance Rules grid.. This has the same problem as the appointments for medication non-compliance – the denominator is only capturing the referrals that were ordered, not all of the referrals that occurred. Unlike medication non-compliance appointments, there is not an easy way to make the denominator more accurate. Per the CLAC workflows for MH Consults, the staff member who wants the referral is supposed to put in an order (or submit an MH-5 if they do not have EHRS access), and then call the provider if it is an urgent or emergent consult. The scheduler is then supposed to schedule the consult in a timely fashion. If this always occurred, the denominator would be accurate, and the issue would then become the numerator (since it would be measuring the completed consults, which means the psychiatrist would have to have EHRS access, which is not possible outside of business hours), but there are clearly many consults occurring without an order.

Emergent consult

Urgent consult

Routine consult

Psychiatrist continuity of care: "Percentage of psychiatrist contacts seen by the most frequent provider." Denominator = All psychiatry contacts seen in person during the 5 months before the start of the reporting period through the end of the reporting period (6 months total) for any patient who has been EOP in the same housing program at the same institution, without interruption, for the past six months.

Confidential vs. Non-confidential – this is not an indicator, but it is important to note that the check out screen defaults to confidential, so unless a psychiatrist knows how to change it to Non-confidential, and they take the time to change it, all appointments will be recorded as confidential.

1 of 1 100% Find | Next

Quick List: SAC
Appointments seen as scheduled from 2/01/18 thru 2/28/18
Placement: ALL
Data last refreshed 7/30/2018 8:57:00 PM

(2)

	Measurements	Appts Seen as Scheduled	Compliance
Appointments seen as scheduled	745319	678395	91%
ProviderUnavailable		0	0%
ModifiedProgram		0	0%
TechnicalDifficulties		0	0%
Seen		678395	91%

Aug 1 2018

⊞ Details

Seen Reason	Placement	Inst	CDCR#	Name	Date	Appts Seen as Scheduled
⊞ ModifiedProgram (2444)						
⊞ ProviderUnavailable (63544)						
⊞ TechnicalDifficulties (936)						

Aug 1, 2018 3

Appointments seen as scheduled – The denominator is "All scheduled appointments", and the numerator is "All appointments from the denominator that were completed as seen", but this may not be the case. The percentage for Appointments seen as scheduled is surprisingly high, and the drill down for this indicator only shows appointments that were Seen, Cancelled due to ProviderUnavailable, Cancelled due to ModifiedProgram, or Cancelled due to TechnicalDifficulties. It is unclear why IP Refusals, No Shows, and other cancelled appointments do not appear here. If those were included, the number would be far, far less.

Encounters Per Psychiatrist (on the Dashboard) – "Average number of patient encounters completed per psychiatrist per workday. Excludes encounters completed by Chief Psychiatrist." This number is extremely low, and doesn't match what we see in the field. Kevin said he has had meetings with Mike Selby and others to fix this indicator, because it is obviously inaccurate, but no changes have been implemented yet.

Non-Formulary by Psychiatrist

Diagnostic Monitoring: "Percentage of patients prescribed select high risk medications who received appropriate diagnostic monitoring consistent with clinical guidelines. This measure is a composite of 29 measures that assess whether patients on medications that meet specified high risk criteria are receiving appropriate monitoring. Data sources: Electronic Unit Health Record, Guardian Pharmacy Database, Quest Diagnostics Laboratory Database, Strategic Offender Management System. Is this MAPIP? If so, it is measuring a laughably small subset of patients. * The denominator for this indicator was 5 at SAC each month.*

Confidential vs. Non-Confidential

Aug 1, 2018 4

SAC AdSeg EOP (includes ASU and ASUHub)

May 1 to May 31

168 scheduled appointments

64 cancelled

104 completed

41 non-confidential (39%)

63 confidential (61%) – No way! Virtually every pt is seen cellside.

If broken down by initial and routine appointments:

66 initial appointments – 26 non-confidential, 40 confidential (61% confidential)

38 routine appointments – 15 non-confidential, 23 confidential (61% confidential)

(See Excel spreadsheet SAC AdSeg EOP Appointments May 2018)

Confidential vs. Non-Confidential

Aug 1, 2018 5

CCWF MHCB

May 1 to May 31

104 scheduled appointments

8 cancelled

96 completed

100% confidential → Every double-cell is non-confidential.

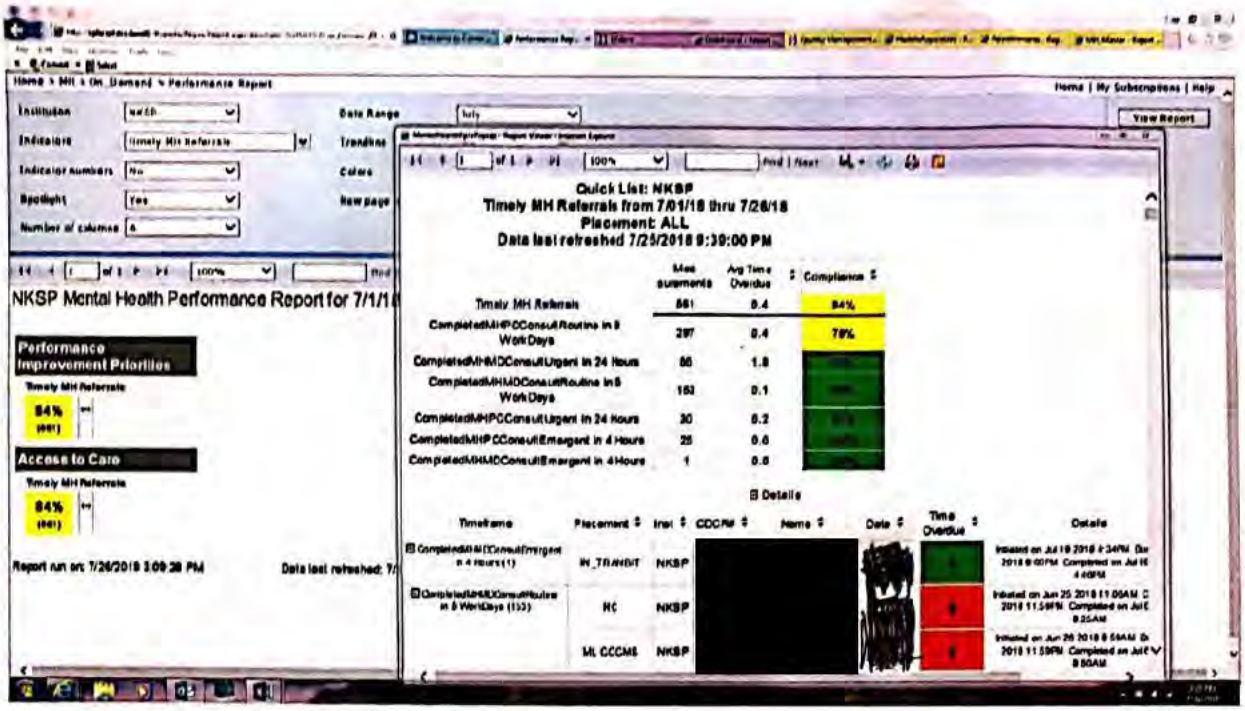
There were no non-confidential appointments.

(See Excel spreadsheet CCWF MHCB Appointments May 2018)

Referrals

Aug 1, 2018

6



The "Timely MH Referrals" report gives the percentage of scheduled referrals that are completed on time. It does not include MH referrals that occur without a scheduled referral, thus it does not provide a complete picture of what percentage of referrals are actually completed on time. It is highly likely that referrals that are scheduled are more likely to be completed on time, thus the reported percentage is overinflating compliance.

NKSP Psychiatrist sees 1 (one) person and is 100% compliant.

But there are likely many more than one person who needed to be seen!

All Med Non-compliance appointments at CHCF in May 2018
Aug 1 2018 (7) (8) Dr. [redacted] was the only one who had any non-compliant pts c meds (not true!)
Her ©6 was

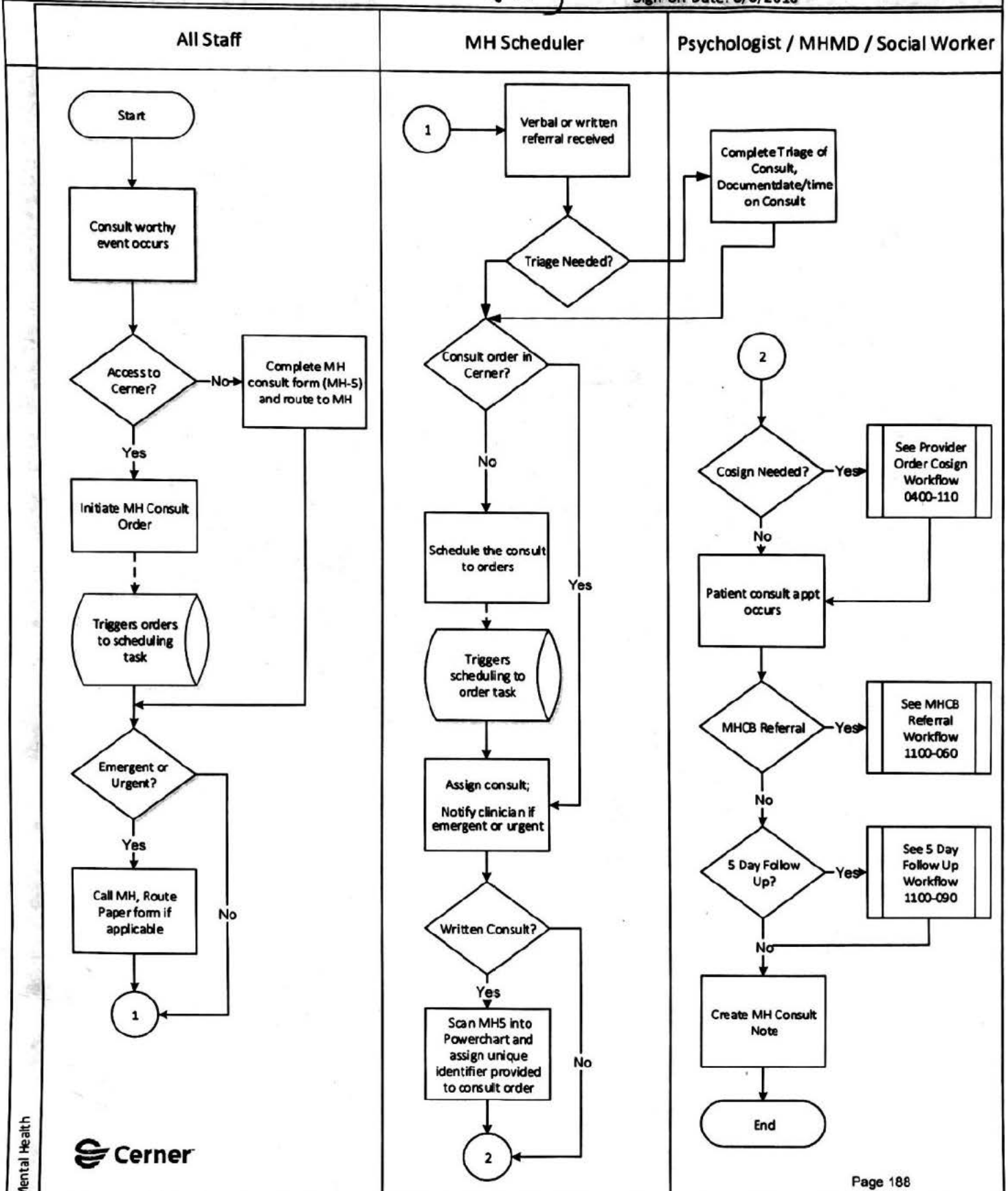
Inst	CDCR	IP Name	Appt MHI	Appt Date	Provider Name	Reason	Outcome Type	Status Reason	Detail	Confidential
CHCF	[redacted]		EOP	5/1/2018 9:15:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	1
CHCF			EOP	5/25/2018 11:43:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/23/2018 9:01:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/31/2018 12:58:00 PM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/17/2018 11:19:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/31/2018 12:24:00 PM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/7/2018 11:04:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/7/2018 8:56:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/31/2018 8:45:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	1
CHCF			EOP	5/31/2018 12:05:00 PM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/23/2018 9:48:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/25/2018 9:19:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/1/2018 8:45:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	1
CHCF			EOP	5/21/2018 8:02:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/1/2018 8:15:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	1
CHCF			EOP	5/21/2018 10:57:00 AM	[redacted]	PSY_RX_NON-COMP	Completed	Seen	Med Non Adherence	1
CHCF			EOP	5/21/2018 9:15:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	1
CHCF			EOP	5/21/2018 8:45:00 AM	[redacted]	PSY_RX_NON-COMP	Cancelled	CancelledUnspecified	Med Non Adherence	0
CHCF			EOP	5/21/2018 8:45:00 AM	[redacted]	PSY_RX_NON-COMP	Refused	No Show	Med Non Adherence	0

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Aug 1 2018 (8)

1100-071 Mental Health Consult Business Hours

Last Date Updated: 5/25/2016
Reviewed by: Integrated Meeting 5/26/2016
Approver: Clinical Leadership Advisory Committee
Sign-off Date: 6/6/2016

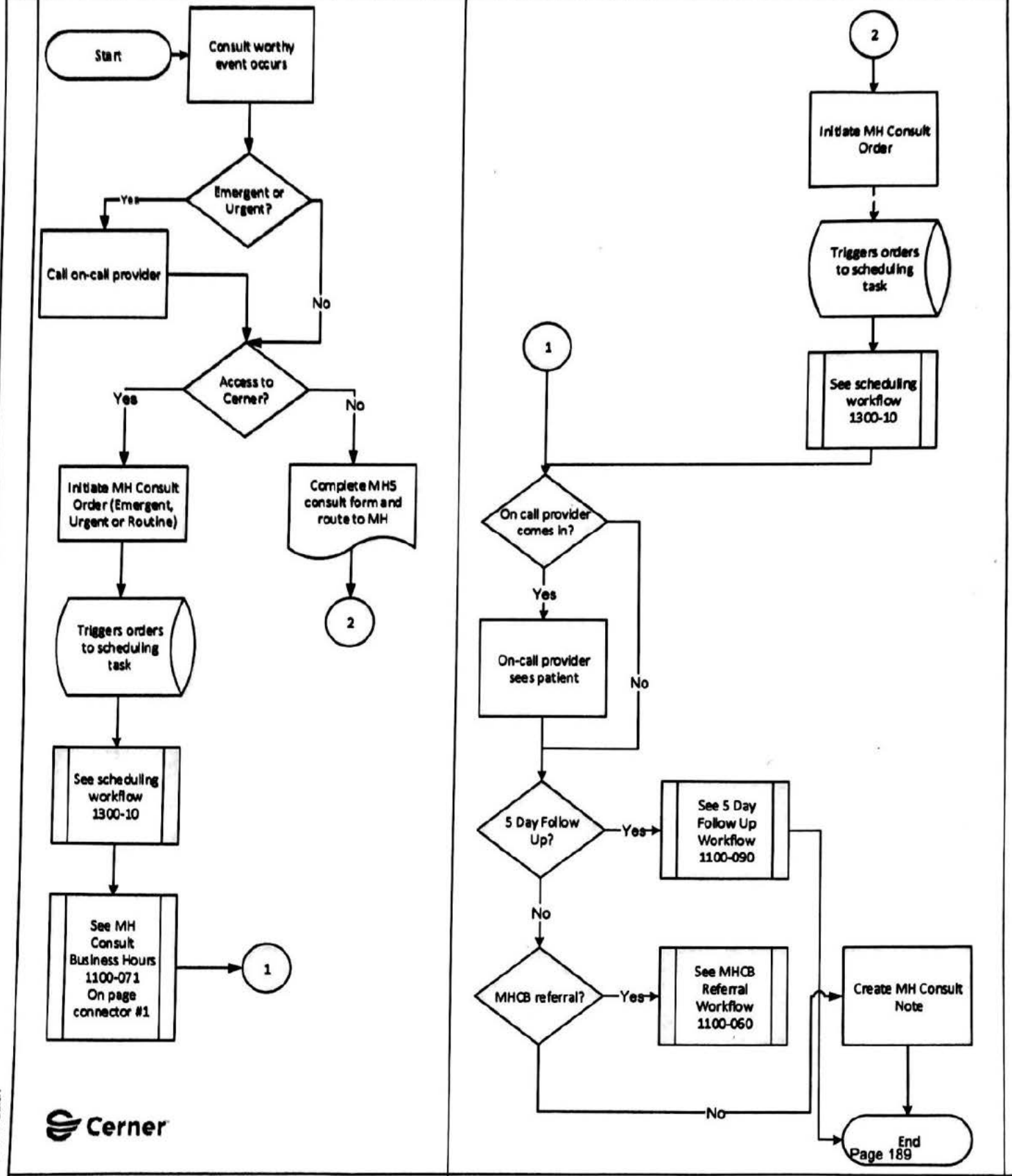


CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

1100-072 Mental Health Consult On-Call Hours

As 12/18 (9)

Last Date Updated: 5/25/2016
Reviewed by: Integrated Meeting 5/26/2016
Approver: Clinical Leadership Advisory Committee
Sign-off Date: 6/6/2016



Confidential vs. Non-Confidential

CHCF MHCB

May 1 to May 31

459 scheduled appointments

24 cancelled

435 completed

242 non-confidential (56%)

193 confidential (44%) → Impossible. 100% of followups are non-confidential!!

If broken down by initial and routine appointments:

146 initial appointments – 42 non-confidential, 104 confidential (71% confidential)

289 routine appointments – 200 non-confidential, 89 confidential (31% confidential)

(See Excel spreadsheet CHCF MHCB Appointments May 2018)

Aug 1, 2018

10

EXHIBIT KK
(2018-08-01closeup1)

1 of 1 100% Find | Next

Quick List: SAC
Appointments seen as scheduled from 2/01/18 thru 2/28/18
Placement: ALL
Data last refreshed 7/30/2018 8:57:00 PM

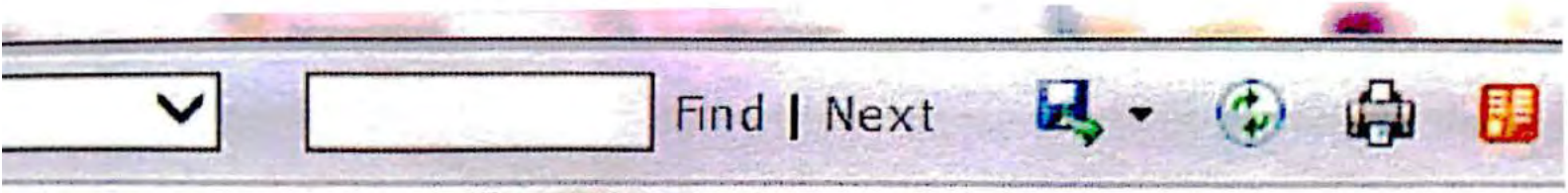
(2)

	Measurements	Appts Seen as Scheduled	Compliance
Appointments seen as scheduled	745319	678395	91%
ProviderUnavailable		0	0%
ModifiedProgram		0	0%
TechnicalDifficulties		0	0%
Seen		678395	91%

Aug 1 2018

⊞ Details

Seen Reason	Placement	Inst	CDCR#	Name	Date	Appts Seen as Scheduled
⊞ ModifiedProgram (2444)						
⊞ ProviderUnavailable (63544)						
⊞ TechnicalDifficulties (936)						



List: SAC
eduled from 2/01/18 thru 2/28/18
ment: ALL
1 7/30/2018 8:57:00 PM

Mea surements	Appts Seen as Scheduled	Compliance
745319	678395	91%
	0	0%
	0	0%
	0	0%
	678395	91%

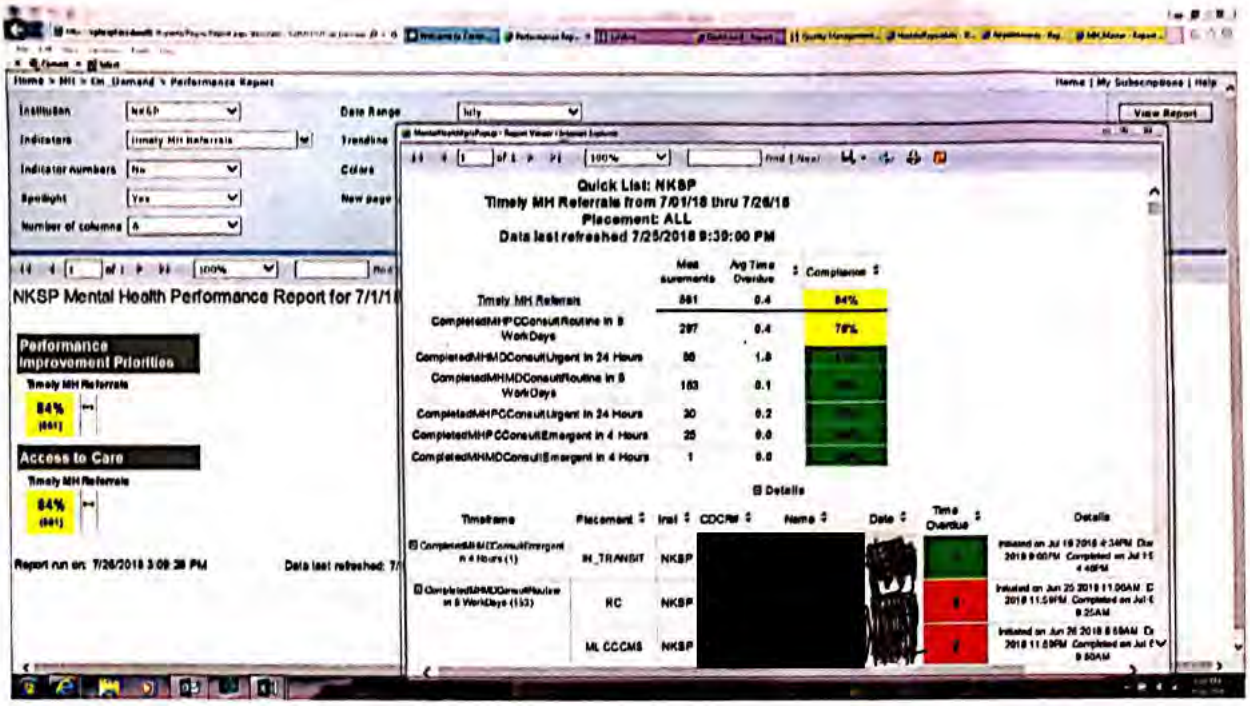
⊞ Details

CDCR#	Name	Date	Appts Seen as Scheduled

EXHIBIT LL
(2018-08-01closeup2)

Referrals Aug 1, 2018

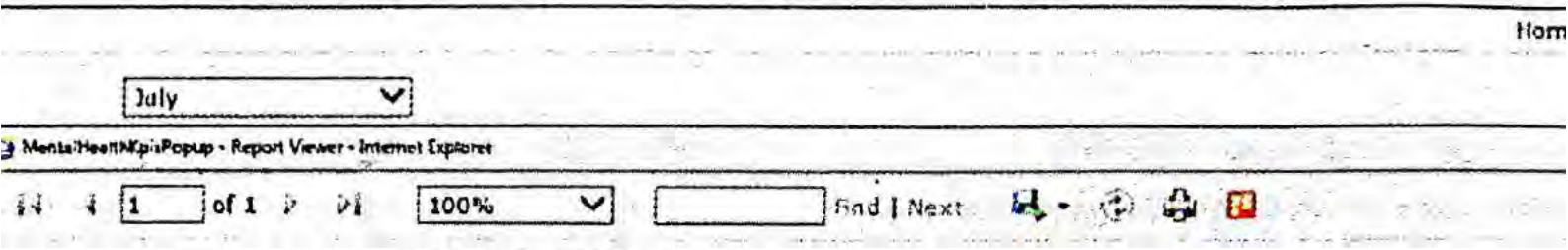
6



The "Timely MH Referrals" report gives the percentage of scheduled referrals that are completed on time. It does not include MH referrals that occur without a scheduled referral, thus it does not provide a complete picture of what percentage of referrals are actually completed on time. It is highly likely that referrals that are scheduled are more likely to be completed on time, thus the reported percentage is overinflating compliance.

NKSP Psychiatrist sees 1 (one) person and is 100% compliant.

But there are likely many more than one person who needed to be seen!



Quick List: NKSP
Timely MH Referrals from 7/01/18 thru 7/26/18
Placement: ALL
Data last refreshed 7/25/2018 9:39:00 PM

	Measurements	Avg Time Overdue	Compliance
Timely MH Referrals	561	0.4	84%
CompletedMHPCConsultRoutine in 5 WorkDays	297	0.4	76%
CompletedMHMDConsultUrgent in 24 Hours	55	1.8	91%
CompletedMHMDConsultRoutine in 5 WorkDays	153	0.1	92%
CompletedMHPCConsultUrgent in 24 Hours	30	0.2	97%
CompletedMHPCConsultEmergent in 4 Hours	25	0.0	100%
CompletedMHMDConsultEmergent in 4 Hours	1	0.0	100%

⊟ Details

Timeframe	Placement	Inst	CDCR#	Name	Date	Time Overdue	Det
⊟ CompletedMHMDConsultEmergent in 4 Hours (1)	IN_TRANSIT	NKSP	[redacted]			0	Initiated on Jul 19 201 2018 9:00PM. Compl 4:4
⊟ CompletedMHMDConsultRoutine in 5 WorkDays (153)	RC	NKSP				3	Initiated on Jun 25 201 2018 11:59PM. Comp 8:25
	ML CCCMS	NKSP				2	Initiated on Jun 26 201 2018 11:59PM. Comp 8:50

EXHIBIT MM
(2018-08-02-1232hrs)

Aug 2, 2018 ①

Golding, Michael@CDCR

"Everyone" (or bts) can determine physician workflows except physicians"!

From: Golding, Michael@CDCR
Sent: Thursday, August 02, 2018 12:32 PM
To: [redacted]@CDCR
Subject: Re: MH Change Management Committee

Hi,

The real problem is that those who know not much and psychologists can determine fully and completely psychiatric workflows, though the two psychiatry voting members (you and I) do not have a chance.

Most work for the psychologists and/or are part of the psychology teams that design these things.

The workflows designed, in addition, continue to focus on "scheduling" so as to fit in their interesting model that in many circumstances, only that which a psychiatrist scheduled occurred, which leads to all the ways in which compliance reports are biased, usually toward making us look better than we are doing.

It also allows our psychologists to continue to try to force our psychiatric physicians to use inefficient power plans and forms which, in addition to being quiet inefficient, also try to mandate the time-frame in which psychiatrists see patients.

Appointments are not even considered late -- or % weeks late — if a psychiatrist schedules it before the maximum timeline and in fact the apppintment is actually (potentially months) late.

And of course our medical colleagues are not forced to use our power plans, nor nursing, nor dental.

This whole thing is just sad that we can't be allowed to interact efficiently because those who have little knowledge of what physician workflows should be, determine physician workflows, and our physicians can not. It is remarkable, despite our even polling our psychiatric physician colleagues to know how they think we can be more efficient, we still cannot make these determinations.
Gosh.
Michael

Sent from my iPhone

On Aug 2, 2018, at 11:12 AM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

> Hi Michael,
>
> Just relaying to you an interesting exchange I had today in the above noted meeting.
>
> It was confirmed that there is no quorum requirement for the meeting. Decisions are based on the number of members approving the change.
>
> We had a change request today to build an IPOC for the PIPs. It made sense to approve, but my concern was that Crystal Bender would be voting on this proposal. I asked her point blank if she could explain what an IPOC was, which she could not. My point to the committee was that we have members on the committee voting on things they do not understand. Other voting committee members who would similarly be likely unable to describe what an IPOC would be are:
>
> [redacted]

[redacted]

Aug 2, 2018 (2)

Since this is such a loose committee with unclear rules and is the gate keeper to move changes into the EHRS, I wanted to make it clear there is some concern about folks being capable of casting an informed vote, given that it seems that everyone has a vote.

Nothing for you to do.....just information.

Thanks,

[redacted]

[redacted] M.D.
[redacted]
Statewide Telepsychiatry Program
Mental Health Support Program
Elk Grove - Headquarters
California Correctional Health Care Services
California Department of Corrections and Rehabilitation
[redacted] desk
mobile
[redacted]@cdcr.ca.gov

<image001.jpg>

EXHIBIT NN
(2018-08-10-1116hrs)

Aug 10, 2018
11:16

PMH-01 of pt 6, E
documentation of repeated screaming

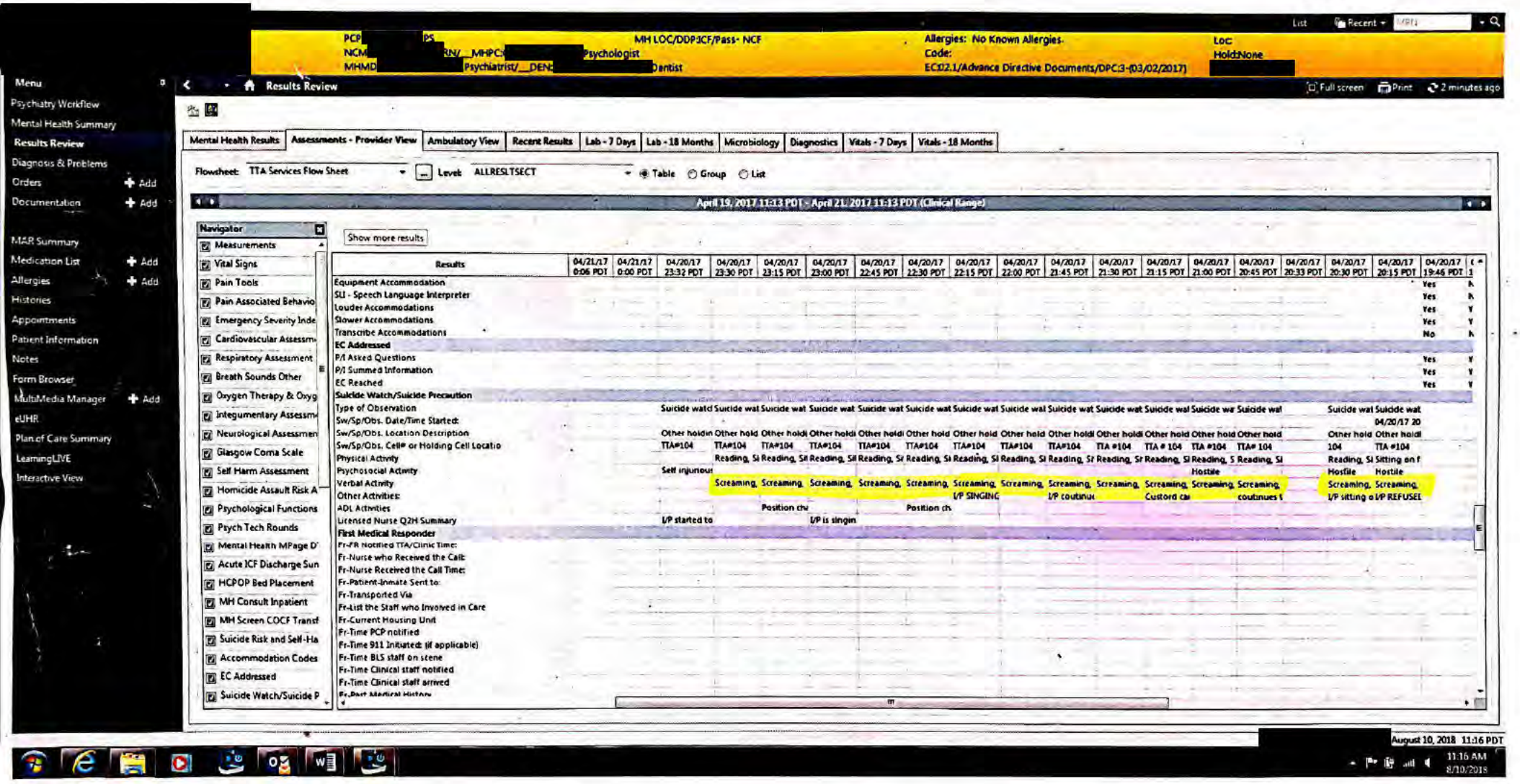


Table Group List

April 19, 2017 11:13 PDT - April 20, 2017 11:13 PDT (Custom Range)

/17 PDT	04/20/17 23:32 PDT	04/20/17 23:30 PDT	04/20/17 23:15 PDT	04/20/17 23:00 PDT	04/20/17 22:45 PDT	04/20/17 22:30 PDT	04/20/17 22:15 PDT	04/20/17 22:00 PDT	04/20/17 21:45 PDT	04/20/17 21:30 PDT	04/20/17 21:15 PDT	04/20/17 21:00 PDT	04/20/17 20:45 PDT	04/20/17 20:33 PDT	04/20/17 20:30 PDT	04/20/17 20:15 PDT	04/20/17 19:46 PDT	(1
																	Yes	N
																	Yes	N
																	Yes	Y
																	Yes	Y
																	No	N
																	Yes	Y
																	Yes	Y
																	Yes	Y
Suicide watd	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wa	Suicide wal		Suicide wat	Suicide wat		
																04/20/17 20		
Other holdin	Other hold	Other holdi	Other holdi	Other holdi	Other holdi	Other hold	Other hold	Other hold	Other holdi	Other holdi	Other hold	Other hold	Other hold		Other hold	Other holdi		
TTA#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA #104	TTA # 104	TTA #104	TTA# 104			104	TTA #104		
	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, Si	Reading, S	Reading, Si		Reading, Si	Sitting on f		
Self injurious												Hostile			Hosfile	Hostile		
	Screaming,	Screaming,	Screaming,	Screaming,	Screaming,	Screaming,	I/P SINGING	Screaming,	I/P coutinue	Screaming,	Custord car	Screaming,	coutinues t		Screaming,	Screaming,		
		Position cha				Position ch									I/P sitting o	I/P REFUSES		
I/P started to			I/P is singin															

August 10, 2018 11:16 PDT

11:16 AM
8/10/2018

04/20/17 23:30 PDT	04/20/17 23:15 PDT	04/20/17 23:00 PDT	04/20/17 22:45 PDT	04/20/17 22:30 PDT	04/20/17 22:15 PD
uicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide wat	Suicide w
ther hold	Other holdi	Other holdi	Other holdi	Other hold	Other hol
A#104	TTA#104	TTA#104	TTA#104	TTA#104	TTA#104
ading, Si	Reading, Sil	Reading, Sil	Reading, Sr	Reading, Si	Reading,
eaming,	Screaming,	Screaming,	Screaming,	Screaming,	Screaming
					I/P SINGIN
	Position cha			Position ch	
	I/P is singin				

EXHIBIT OO
(2018-08-13-1450hrs)

>
>> On Aug 13, 2018, at 2:50 PM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:
>>
>> I can't find anything that combines all scheduled and missed appointments. I asked [redacted](she works with [redacted] and [redacted], and she said she doesn't know of any indicator or report that shows all scheduled and missed appointments, or even one just for refused appointments.
>>
>> There is a report called "Appointments" that allows for searching a specific institution (or all of CDCR), program, date range, and appointment type, and getting a list of all appointments that meet the search criteria. For example, I searched CDCR, ML CCCMS, psychiatrist contacts on 7/10/18 with all outcome types, and received a table with 955 rows (954 patient appointments). I then changed the outcome type to "cancelled", "refused", or "pending" (all of the outcome types except "completed"), and received a table with 461 patient appointments. So on 7/10/18 in all of CDCR, the percentage of scheduled psychiatry appointments that were missed was 48%, or to put it in performance report terms, the percentage of Appointments seen as scheduled was 52%. This doesn't include the appointments that were just rescheduled by schedulers without marking them as cancelled, but there's no way to track that. However, this is definitely not a quick or easy way to obtain appointment data.
>>
>> [redacted], MD
>> Senior Psychiatrist, Specialist
>> Elk Grove - Headquarters
>> California Department of Corrections and Rehabilitation
>> [redacted]
>> Cell phone: [redacted]

EXHIBIT PP
(2018-08-14-1100hrs)

[redacted] 8/14/18 @11:00AM (1)

The attached information regards [redacted] who was admitted to MHCB on 7/20/18 for SI with plan. He was clinically discharged on 8/1/18, despite the psychiatrist's strong objections[1]. Two significant issues to note: 1) The psychiatrist saw the patient every day of his admission, with the exception of 7/28/18, whereas the patient was seen by 7 different primary clinicians during his stay. The psychiatrist was the staff member with the most knowledge and familiarity of the patient, but he was overruled regarding the discharge; 2) The patient was discharged by a post-doc psychology intern, on the day she met the patient[2]. The psychiatrist strongly disagreed with discharging the patient, but the patient was still discharged. This clearly demonstrates that the unlicensed psychology intern, and not the psychiatric physician, was the primary clinical decision-maker.

1. Dr. [redacted] 8/1/18 MHMD Inpatient Progress Note and 8/1/18 MHMD Discharge Summary
2. Dr. [redacted] 8/1/18 IDTT Progress Note

MHPC = Psychologist or Social Worker 8/14/18 (2)

[redacted] is a [redacted] year old [redacted] male with a history of depression, CAH and multiple suicide attempts via overdosing on pills and cutting self, who was admitted to MHCB on 7/20/18 for SI with a plan to cut himself due to receiving an RVR for battery on a peace officer, and learning that he may have more time added to his sentence. He has a history of EOP, prior MHCB admissions, and was in DMH Vacaville from 2000 to 2001 for SI, but had not been in MHSDS for one year prior to this MHCB admission. Per the MHPC initial assessment dated 7/21/18, IP has three prior suicide attempts – in 2000 via cutting wrist, unknown date via overdosing on pills, and in 2013 via overdosing on pills. Past medication trials include Zyprexa, Celexa, Remeron, Paxil, and Elavil. On admission to MHCB he was taking Zyprexa and Vistaril. Celexa 20mg daily was started on 7/23/18, titrated to 30mg on 7/27/18, and to 40mg on 7/30/18. Zyprexa was tapered from 20mg QHS to 15mg QHS on 7/24/18, and to 10mg QHS on 7/25/18.

Seen by Dr. [redacted] (psychiatrist) on: 7/23, 7/24, 7/25, 7/26, 7/27, 7/29, 7/30, 7/31, 8/1

Seen by the following psychologists/social workers: CSW [redacted] on 7/21, 7/28 and 7/29; CSW [redacted] on 7/22; Dr. [redacted] on 7/23, 7/24 (cell front), 7/25, 7/26 (cell front); Dr. [redacted] on 7/27; Dr. [redacted] on 7/30; Dr. [redacted] on 7/31; Dr. [redacted] (Post-Doc Intern) on 8/1.

Unlicensed Intern

In Dr. [redacted] 8/1/18 IDTT Progress Note, she wrote: "Met with patient for IDTT. Introduced myself as covering for his primary PC. Informed patient that after reviewing his chart notes, emailing yard PC and speaking today with primary PC, there does not appear to be a reason to continue to keep him after 1 days. Asked patient how he has been able to function on the yard for 611 days and this is the first time he has been to crisis? Patient stated he had a TV and his yard PC said he would help him. Patient state he did better at DSH. Told patient that if things just don't get better, his yard PC can send him to the hospital as well or he could come back to crisis. CC1 told patient his case hasn't been heard yet, has a chance to explain his side of the situation. Patient continued to express that he doesn't have any hope, if he paroles can't get a job that will support him, will be too old and he is not a US citizen." Her plan was "DC to LTRH CCCMS, take medication as prescribed to decrease psychosis"

In Dr. [redacted] 8/1/18 MHMD Inpatient Progress Note, he wrote: "Plan: 1. As per team IP will be discharged back today to his yard. This psychiatrist is recommending additional observation in view of his Hx, long sentence, residual depressive Sxs and the recent initiation of AD medication however this opinion was felt to be unnecessary by the other team members. Will be followed daily for 5 days subsequently will need to be followed weekly initially to monitor risk of self harm."

In Dr. [redacted] 8/1/18 MHMD Discharge Summary, he wrote: "*Response to Treatment :* Medication adjustment included reduscton of his Zyprexa dose from 20mg to 10 mg a day to reduce sedation and initiation f Celexa which was progressively raised to a dose of 40mg daily to address his depressive Sxs. Vistaril PRN was used for sleep induction.No SIB or aggressive behavior was noted throughout his hospital stay. Team felt IP was ready for discharge on 8/1/8 despite this Psychiatrist recommending additional observation and monitoring in view of his risk factors and the possibility of increased risk of suicide after initiation of Antidepressants."

8/14/18

3

MHMD Inpatient Progress Note 8/14/18(4) [redacted]

(Please refer to discharge summary dated 8/1/18)

[redacted] year old married [redacted] male serving Life with Parole admitted to COR-MHCB on 7/20/18 for DTS.

Hx of Present Illness
IP was admitted after expressing suicidal ideation with a plan to cut himself after learning that his term may be extended due to an altercation with custody. He reported insomnia, anxiety, generalized body aches and CAH ordering him to kill himself .Expressed thoughts of committing suicide by hanging or cutting himself. On 7/18/18 he was involved in an altercation and was evaluated at the TTA and asked several questions about DSH and how to get referred there. Recently on 7/3/18 he received an RVR for battery on peace officer (Note that as of the time of this evaluation this RVR is not found iin SOMS). During his recent admission to MHCB (7/5-7/13/18) he denied SI upon his admission and admitted that he had claimed suicidal ideation to obtain medical care.

Past Psychiatric Hx
Reported a Hx of depression dating back to the age of 17 when he cut wrist but never received MH treatment prior to being incarcerated. Hx of depressive episodes lasting more than 2 weeks with depressed mood, low energy, poor concentration, worthlessness/hopelessness, weight loss and SI. Reported he first started hearing voices at the time of his arrest when he was 21-22. These AH would typically tell him things such as "be good to people" or that "It's is all right to drink but don't get crazy drunk". Within the MHSDS he was at the EOP- LOC but more recently was excluded from MHSDS for about year. History of multiple MHCB admissions most recently from 7/5/18 to 7/13/18 at COR- MHCB. Hx of DMH at Vacaville between 2000 to 2001<SI(cut his wrist after being informed he will be transferred away from his family to HDSP). Claimed he attempted to OD on various pills including Ibuprofen but staff was not alerted and he cannot recall when. Reports another OD attempt in 2013. Past medication trials: Zyprexa, Celexa , Remeron, Paxil, Elavil. No clear Hx of manic or miuxed episodes.

Substance abuse Hx
Alcohol 17-22(mainly beer, No Hx of wdl)

Past Medical Hx
Asthma; Chronic back pain, Rib contusion S/P altercation 7/04/18 (multiple x-rays negative for fractures); S/P Rhinoplastyx2 (1989,2015)

Legal Hx
1st termer; Serving Life with Parole for Att.kidnapping with intent to commit rape (5 counts), AWDW, kidnap victim under 14 years, kidnap, ransom, extortion/667, oral copulation with force person<14, rape by force/fear(2 counts), fear of bodily injury (offense committed [redacted]). PC 290 registartion required. Denied gang affiliation. [redacted]

Psychosocial Hx
Denied Hx of abuse, HS graduate, no Hx od special education; Worked in construction

Family Psychiatric Hx
Denied

Current Medications
Zyprexa 10 mg PO
QHS
Celexa 40mg PO
QHS
Vistaril 100mg PO QPM
Mometasone MDI 2 puffs PO BID
Polycarbophil 1,250 mg PO BID
PRNs:
Tylenol 650mg PO Q6Hrs
Vistaril 50mg PO QHS
Levalbuterol MDI 2 puff PO Q6Hrs
Triamcinolone nasal spray 1 spray/ Each-nostril Daily

MHMD Inpatient Progress Note 8/14/18 (5) [redacted]

Informed Consent
Today 7/23/18

Allergies
Indomethacin

AIMS
7/6/18: Zero

Vital signs
BP108/72; HR 67; RR 18; SpO2 98

EKG
7/19/18: NSR; QTc 424ms

Laboratory test and diagnostics
(7/24/18)
CBC: WBC 5.2 /Hgb 13.6/Hct 41.5/Plt 190/ANC 1368 * (L)
CMP:Na 144/K 4.2/Bun 8/ Creat 0.79 /Glu 91/ AST 21/ALT 28/ GFR 109
TSH : 2.92
Chest X-ray (7/7/18):L basilar atelectasis vs scarring; Lumbar Spine: DJD w/o Fx; Ribs: Noacute Fx; R wrist: No acute Fx;
UDS: +Methadone
No recent labs found in EHR and IP refused labs orderd for 7/23/18.

Hospital course
Medication adjustment included reduscton of his Zyprexa dose from 20mg to 10 mg a day to reduce sedation and initiation f Celexa which was progressively raised to a dose of 40mg daily to address his depressive Sxs. Vistaril PRN was used for sleep induction.No SIB or aggressive behavior was noted throughout his hospital stay. Team felt IP was ready for discharge on 8/1/8 despite this Psychiatrist recommending additional observation and monitoring in view of his risk factors and the possibility of increased risk of suicide after initiation of Antidepressants.

MSE
Calm and cooperative; Alert and free of PMR or agitation. Eye contact is fair and speech normal in rate and volume; No TDs /EPSes are noted. Mood is " depressed". Affect is mod congruent. Thought Process is goal directed without loosening of associations or flight of ideas. Thought Content is free of A/V hallucinations or delusions. I/P reports thoughts of cutting/hanging w/o intent in MHCB; Denies HI/Plans; His insight and Judgment appear to be limited.

Assessment
[redacted] year old married [redacted] male serving Life with Parole admitted to COR-MHCB on 7/20/18 for DTS.
Dx: MDD, RS with PF; ASPD; Asthma; Chronic back pain

Plan:
1. As per team IP will be discharged back today to his yard. This psychiatrist is recommending additional observation in view of his Hx, long sentence, residual depressive Sxs and the recent initiation of AD medication however this opinion was felt to be unnecessary by the other team members. Will be followed daily for 5 days subsequently **will need to be followed weekly initially to monitor risk of self harm.**

2. Medication management: Continue Celexa 40mg daily for depression and anxiety, continue Zyprexa for AH and Vistrail PRN for insomnia. Adjust medications as indicated.
3.Non-pharmacological interventions as per MHPC.

Education
1. I/P was educated regarding the risks and benefits of his current medications, the need to comply and the possible outcomes of failing to comply with his treatment.SEs of Celexa,Vistaril and Zyprexa were reviewed including risk of arrhythmia, TDs, NMS and metabolic syndrome.
2. IP is aware of the need to notify staff should his Sxs worsen, if he experiences S/H intent or if side effects to his medications occur.

MHMD Inpatient Progress Note

8/14/18 (6)

[redacted]

Result type: MHMD Inpatient Progress Note
Result date: 8/1/18 10:50 PDT
Performed by: [redacted] [redacted] (Psychiatrist)

MHMD Discharge Summary - Text

8/14/18 7 [redacted]

MHMD Discharge Summary Entered On: 8/1/2018 8:10 PDT
Performed On: 8/1/2018 8:10 PDT by Barda, Raphael Psychiatrist

Admission Details
Reason for Consult Details : [redacted] year old married [redacted] male serving Life with Parole admitted to COR-MHCB on 7/20/18 for DTS.

Hx of Present Illness
IP was admitted after expressing suicidal ideation with a plan to cut himself after learning that his term may be extended due to an altercation with custody. He reported insomnia, anxiety, generalized body aches and CAH ordering him to kill himself .Expressed thoughts of committing suicide by hanging or cutting himself. On 7/18/18 he was involved in an altercation and was evaluated at the TTA and asked several questions about DSH and how to get referred there. Recently on 7/3/18 he received an RVR for battery on peace officer (Note that as of the time of this evaluation this RVR is not found iin SOMS). During his recent admission to MHCB (7/5-7/13/18) he denied SI upon his admission and admitted that he had claimed suicidal ideation to obtain medical care.

Past Psychiatric Hx
Reported a Hx of depression dating back to the age of 17 when he cut wrist but never received MH treatment prior to being incarcerated. Hx of depressive episodes lasting more than 2 weeks with depressed mood, low energy, poor concentration, worthlessness/hopelessness, weight loss and SI. Reported he first started hearing voices at the time of his arrest when he was 21-22. These AH would typically tell him things such as "be good to people" or that "It's is all right to drink but don't get crazy drunk". Within the MHSDS he was at the EOP- LOC but more recently was excluded from MHSDS for about year. History of multiple MHCB admissions most recently from 7/5/18 to 7/13/18 at COR- MHCB. Hx of DMH at Vacaville between 2000 to 2001<SI(cut his wrist after being informed he will be transferred away from his family to HDSP). Claimed he attempted to OD on various pills including Ibuprofen but staff was not alerted and he cannot recall when. Reports another OD attempt in 2013. Past medication trials: Zyprexa, Celexa , Remeron, Paxil, Elavil. No clear Hx of manic or miuxed episodes.

Substance abuse Hx
Alcohol 17-22(mainly beer, No Hx of wdl)

Past Medical Hx
Asthma; Chronic back pain, Rib contusion S/P altercation 7/04/18 (multiple x-rays negative for fractures); S/P Rhinoplastyx2 (1989,2015)

Legal Hx
1st termer; Serving Life with Parole for Att.kidnapping with intent to commit rape (5 counts), AWDW, kidnap victim under 14 years, kidnap, ransom, extortion/667, oral copulation with force person<14, rape by force/fear(2 counts), fear of bodily injury(offense committed [redacted]). PC 290 registartion required. Denied gang affiliation. [redacted]

Psychosocial Hx
Denied Hx of abuse, HS graduate, no Hx od special education; Worked in construction

Family Psychiatric Hx
Denied

MHMD Discharge Summary - Text

8/14/18 (8) [redacted]

Current Medications
Zyprexa 10 mg PO QHS
Celexa 40mg PO QHS
Vistaril 100mg PO QPM
Mometasone MDI 2 puffs PO BID
Polycarbophil 1,250 mg PO BID
PRNs:
Tylenol 650mg PO Q6Hrs
Vistaril 50mg PO QHS
Levalbuterol MDI 2 puff PO Q6Hrs
Triamcinolone nasal spray 1 spray/ Each-nostril Daily

Informed Consent
Today 7/23/18

Allergies
Indomethacin

AIMS
7/6/18: Zero

Vital signs
BP108/72; HR 67; RR 18; SpO2 98

EKG
7/19/18: NSR; QTc 424ms

Laboratory test and diagnostics
(7/24/18)
CBC: WBC 5.2 /Hgb 13.6/Hct 41.5/Plt 190/ANC 1368 * (L)
CMP:Na 144/K 4.2/Bun 8/ Creat 0.79 /Glu 91/ AST 21/ALT 28/ GFR 109
TSH : 2.92
Chest X-ray (7/7/18):L basilar atelectasis vs scarring; Lumbar Spine: DJD w/o Fx; Ribs: Noacute Fx; R wrist: No acute Fx;
UDS: +Methadone
No recent labs found in EHR and IP refused labs orderd for 7/23/18.

[redacted] Psychiatrist - 8/1/2018 8:14 PDT

Admitting Date : 7/20/2018 15:58 PDT
Discharge Date : 8/1/2018 08:10 PDT
Consult For MH Inpatient : MHCB
Reason for MHCB Consult : Danger to self

[redacted] Psychiatrist - 8/1/2018 8:10 PDT

Psychiatry Treatment Course
Response to Treatment : Medication adjustment included reduscion of his Zyprexa dose from 20mg to 10 mg a day to reduce sedation and initiation f Celexa which was progressively raised to a dose of 40mg daily to address his depressive Sxs. Vistaril PRN was used for sleep induction.No SIB or aggressive behavior was noted throughout his hospital stay. Team felt IP was ready for discharge on 8/1/8 despite this Psychiatrist recommending additional observation and monitoring in view of his risk factors and the possibility of increased risk of suicide after initiation of Antidepressants.

MHMD Discharge Summary - Text

8/14/18
(9)
[redacted]

Keyhea : No
Mental Status on Discharge : Calm and cooperative; Alert and free of PMR or agitation. Eye contact is fair and speech normal in rate and volume; No TDs /EPSes are noted. Mood is " depressed". Affect is mod congruent. Thought Process is goal directed without loosening of associations or flight of ideas. Thought Content is free of A/V hallucinations or delusions. I/P reports thoughts of cutting/hanging w/o intent in MHCB; Denies HI/Plans; His insight and Judgment appear to be limited.

IPOC Template : Current IPOCs
Goals(Activated):
MH Depressed Mood IPOC(Initiated) 07/23/2018 09:25
Indicators & Orders
Indicators
PLO Depressed Mood - Done
PLO Depressed Mood - 07/23/2018 10:29 - Activated
PLO Depressed Mood - 07/30/2018 10:47 - Activated
PLO IDTT - Done
PLO IDTT - 07/23/2018 10:31 - Activated
PLO IDTT - 07/30/2018 10:47 - Activated
MH Master Treatment Plan - Done
MH Master Treatment Plan - 07/23/2018 15:03 - Activated

MH Depressed Mood IPOC(Initiated) 07/23/2018 09:24
Outcomes & Interventions
Outcomes(Initiated):
Component: Reduce depressed mood - rated as a 8 or below as measured by self report by next IDTT interval(Initiated)
Status: Activated
Detail: By Discharge
Outcome Description Author
07/23/2018 10:27 am Reduce depressed mood - rated as a 8 or below as measured by self report by next IDTT interval [redacted] Psychologist .Psychologist
07/25/2018 10:14 am Reduce depressed mood - rated as a 8 or below as measured by self report by next IDTT interval [redacted] RN .Inpatient RN

Component: Depressed mood will remain in remission for a period of three months(Initiated)
Status: Activated
Detail: By Discharge
Outcome Description Author
07/23/2018 10:27 am Depressed mood will remain in remission for a period of three months [redacted] Psychologist .Psychologist
07/25/2018 10:14 am Depressed mood will remain in remission for a period of three months [redacted] RN .Inpatient RN
07/30/2018 03:15 am Depressed mood will remain in remission for a period of three months [redacted] RN .Inpatient RN

Ineffective Coping IPOC(Initiated) 07/20/2018 20:03
Ineffective Coping Plan of Care

8/14/18 (TO)

MHMD Discharge Summary - Text [redacted]

Outcomes(Initiated):
Component: Verbalize Awareness of Own Coping Abilities/Strengths(Initiated)
Status: Activated
Detail: By Phase End

Outcome	Description	Author
07/21/2018 00:05	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/21/2018 10:30	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/21/2018 10:30	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/22/2018 00:50	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/23/2018 02:00	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/24/2018 04:01	pm	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/25/2018 10:14	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/25/2018 03:07	pm	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/26/2018 01:25	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/26/2018 10:25	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/26/2018 06:01	pm	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/27/2018 01:43	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Outpatient RN
07/27/2018 11:04	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/28/2018 00:53	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/28/2018 10:33	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/29/2018 00:38	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN
07/29/2018 01:02	pm	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Outpatient RN
07/30/2018 03:15	am	Verbalize Awareness of Own Coping Abilities/Strengths [redacted] RN .Inpatient RN

Component: Verbalize Feelings and Meet Psychological Needs(Initiated)
Status: Activated
Detail: By Phase End

Outcome	Description	Author
07/21/2018 10:30	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/21/2018 10:30	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/22/2018 07:34	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/24/2018 04:01	pm	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/26/2018 10:25	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/27/2018 11:04	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/28/2018 10:33	am	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Inpatient RN
07/29/2018 01:02	pm	Verbalize Feelings and Meet Psychological Needs [redacted] RN .Outpatient RN

Component: Assess Current Situation Accurately(Initiated)
Status: Activated
Detail: By Phase End

Outcome	Description	Author
07/21/2018 00:05	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/21/2018 10:30	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/21/2018 10:31	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/22/2018 00:50	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/23/2018 02:00	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/24/2018 04:01	pm	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/26/2018 01:25	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/26/2018 10:26	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/26/2018 06:01	pm	Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/27/2018 01:43	am	Assess Current Situation Accurately [redacted] RN .Outpatient RN
07/27/2018 11:04	am	Assess Current Situation Accurately [redacted] RN .Inpatient RN

8/14/18 (11)

MHMD Discharge Summary - Text

[redacted]

07/28/2018 00:53 am Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/28/2018 10:33 am Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/29/2018 00:38 am Assess Current Situation Accurately [redacted] RN .Inpatient RN
07/29/2018 01:03 pm Assess Current Situation Accurately [redacted] RN .Outpatient RN
07/30/2018 03:15 am Assess Current Situation Accurately [redacted] RN .Inpatient RN

Component: Use Effective Coping Strategies(Initiated)
Status: Activated
Detail: By Phase End

Outcome Description Author

07/21/2018 00:05 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/21/2018 10:30 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/21/2018 10:31 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/22/2018 00:50 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/23/2018 02:00 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/24/2018 04:01 pm Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/25/2018 10:14 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/25/2018 03:07 pm Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/26/2018 01:25 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/26/2018 10:26 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/27/2018 01:43 am Use Effective Coping Strategies [redacted] RN .Outpatient RN
07/27/2018 11:04 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/28/2018 00:53 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/28/2018 10:34 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/29/2018 00:38 am Use Effective Coping Strategies [redacted] RN .Inpatient RN
07/29/2018 01:03 pm Use Effective Coping Strategies [redacted] RN .Outpatient RN
07/30/2018 03:15 am Use Effective Coping Strategies [redacted] RN .Inpatient RN

Interventions(Initiated):
Component: Identify Individual Stressors(Initiated)
Status: Activated
Detail: By Phase End

Outcome Description Author

07/21/2018 00:05 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/21/2018 10:30 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/21/2018 10:31 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/22/2018 00:50 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/23/2018 02:00 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/24/2018 04:01 pm Identify Individual Stressors [redacted] RN .Inpatient RN
07/25/2018 10:14 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/25/2018 03:07 pm Identify Individual Stressors [redacted] RN .Inpatient RN
07/26/2018 01:25 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/26/2018 10:26 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/26/2018 06:01 pm Identify Individual Stressors [redacted] RN .Inpatient RN
07/27/2018 01:43 am Identify Individual Stressors [redacted] RN .Outpatient RN
07/27/2018 11:04 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/28/2018 00:53 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/28/2018 10:34 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/29/2018 00:38 am Identify Individual Stressors [redacted] RN .Inpatient RN
07/29/2018 01:03 pm Identify Individual Stressors [redacted] RN .Outpatient RN
07/30/2018 03:15 am Identify Individual Stressors [redacted] RN .Inpatient RN

Component: Encourage Verbalization of Fears, Anxieties, and Feelings(Initiated)

8/14/18 (12)

MHMD Discharge Summary - Text [redacted]

Status: Activated
Detail: By Phase End

Outcome	Description	Author
07/21/2018 00:05 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/21/2018 10:30 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/21/2018 10:31 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/22/2018 00:50 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/23/2018 02:00 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/24/2018 04:01 pm	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/25/2018 10:14 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/25/2018 03:07 pm	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/26/2018 01:25 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/26/2018 10:26 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/26/2018 06:01 pm	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/27/2018 01:43 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Outpatient RN
07/27/2018 11:04 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/28/2018 00:53 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/28/2018 10:34 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/29/2018 00:38 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN
07/29/2018 01:03 pm	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Outpatient RN
07/30/2018 03:15 am	Encourage Verbalization of Fears, Anxieties, and Feelings	[redacted] RN .Inpatient RN

Component: Provide for Gradual Implementation of Lifestyle Changes(Initiated)
Status: Activated
Detail: By Phase End

Outcome	Description	Author
07/21/2018 00:05 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/21/2018 10:30 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/21/2018 10:31 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/22/2018 00:50 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/23/2018 02:00 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/24/2018 04:01 pm	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/26/2018 01:25 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/26/2018 10:26 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/27/2018 01:43 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Outpatient RN
07/27/2018 11:04 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/28/2018 00:53 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/28/2018 10:34 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/29/2018 00:38 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN
07/29/2018 01:03 pm	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Outpatient RN
07/30/2018 03:15 am	Provide for Gradual Implementation of Lifestyle Changes	[redacted] RN .Inpatient RN

Orders

[redacted] Psychiatrist - 8/1/2018 8:14 PDT
(As Of: 8/1/2018 11:22:43 PDT)

8/14/18 (13)

MHMD Discharge Summary - Text [redacted]

Problems(Active)

Allergic rhinitis (SNOMED CT :102311013)	*Name of Problem:* Allergic rhinitis ; *Recorder:* [redacted] P&S; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 102311013 ; *Contributor System:* PowerChart ; *Last Updated:* 6/13/2018 10:21 PDT ; *Life Cycle Date:* 6/13/2018 ; *Life Cycle Status:* Active ; *Responsible Provider:* [redacted] P&S; *Vocabulary:* SNOMED CT
Asthma (SNOMED CT :2475605013)	*Name of Problem:* Asthma ; *Recorder:* [redacted] P&S; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 2475605013 ; *Contributor System:* PowerChart ; *Last Updated:* 6/13/2018 10:21 PDT ; *Life Cycle Date:* 6/13/2018 ; *Life Cycle Status:* Active ; *Responsible Provider:* [redacted] P&S; *Vocabulary:* SNOMED CT
Chronic back pain (SNOMED CT :216213018)	*Name of Problem:* Chronic back pain ; *Recorder:* [redacted] P&S; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 216213018 ; *Contributor System:* PowerChart ; *Last Updated:* 6/13/2018 10:21 PDT ; *Life Cycle Date:* 6/13/2018 ; *Life Cycle Status:* Active ; *Responsible Provider:* [redacted] P&S; *Vocabulary:* SNOMED CT
Skin lesion (SNOMED CT :157896011)	*Name of Problem:* Skin lesion ; *Recorder:* [redacted] P&S; *Confirmation:* Confirmed ; *Classification:* Medical ; *Code:* 157896011 ; *Contributor System:* PowerChart ; *Last Updated:* 11/7/2017 12:05 PST ; *Life Cycle Date:* 11/7/2017 ; *Life Cycle Status:* Active ; *Responsible Provider:* [redacted] P&S; *Vocabulary:* SNOMED CT ; *Comments:* 11/7/2017 12:05 - [redacted] P&S Pathology report scar with areas of enlarged nuclei. Second opinion pending for the mid abdomen skin excisional biopsy. For the left temporal biopsy pathology reported hyperpigmented lesion and again second opinion pending

Diagnoses(Active)

Major depressivedisorder, Recurrent episode, With psychotic features	*Date:* 7/23/2018 ; *Diagnosis Type:* Working ; *Confirmation:* Provisional ; *Clinical Dx:* Major depressivedisorder, Recurrent episode, With psychotic features ; *Classification:* Medical ; *Clinical Service:* Non-Specified ; *Code:* ICD-10-CM ; *Probability:* 0 ; *Ranking:* Primary ; *Diagnosis Code:* F33.3
Psychosis	*Date:* 7/24/2018 ; *Diagnosis Type:* Discharge ; *Confirmation:* Confirmed ; *Clinical Dx:* Psychosis ; *Classification:* Medical ; *Clinical Service:* Non-Specified ; *Code:* ICD-10-CM ; *Probability:* 0 ; *Diagnosis Code:* F29

8/14/18 18

MHMD Discharge Summary - Text

[redacted]

Unspecified anxiety disorder	*Date:* 7/20/2018 ; *Diagnosis Type:* Working ; *Confirmation:* Possible ; *Clinical Dx:* Unspecified anxiety disorder ; *Classification:* Mental Health ; *Clinical Service:* Non-Specified ; *Code:* ICD-10-CM ; *Probability:* 0 ; *Ranking:* Tertiary ; *Diagnosis Code:* F41.9

Medication List

(As Of: 8/1/2018 11:22:43 PDT)

Normal Order +triamcinolone 55 mcg Spray-Nasal 16.9 mL (120 Sprays)	: +triamcinolone 55 mcg Spray-Nasal 16.9 mL (120 Sprays) ; *Status:* Ordered ; *Ordered As Mnemonic:* Nasacort AQ 55 mcg/inh nasal spray ; *Simple Display Line:* 55 mcg, 1 spray, Each-nostril, Daily, PRN: allergic rhinitis ; *Ordering Provider:* [redacted] P&S; *Catalog Code:* triamcinolone nasal ; *Order Dt/Tm:* 7/20/2018 16:04:01 ; *Comment:* Request Refills. ONE-FOR-ONE EXCHANGE
+ polycarbophil 625 mg Tab NP	: + polycarbophil 625 mg Tab NP ; *Status:* Ordered ; *Ordered As Mnemonic:* Fiber Lax ; *Simple Display Line:* 1,250 mg, Oral, BIDAM+BED, PRN: constipation ; *Ordering Provider:* [redacted] P&S; *Catalog Code:* polycarbophil ; *Order Dt/Tm:* 7/20/2018 16:04:45 ; *Comment:* Take 2 tablets (total dose =1,250mg) by mouth twice a day with lots of water "Request Refill" dispense qty 30
+1-OLANZapine 10 mg Tab	: +1-OLANZapine 10 mg Tab ; *Status:* Ordered ; *Ordered As Mnemonic:* ZyPREXA ; *Simple Display Line:* 10 mg, Oral, Once a day at bedtime ; *Ordering Provider:* [redacted] Psychiatrist; *Catalog Code:* OLANZapine ; *Order Dt/Tm:* 7/25/2018 12:07:34 ; *Comment:* Heat Risk Medication
+mometasone 100 mcg/inh Aerosol 120 puffs	: +mometasone 100 mcg/inh Aerosol 120 puffs ; *Status:* Ordered ; *Ordered As Mnemonic:* ASMANEX HFA 100 MCG INHALER ; *Simple Display Line:* 200 mcg, Oral, BIDAM+PM ; *Ordering Provider:* [redacted] P&S; *Catalog Code:* mometasone ; *Order Dt/Tm:* 7/20/2018 16:05:37 ; *Comment:* Inhale 2 puffs by mouth twice a day 1 for 1 exchange Request Refill Dispense # 13 gm ***One for One Exchange rinse mouth after use do not swallow
+levalbuterol 45 mcg/puff Aerosol 15 gm	: +levalbuterol 45 mcg/puff Aerosol 15 gm ; *Status:* Ordered ; *Ordered As Mnemonic:* XOPENEX HFA 45 MCG INHALER ; *Simple Display Line:* 90 mcg, Oral, QID, PRN: shortness of breath ; *Ordering Provider:* [redacted] P&S; *Catalog Code:* levalbuterol ; *Order Dt/Tm:* 7/20/2018 16:07:05 ; *Comment:* request refills

8/14/18 (15)

MHMD Discharge Summary - Text [redacted]

+1-hydrOXYzine pamoate 50 mg Cap	: +1-hydrOXYzine pamoate 50 mg Cap ; *Status:* Canceled ; *Ordered As Mnemonic:* Vistaril ; *Simple Display Line:* 100 mg, Oral, Once a day at bedtime, PRN: insomnia ; *Ordering Provider:* [redacted] Psychiatrist; *Catalog Code:* hydrOXYzine ; *Order Dt/Tm:* 7/31/2018 06:50:13
+1-hydrOXYzine pamoate 50 mg Cap	: +1-hydrOXYzine pamoate 50 mg Cap ; *Status:* Ordered ; *Ordered As Mnemonic:* Vistaril ; *Simple Display Line:* 100 mg, Oral, qPM, PRN: insomnia ; *Ordering Provider:* [redacted] Psychiatrist; *Catalog Code:* hydrOXYzine ; *Order Dt/Tm:* 7/31/2018 11:45:40
+1-citalopram 40 mg Tab	: +1-citalopram 40 mg Tab ; *Status:* Ordered ; *Ordered As Mnemonic:* CeleXA ; *Simple Display Line:* 40 mg, Oral, qPM ; *Ordering Provider:* [redacted] Psychiatrist; *Catalog Code:* citalopram ; *Order Dt/Tm:* 7/31/2018 12:22:33

Discharge Plan
Discharge Plan : Assessment
[redacted] year old married [redacted] male serving Life with Parole admitted to COR-MHCB on 7/20/18 for DTS.
Dx: MDD, RS with PF; ASPD; Asthma; Chronic back pain

Plan:
1. As per team IP will be discharged back to his yard. This psychiatrist recommended additional observation in view of his Hx, long sentence, residual depressive Sxs and the recent initiation of AD medication however this was felt to be unnecessary by the other team members. Will be followed daily for 5 days subsequently will need to be followed weekly initially to monitor risk of self harm.
2. Medication management: Continue Celexa 40mg daily for depressiom and anxiety, continue Zyprexa for AH and Vistrail PRN for insomnia. Adjust medications as indicated.
3.Non-pharmacological interventions as per MHPC.

Education
1. I/P was educated regarding the risks and benefits of his current medications, the need to comply and the possible outcomes of failing to comply with his treatment.SEs of Celexa,Vistaril and Zyprexa were reviewed including risk of arrhythmia, TDs, NMS and metabolic syndrome.
2. IP is aware of the need to notify staff should his Sxs worsen, if he experiences S/H intent or if side effects to his medications occur.

[redacted] Psychiatrist - 8/1/2018 8:14 PDT

8/14/18 16

IDTT Progress Note [redacted]

Inmate's Program and Level of Care
MHCB, CCCMS

New Issues/Complaints
Presenting Problem MH

08/01/2018: Met with patient for IDTT. Introduced myself as covering for his primary PC. Informed patient that after reviewing his chart notes, emailing yard PC and speaking today with primary PC, there does not appear to be a reason to continue to keep him after 1 days. Asked patient how he has been able to function on the yard for 611 days and this is the first time he has been to crisis? Patient stated he had a TV and his yard PC said he would help him. Patient state he did better at DSH. Told patient that if things just don't get better, his yard PC can send him to the hospital as well or he could come back to crisis. CC1 told patient his case hasn't been heard yet, has a chance to explain his side of the situation. Patient continued to express that he doesn't have any hope, if he paroles can't get a job that will support him, will be too old and he is not a US citizen.

Current Status of Illness
unchanged

Collateral
psychiatrist=explained the medication may take. cc1=RVR hasn't been heard.

Mental Status
No results documented

Mental Health Assessments
Long hair, minimal eye contact, Ox3, cooperative, safety smock

Estimated Length of Stay
12 days

Assessment/Progress Towards Discharge
Major depressivedisorder, Recurrent episode, With psychotic features
Psychosis
Unspecified anxiety disorder

Plan/Disposition
DC to LTRH CCCMS, take medication as prescribed to decrease psychosis

Problem List/Past Medical History
Ongoing
- Allergic rhinitis
- Asthma
- Chronic back pain
- Skin lesion

Historical
- No qualifying data

IPOC Goals
Current IPOCs
Goals(Activated):
Depressed Mood IPOC(Initiated) 07/23/2018 09:25
Indicators & Orders
Depressed Mood IPOC(Initiated) 07/23/2018 09:24
Outcomes & Interventions
Outcomes(Initiated):
Reduce depressed mood - rated as a 8 or below as measured by self report by next IDTT interval(Initiated)
X9 - Severe-Extreme-07/23/2018 10:27 am
O3 - Mild-07/25/2018 10:14 am
Depressed mood will remain in remission for a period of three months(Initiated)
XProgressing, continue-07/23/2018 10:27 am
OGoal met-07/25/2018 10:14 am
OGoal met-07/30/2018 03:15 am
Coping IPOC(Initiated) 07/20/2018 20:03
Ineffective Coping Plan of Care
Outcomes(Initiated):
Verbalize Awareness of Own Coping Abilities/Strengths(Initiated)
OMet-07/21/2018 00:05 am
XProgressing-07/21/2018 10:30 am
XNot met-07/21/2018 10:30 am
OMet-07/22/2018 00:50 am
OMet-07/23/2018 02:00 am
XProgressing-07/24/2018 04:01 pm
OMet-07/25/2018 10:14 am
OMet-07/25/2018 03:07 pm
OMet-07/26/2018 01:25 am
XProgressing-07/26/2018 10:25 am
OMet-07/26/2018 06:01 pm
OMet-07/27/2018 01:43 am
XProgressing-07/27/2018 11:04 am
OMet-07/28/2018 00:53 am
XProgressing-07/28/2018 10:33 am
OMet-07/29/2018 00:38 am
OMet-07/29/2018 01:02 pm
OMet-07/30/2018 03:15 am
OMet-07/31/2018 04:29 am
OMet-07/31/2018 07:12 am

IDTT Progress Note

8/14/18 [redacted] 17

OMet-08/01/2018 02:35 am
OMet-08/01/2018 02:35 am
Verbalize Feelings and Meet Psychological Needs(Initiated)
OUse of resources-07/21/2018 10:30 am
OUse of resources-07/21/2018 10:30 am
OExpression of feelings-07/22/2018 07:34 am
OUse of resources-07/24/2018 04:01 pm
OUse of resources-07/26/2018 10:25 am
OUse of resources-07/27/2018 11:04 am
OUse of resources-07/28/2018 10:33 am
OExpression of feelings-07/29/2018 01:02 pm
XExpression of feelings, Options identified, Use of resources-08/01/2018 06:12 am
Assess Current Situation Accurately (Initiated)
OMet-07/21/2018 00:05 am
XProgressing-07/21/2018 10:30 am
XNot met-07/21/2018 10:31 am
OMet-07/22/2018 00:50 am
OMet-07/23/2018 02:00 am
XProgressing-07/24/2018 04:01 pm
OMet-07/26/2018 01:25 am
XProgressing-07/26/2018 10:26 am
OMet-07/26/2018 06:01 pm
OMet-07/27/2018 01:43 am
XProgressing-07/27/2018 11:04 am
OMet-07/28/2018 00:53 am
XProgressing-07/28/2018 10:33 am
OMet-07/29/2018 00:38 am
OMet-07/29/2018 01:03 pm
OMet-07/30/2018 03:15 am
OMet-07/31/2018 04:29 am
OMet-07/31/2018 02:57 pm
OMet-08/01/2018 02:35 am
OMet-08/01/2018 02:35 am
OMet-08/01/2018 06:12 am
Use Effective Coping Strategies (Initiated)
OMet-07/21/2018 00:05 am
XProgressing-07/21/2018 10:30 am
XNot met-07/21/2018 10:31 am
OMet-07/22/2018 00:50 am
OMet-07/23/2018 02:00 am
XProgressing-07/24/2018 04:01 pm
OMet-07/25/2018 10:14 am
OMet-07/25/2018 03:07 pm
OMet-07/26/2018 01:25 am
OMet-07/26/2018 10:26 am
OMet-07/27/2018 01:43 am

IDTT Progress Note

8/14/18 [redacted]

XProgressing-07/27/2018 11:04 am
OMet-07/28/2018 00:53 am
XProgressing-07/28/2018 10:34 am
OMet-07/29/2018 00:38 am
OMet-07/29/2018 01:03 pm
OMet-07/30/2018 03:15 am
OMet-07/31/2018 04:30 am
OMet-07/31/2018 04:50 pm
OMet-08/01/2018 02:35 am
OMet-08/01/2018 02:35 am
OMet-08/01/2018 06:12 am

Scales and Assessments Interpretations (for assessments without interpretations, please manually enter one here)
No results documented

Endorsed Suicide Documentation
No result documented

Signature Line
Electronically Signed on 08/01/2018 12:24 PM PDT

[redacted] Post-Doc Intern, Post-Doc I

Printed by: [redacted] Psychiatrist
Printed on: 8/13/2018 13:08 PDT

8/14/18 19 [redacted]

MH Master Treatment Plan - Text

Transfer/Discharge to: : CCCMS
MHLowerRationale : Patient is assign to CCCMS
IP is being retained in the MHCB at this time. He will have daily PC contact, medication monitoring by MHMD. He continues to report poor sleep, dperession, CAH, and passive SI.

[redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

Collateral Information
Input from other CDCR disciplines : cc1=patient stated his RVR hasn't been heard and has a chance to tell his story

[redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

EOP Functional Evaluation
FE ability to understand instructions FE ability to understand instructions : same
N/A - CCCMS LOC

FE ability to respond to coworkers : same
N/A

FE ability to be around objects : same
N/A

FE ability to respond to work situations : same
N/A

FE ability to work in hot weather : same
N/A

FE ability to work in large groups : same
N/A

FE ability to deal with changes : same
N/A

FE any other MH limitations : same
N/A

FE activities/tasks the IP can still do : same
N/A

[redacted] [redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

Clinical Summary & Case Formulation
Clinical Summary : 8/1/2018: Patient stated he is feeling the same, has lost all hope. Has good repore with yard PC, said he would help him. Patient said was hoping to be sent to hospital. Informed patient is ws on the yard for 611 days, couldn't say how he managed.

7/23/18: Patient is a [redacted] year old [redacted] male who is service Life with Parole, 51 years, for kidnap with intent to commit rape, assault with a deadly weapon, kidnap victim under 14 years, kidnap, ransom, extortion/667, oral copulation with force, rape with force/violence/fear of bodiy injury. IP has a history of multiple MHCB admissions last one was from 7/5/18 to 7/13/18 at Cor MHCB. He was at DMH Vacaville between 2000 to 2001, "they said because I wanted to committ suicide."

IP admitted to the MHCB on 7/20/18 due to reporting SI with plan to cut himself, thus requiring 24 hour nursing supervision. He continues to report passive SI, secondary to CAH, "blurry voices telling me 'kill yourself, just die,'" poor

sleep, depression, and chronic pain. This is his second MHCB referral in the last month, for similarly reported sxs, after receiving an 115 on 7/4/2018 for battery on a peace officer. The treatment team has elected not to refer to DSH at this time as his sxs and concerns can be addressed with clinical contact at the current LOC, and with medication adjustments/monitoring.
The I/P is alert and oriented X3, looks stated age and appears disheveled with long and unkempt hair. He is drowsy but appears well hydrated/nourished. Speech is slow and mood is "depressed." Affect is blunted and dysphoric. Thought Process is goal directed without loosening of associations or flight of ideas. Thought Content is free of AH/VH or delusions. I/P denies suicidal or homicidal ideation/intent or plans while in MHCB. His insight and Judgment appear to be limited.

Predisposing Factors : same
H/o depressive episodes preceding incarceration. H/o moving to US and living here without the benefit of residency. He is from [redacted] and it's unclear how long he was there, but it's often thought of as a hardship being from [redacted] even for those with resources, given the chronicity and severeity as well as recency of strife in this country. For example, if a person sees a family member's body laying in the street, one dares not investigate it for fear of being seen expressing sympathy or concern and ending up like that themself.

MH Perpetuating Factors : same
The inmate-patient has a long sentence and his h/o relatively notorious crimes may lead to conflict with other inmates. He has been trying to cope with physical pain and asthma.

Precipitating Factors : same
He received a RVR for battery on a peace officer. Before that, he had been doing relatively well and had been excluded from MHSDS. Now, he feels quite depressed and this morning, endorsed SI with intent to cut. At this interview, he says he now feels hope. He was very interested in getting a referral to DSH.

Maintaining Factors : same
Denies family h/o psychiatric disorder. Says he feels hopeful during today's interview, after expressing SI with plan to cut and intent earlier this morning.

MH Case Formulation : no new information
In childhood and adolescence, inmate-patient [redacted] had to deal with life in a chaotic country and then he came to this country, where he was unable to get help with problems because he was not a resident (ORIGINS). As a result, inmate-patient [redacted] may have learned the schemas "I'm inadequate, a loser", and "Others are critical, attacking, and unsupportive of me", it's not clear because he was unable or unwilling to finish this part of the interview (MECHANISMS). These schemas may have been activated recently by a negative interaction with an officer who was to search his cell, leading to charges of battery on an inmate (PRECIPITANT). As a result, inmate-patient [redacted] may have begun having many automatic thoughts (MECHANISMS), including, "I can't handle this place", and may have experienced anxiety and depression (SYMPTOMS, PROBLEMS), which he may have coped with by avoiding (MECHANISM) others (PROBLEMS). The avoidance, if any, may have caused inmate-patient [redacted] to miss some deadlines (PROBLEM), which may have resulted in criticism from inmates and staff (PROBLEM) and may have led to increased sadness, feelings of worthlessness, self-criticism and self-blame, low energy, and/or loss of interest in others (SYMPTOMS, PROBLEMS). Inmate-patient [redacted] low energy and hopelessness, if any, (PROBLEM) may cause him to stop his regular program of exercise, which may exacerbated certain medical conditions (PROBLEM).

[redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

Goal Setting with Patient
Contributed to goals and plan : Yes
Aware of plan content : Yes
Present at team meeting : Yes
Refused to participate : No
Unable to participate : No

MH Master Treatment Plan - Text [redacted]

8/14/18 (21)

Inmate-patient's comments : "I tried for 2 years, just couldn't keep things up."
"Nothing coming my way"

IPOC Indicator MH MTP
MH Master Treatment Plan : Done

[redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

[redacted] Post-Doc Intern - 8/1/2018 10:53 PDT

Suicide Risk and Self-Harm Eval - Text [redacted]

8/14/18 (22)

Suicide Risk and Self-Harm Evaluation Entered On: 8/1/2018 12:43 PDT
Performed On: 8/1/2018 12:25 PDT by [redacted] Post-Doc Intern

Reason for Assessment
Reason for Assessment: : Patient is being discharged

Sources of information : I/P Interview, UHR, Other: interview & chart review
[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

C-SSRS Suicidal Ideation
1a. Have you wished you were dead or wished you could go to sleep and not wake up in the past month? (ref) : Yes
If yes, describe: : "Right now... I am in that cell and everything is just gloomy in there and on top of that I got this news... I am tryihng to understnad... no yard, I am not able to go anywhere, they would not let me get my showers, bcut me iof my pain medications, I am
CSSRS Wish to be Dead 2 : No
2a. Have you actually had any thoughts of killing yourself in the past month? (ref) : Yes
If yes, describe: : same
"Right now, over and over, I think so", has been having thoughts to cut and hanging, does not want to hang self, "the way the situation looks, it's the only way I can put myself to rest... it's so cold in the cell that I cannot sleep"
CSSRS NonSpecific Active Suicide Thought 2 : Yes
CSSRS Non Specific Suicide Thought Cmnt 2 : cut wrist, OD
3a. Have you been thinking about how you might do this in the last month? (ref) : Yes
CSSRS Suicidal Ideation w- Method Cmnt : same, no plans, just feelings
"A little bit, I guess, I don;t really think about it, it just hits me with it like a big pictures, it just slams in to my head, into my thinking I guess".
CSSRS Suicide Idea w- Method No Intent 2 : Yes
CSSRS Suicidal Ideation w- Method Cmnt 2 : pills, cutting
4a. Have you had these thoughts and had some intention of acting on them in the past month? (ref) : Yes
If yes, describe: : 8/1/2018, didn't express a plan
"All I can think about is finding a razor and cutting nmyself and laying down and pass away"
CSSRS Active Suicide Idea Intent no Plan 2 : Yes
CSSRS Suicidal Ideation w- Intent Comment 2 : pills, cutting
5a. Have you started to work out or worked out the details of how to kill yourself in the past month? Do you intend to carry out this plan? (ref) : Yes
If yes, describe: : same
Yeah kinda of a little bit, when I go to the showers they give me a rozor, I have thought about breaking it open and pulling the razor out (yawns) I am so tired I want to go to sleep and not think of anything right now"
CSSRS Suicidal Ideation Intent w-Plan 2 : Yes
CSSRS Suicide Idea Intent w- Plan Cmnt 2 : collected pills
SRASHE Calculation : 13
Mims, [redacted]-Doc Intern - 8/1/2018 12:25 PDT

C-SSRS Intensity of Ideation
Intensity of Most Severe Lifetime Ideation : 3
Description of Most Severe Lifetime Ideation : cutting wrist 2013
Intensity of Most Severe Recent Ideation : 1
Description of Most Severe Recent Ideation : just thoughts, maybe a razor
How many times have you had these thoughts? : Less than one week

Suicide Risk and Self-Harm Eval - Text

8/14/18 (23) [redacted]

When you have the thoughts how long do they last? : Fleeting, few seconds or minutes
CSSRS Controllability of Suicidal Thoughts : Can control thoughts with some difficulty
Are there things, anyone or anything (e.g., family, religion, pain of death) that stopped you from wanting to die or acting on thoughts of committing suicide? : Uncertain that deterrents stopped you
What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't : Does not apply

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

C-SSRS Intensity of Ideation Score
CSSRS Intensity of Ideation Total Score : 7

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

C-SSRS Suicidal Behavior
1a. Actual Attempt in past 3 months (ref) : No
CSSRS Actual Suicide Attempt 2 : Yes
Lifetime Total Number of Attempts : 4
CSSRS Actual Suicide Attempt Comment 2 : pills, cutting
2a. Has subject engaged in Self-harm without intent in past 3 months? : No
CSSRS Engaged Non Suicidal Injury 2 : No
3a. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything in the past 3 months? (ref) : No
CSSRS Interrupted Suicide Attempts 2 : No
4a. Has there been a time when you started to do something to try and end your life but you stopped yourself before you actually did anything in the past 3 months? (ref) : No
CSSRS Aborted Self Inter Attempts 2 : No
5a. Have you taken any steps towards making a suicide attempt or preparing to kill yourself in the last 3 months(such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? (ref) : No
CSSRS Prepatory Acts or Behavior 2 : Yes
Lifetime Total of Preparatory Acts : 2
CSSRS Prep Acts, Behavior Comment 2 : pills

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Lethality and Medical Damage
Actual Lethality, Most Recent Attempt Date : 2013, took pills, OD
Actual Lethality, Most Recent Attempt : Minor injury
Preparation for most recent attempt : Some preparation
Actual Lethality, Most Lethal Attempt Date : 2013, took pills
Actual Lethality, Most Lethal Attempt : Minor injury
Preparation for most lethal attempt : Some preparation
Actual Lethality, Initial 1st Attempt Date : 2000, cut wrist
Actual Lethality, Initial 1st Attempt : No apparent injury
Preparation for 1st attempt : Some preparation

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Suicide and Self-Harm Summary
Suicide and Self-Harm History : Yes
Suicide and Self-Harm History Narrative : no new information
7/21/18: Patient is a [redacted] year old [redacted] male who is service Life with Parole, 51 years, for kidnap with intent to commit rape, assault with a deadly weapon, kidnap victim under 14 years, kidnap, ransom, extortion/667, oral copulation with force, rape with force/violence/fear of bodiy injury. IP has a history of multiple MHCB admissions last one was from 7/5/18 to 7/13/18 at Cor MHCB. He was at DMH Vacaville between 2000 to 2001, "they said because I wanted to committ suicide". Patient was sent to MHCB due to suicidal ideations with a plan to cut himself. Custody informed him that he may be receiving more time on his sentence which caused him to become suicidal. This was due to an incident where he got into an incident with Custody staff. He is also having difficult with sleep. Today patient stated using a scale from 1 to 10(worst) he is at a "10" for suicidal ideations with a plan to cut himself or hang himself, anything that will kill me"; a "0" for homicidal ideations; an "8" for auditory hallucinations telling me to kil myself; he also reports physical pain on his back,

8/14/18 24 [redacted]

Suicide Risk and Self-Harm Eval - Text

chest, arm, jaw, back of his nect, main ones are my ribs and my back".
++
Below is Historical Information on Patient:

Admits h/o SA/SIB as follows: "At least twice, could have been three. First time was in prison, by cutting wrist, c. 2000, in context of "when I finally lost it and decided to do it, I was informed that I would be transferred from where my family could see me often to a place where they would probably never see me again... HDSP... I was only an hour away from home... it created such a shock in me I bid them farewell... couldn't handle being away from my family... ended up slash my risk... they found me on the yard passed out and sent me to DSH... can you send me back over there because I am feeling awful... I would really appreciate it and I would work on... they sent me for three months and I ended up making a big mistake of telling them to let me go after two months" Last SA: "I can't pinpoint the date but I took a lot of I think ibuprofen, bunch of other meds I found" in the context of "I don't remember" and resulted in "I don't know" and ended up being placed in EOP after this. had asked other inmates for unwanted meds. Is not sure how anyone found out, woke up in cell after long time feeling sick, throwing up, diarrhea, "you name it, muscle cramps, all that... I don't remember what happened after that... the closest I ever came... worst than clashing my wrist... don't know what happened before that... could hav been the weight of my sentence... if I remember right, that is what led to my decision". Then suddenly recalls fighting his case in the federal courts at the time and all was looking well and he had hope but then the DA started lying and he could not prove otherwise in court, "the procedure was too much for me" and then he started losing the case in the context of the serious allegations, "something snapped in me... this world is so unfair that the lies are going to outweigh the truth and I am going to spend the rest of my life in prison".

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Suicide History Grid

	Suicide Attempt #1	Suicide Attempt #2	Suicide Attempt #3
Suicide Attempt Date :	1/1/2000 PST		1/1/2013 PST
Intent to Die :	Yes	Yes	Yes
Suicide Method :	Cut wrist	Pills/Overdose	Pills/Overdose
Lethal Method? :	Yes - if the inmate had not been discovered he/she would have died	Yes - if the inmate had not been discovered he/she would have died	Yes - if the inmate had not been discovered he/she would have died
Medical Severity (1-4) :	2 - Minor, superficial	1 - No apparent injury	1 - No apparent injury
Mental Health Follow-Up :	Yes		Yes
Details :	Lost enough blood to pass out, that is how he was found	Asked others for pills	He did ask for help and was sent to MHCB
Source :	I/P	I/P	I/P
	[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT	[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT	[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Chronic Risk Factors
Family history of suicide(s) : Yes
History of psychiatric disorder : Yes
History of abuse : Yes

Printed by: [redacted] Psychiatrist
Printed on: 8/13/2018 12:55 PDT

8/14/18 25

[redacted]

Suicide Risk and Self-Harm Eval - Text

History of substance abuse : Yes
History of violence (including index crime) : Yes
Chronic medical illness : No
Chronic pain problem : Yes
First prison term : Yes
Sex offender : Yes
Long or life sentence : Yes
Caucasian/White ethnicity : No
Older than 35 years of age : Yes
Male : Yes

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Acute Risk Factors
Suicidal Ideation MH : No
Recent suicide attempt : No
Current/recent depressive symptoms : Yes
Current/recent psychotic symptoms : No
Current/recent anxiety or panic symptoms : No
Current/recent subst abuse/intoxication : No
Agitated or angry : No
Disturbance of mood/lability : No
Current/recent violent behavior : Yes
Increasing interpersonal isolation : No
Hopelessness/helplessness : Yes
Recent serious medical diagnosis : No
pain problems : Yes
Medication hoarding/cheeking : No
Recent trauma (including sexual trauma) : No
Recent bad news : No
Anniversary date : No
Recent negative staff interactions : Yes
Recent disciplinary ("115") : Yes
Single cell placement : No
Negative housing change in housing : Yes
Safety concerns (e.g., gang dropout) : No
Early in prison term : No

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Protective Factors / Buffers
Family support : Yes
Religious/spiritual/cultural beliefs : Yes
Interpersonal social support : Yes
Future orientation/plans for future : Yes
Exercises regularly : No
Positive coping/conflict resolution : No
Children at home : Yes
Spousal support : No
Insight into problems : No
Job or school assignment : No
Active and motivated in psych treatment : No
Sense of optimism; self-efficacy : Yes

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Additional Information and Warning Signs
Additional Information : 8/1/2018: Patient report has given up hope but if he went to DSH would be better. Pending RVR

8/14/18 26

Suicide Risk and Self-Harm Eval - Text

[redacted]

has put him in this frame of mind, plus loss of TV. Prior patient had been on yard for 611 days but reports it was hard to do.

[redacted]year old [redacted] male is clean, calm, cooperative, often asks to have questions repeated several times, often changes his answers and offers lots of details so as to appear to have circumstantial TP, does not offer immediate answers and often will now select from list of choices when asked a question, such as in the midst of this SRE and will offer his own response, greatly impeding progress. Mood is depressed, affet is appropriate, R knee bouncing rapidly, SI with plan to cut or hang, with intent and now, after getting news of prosecution of his case, says he is agreeing to honor the aqgreement to ask for help before acting on SI, asked to see this writer because he was suicidal. The officer who brought him over said the inmate-patient at one point retracted his statement that he was suicidal, patient says he told the officer he was feeling suicidal "so I told him today and he says he was going to try to get you", continues to express interest in DSH, asks to be referred to a doctor to give him something to calm him down and lay him out for a couple days, now feeling he wants "to pass away if I don't pass out, I am tired, I need to sleep". AH: "Just a faint voice, just to end this, get it iover with, gets a little louder but not too loud, just faint, let's get this over with, just wend this because it's too much dread into it, there is too much confusion over this issue... I am not able to...", denies VH, admits PI of staff, is convinced they are out to get him, insight is limited, judgment is poor.

SA x 4 as noted previously above.

Warning sign of imminent suicide present : H - Hopelessness: Important, research-based indicator

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Risk Levels and Justification
CHRONIC RISK : Moderate
ACUTE RISK : Moderate
Justification of Risk Level : Chronic and risk both MODERATE. Chronic due to family history of suicide, psychiatric symptoms, emotional.physical abuse, substance abuse, violence, pain, 1st term, sex offender, long sentence. Acute=patient claims hopeless as he thinks he will be found guilty for recent RVR. Patient is Also requesting DSH stating that will help him feel better.

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

Safety/ Treatment Plan
Is this for a MHCB Discharge? : Yes
Safety/Treatment Plan : Patient has a good repore with yard PC and his thinking can be redirected with positive encouragement of his coping skills i.e. ability to stay on yard for 611 dyas.

Patient reports hopeless due to pending RVR that hasn't been heard yet. Encourage patient he has the opportunity to tell his story,might be found innocent.

Contact with his family, children at home and future possibility of being released should be used when he is feeling overwhelmed.

Patient may need a higher loc-EOP for more programming, currently CCCMS/

[redacted] Post-Doc Intern - 8/1/2018 12:25 PDT

EXHIBIT QQ
(2018-08-14-1340hrs)

PSI 8_14_18_1340

Golding, Michael@CDCR

Aug 14 2018 (1)

From: [redacted] @CDCR
Sent: Tuesday, August 14, 2018 1:40 PM
To: Golding, Michael@CDCR
Subject: RE: EOP Yard A CSP-Sacramento
Attachments: [redacted] SAC appointments 7.9.18.PNG

Hi Michael,

Per Dr. [redacted] write-up that you attached, he had 11 patients scheduled to be seen on 7/9/18 – 4 came and were seen, 6 did not come and were not seen, and 1 was out to court and was not seen. I have attached a screenshot of the Appointments report for Dr. [redacted] on 7/9/18, which shows he only had 5 scheduled appointments, 4 of which were seen.

It appears that the scheduler moved the appointments that were not seen on 7/9/18 to the schedule for 7/10/18, instead of marking them as refused on 7/9/18 and rescheduling them. This is a huge problem for two reasons: 1) Those 6 appointments were NOT seen as scheduled, so the Appointments seen as scheduled percentage should be 36% (4/11), but by erasing any record of them from the 7/9/18 schedule, the Appointments seen as scheduled reported percentage is, erroneously, 80% (4/5); and 2) Those 6 appointments should have been marked as No Shows/Refusals, making the appointment refusal rate 55%, but since they were just moved to a different day, the reported refusal rate is 0%.

[redacted]

[redacted], MD
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

From: Golding, Michael@CDCR
Sent: Tuesday, August 14, 2018 12:47 PM
To: [redacted] @CDCR [redacted] @cdcr.ca.gov>
Subject: FW: EOP Yard A CSP-Sacramento

[redacted] of the 12 inmate patients on the C section of the block cound not be interviewed.....

So he say a bunch for 2-minute appointments.

But a bit better than I thought

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541

Email: michael.golding@cdcr.ca.gov

Aug 14, 2018 (2)

Learn easy ways to save water during California's drought at SaveOurWater.com

From: [redacted]@CDCR
Sent: Tuesday, July 10, 2018 5:19 PM
To: Golding, Michael@CDCR
Subject: EOP Yard A CSP-Sacramento

The following are events following 2 (two) days of providing psychiatric care at CSP-Sacramento.

On Monday 07/09/2018 there were a total of 11 patients scheduled. 1 (One) [redacted] of the 11 had an appointment for a PC 2602 renewal interview but had been transferred out to court at 5am that same morning and thus was not seen. Of the remaining 10 only 4 came and were interviewed in the safety of the EOP clinic. The remaining 6 (six) [redacted] were to be seen cell side the next day to limit the amount of time exposed to the dangers of the prison yard and prison block. Of note in the last year time there has been a stabbing on the yard, fights on the yard, and it is not uncommon for inmate patients to have manufactured weapons in their cells. Also on the prison block some inmate patients likely are walking around as they await their turn to use the shower, waiting to be escorted by custody, working as porters, etc. The blocks are also two tiered so there is always a risk that an inmate patient might throw a provider off the highest tier severe injuring or even killing a provider.

On Tuesday 07/10/2018 there were a total of 11 entirely different patients scheduled however 2 were moved to a different block and thus the actual patients scheduled to my care were 9 as the other 2 were now under the care of a different psychiatrist given the movement. Only 3 of the 9 came and were interviewed in the safety of the EOP clinic. The remaining 6 were attempted to be seen on the block in addition to the 6 remaining patients to be seen on the block from the previous day making the total of 12 cell side interviews. 5 (Five) [redacted] of the 12 inmate patients on the C section of the block could not be interviewed because custody informed us that an agitated inmate patient [redacted] was in section C and it would not be safe to enter as the door to section C was closed. The following is regarding the A and B section of the block. 1 (One) [redacted] was not in his cell to do the cell side interview. His cellmate reported that inmate patient [redacted] was somewhere on the yard.

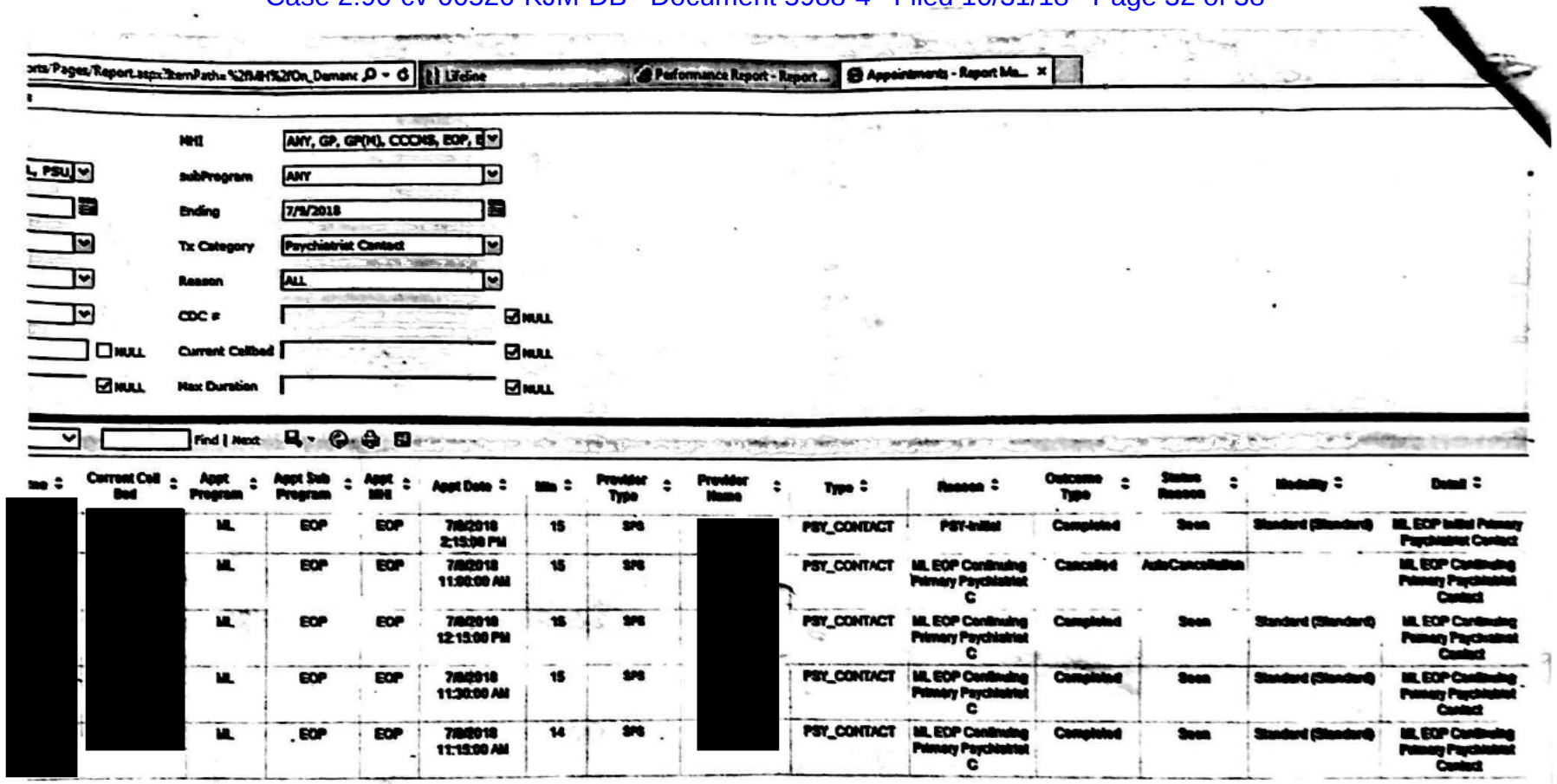
4 (Four) [redacted] of the remaining 6 were interviewed cell side and 1 (One) [redacted] of the 6 was interviewed in the hallways as inmate patient called to me appearing mildly agitated requesting to be taken off his heat medications. Of note the patient was also refusing his other psychiatric medications as well. A brief interview was done in the hallway of the block. Of note, [redacted] reported the he left the EOP clinic this morning before his psychiatry appointment because he had a Telemedicine appointment at the same time. 1 (One) [redacted] of the remaining 6 was spoken to in the open section as he had finished showering and was walking back to his cell. [redacted] reported that he did not come to his EOP clinic appointment because he was in severe pain secondary to his complications from his end stage liver disease and bilateral severe leg edema.

[redacted] reported that he did not come to his EOP clinic appointment because he just recently saw his clinician (psychologist or social worker) and that the ducat he received must have been an erro[redacted] reported and showed us that he only receive a single ducat for group noting "A EOP Trt Cntr Grp RM 2 MH" but did not receive a ducat for his psychiatry 1:1 appointment. [redacted] reported that he had a legal visit at 7:30am that lasted approximately 45 minutes. He reports returning to the block but by this time the second group was already likely brought to the EOP clinic.

[redacted] is prescribed involuntary psychiatric medications under an active PC 2602 court order and was not able to articulate a clear reason why he did not come to his EOP clinic appointment. When pressured to clarify further the patient then reported that he thinks his cell door was not opened.

Of note, two other inmate patients who were not scheduled for today or yesterday [redacted] and [redacted] in different cells requested to speak to me to address their questions and needs. [redacted] eemed to commute better in Spanish but spoke some broken English.

Aug 14 2018 (3)



[redacted]	[redacted]	ML	EOP	EOP	7/9/2018 2:15:00 PM	15	SPR	[redacted]	PSY_CONTACT	PSY-Initial	Completed	Seen	Standard (Standard)	ML EOP Initial Primary Psychiatrist Contact
		ML	EOP	EOP	7/9/2018 11:00:00 AM	15	SPR		PSY_CONTACT	ML EOP Continuing Primary Psychiatrist C	Cancelled	AutoCancelNoShow		ML EOP Continuing Primary Psychiatrist Contact
		ML	EOP	EOP	7/9/2018 12:15:00 PM	15	SPR		PSY_CONTACT	ML EOP Continuing Primary Psychiatrist C	Completed	Seen	Standard (Standard)	ML EOP Continuing Primary Psychiatrist Contact
		ML	EOP	EOP	7/9/2018 11:30:00 AM	15	SPR		PSY_CONTACT	ML EOP Continuing Primary Psychiatrist C	Completed	Seen	Standard (Standard)	ML EOP Continuing Primary Psychiatrist Contact
		ML	EOP	EOP	7/9/2018 11:15:00 AM	14	SPR		PSY_CONTACT	ML EOP Continuing Primary Psychiatrist C	Completed	Seen	Standard (Standard)	ML EOP Continuing Primary Psychiatrist Contact

Aug 14, 2018 (4)

EXHIBIT RR
(2018-08-15-1004hrs)

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Wednesday, August 15, 2018 10:04 AM
To: Golding, Michael@CDCR
Subject: CDCR CCCMS February 2018 Appointments seen as scheduled
Attachments: CDCR appointments seen as scheduled.PNG

Good morning Michael,

Per the attached screenshot of the "Appointments seen as scheduled" report, 95% of ML CCCMS February 2018 appointments in CDCR were seen as scheduled.

To match the data sets up as accurately as possible, I re-ran the "Appointments" report for CDCR ML CCCMS for the month of February 2018 - the 52% figure I gave you previously was from running this report for just one day, 7/10/18, and just for psychiatry appointments. In February 2018 there were 84,120 mental health appointments, 35,642 of which were seen. Thus the percentage of appointments that were seen as scheduled is 42%.

If the "Appointments seen as scheduled" report really included ALL scheduled appointments (as it says it does in the definition of the denominator), these two numbers should be the same. The only reasonable argument for excluding some of the appointments from the denominator is that the system auto-cancels appointments when a patient has been moved to a different institution after their appointment was scheduled but before their appointment occurred. If auto-cancellations are removed from the denominator, then the percentage of appointments seen as scheduled becomes 46%. However, as we previously discussed, this figure does not account for all of the appointments that should have been marked cancelled/refused/no show but are simply rescheduled to a different date. If we were able to include those cases, the percentage of appointments seen as scheduled would be even lower.

The "Appointments seen as scheduled" report does not allow me to filter by psychiatry appointments, but when I filtered by psychiatry appointments in the "Appointments" report I obtained the following numbers: 15,397 appointments, 8,628 of which were seen, for an appointments seen as scheduled percentage of 56%.

One important note about the above - the "Appointments" report is very helpful, but time-intensive. In order to obtain the above percentages, I had to export the data to Excel, and either know how to get Excel to calculate the percentages from the data, or do it manually. The "Appointments seen as scheduled" report is quick and easy - all of the calculations have been done for the user by QM. Most users likely never look at the "Appointments" report, and simply use "Appointments seen as scheduled", which could cause program or clinical decisions to be made based on faulty data.

[redacted]

[redacted] MD
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

-----Original Message-----
From: Golding, Michael@CDCR
Sent: Wednesday, August 15, 2018 7:03 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: 91% Sac figure scheduled figure

(Ex 6)

Can you get me a report FOR ALL institutions (ideally mainline CCC) using the same methodology that generated the 91% SAC figure, to match your quick calculation of 52% of patients seen as scheduled statewide. Then we can compare this figure to the likely more accurate figure of around 50%.

So use the QM method that got 91% for SAC, but apply to all main line CCC.

Thanks,

Michael

Sent from my iPhone

EXHIBIT SS
(2018-08-15-1333hrs)

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Wednesday, August 15, 2018 1:33 PM
To: [redacted]@CDCR
Subject: RE: Dr. [redacted] Patient

Yes this is interesting. So the patient was discharged from a crisis psychiatric HOSPITAL and given an appointment with a psychiatrist 90 days later, by the supervising psychiatric social worker.

This is again, quite sad. And then the patient bounces back into the hospital.

The patient is again discharged (against the advice of the psychiatric physician) and then sent (once more!) to CCC.

Some of this is just hard to fathom.

Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

-----Original Message-----
From: [redacted]e@CDCR
Sent: Wednesday, August 15, 2018 1:18 PM
To: Golding, Michael@CDCR
Subject: RE: Dr. [redacted] Patient

I have attached two screenshots. The CCCMS MHMD appointment order was placed on 7/16/18 by a supervising psych social worker. Unfortunately, I can't find a CCCMS MHMD appointment order from his recent MHCB discharge, but the 7/16/18 appointment order is interesting, because he was discharged from the crisis bed on 7/13/18 and the order is for a 90 day MHMD appointment. So although it isn't relevant to his most recent MHCB stay, it does show that upon leaving MHCB previously, the plan was to have him follow up with a psychiatrist within 90 days of his discharge. The EOP initial MHMD appointment order was placed by a post-doc intern on 8/9/18, for an appointment with a psychiatrist within 14 days, and I don't see anything fishy about it.

The patient's psychiatry appointment that was scheduled for this morning was cancelled, but there is another appointment scheduled for tomorrow. And they did it properly, via cancelling the appointment, not just rescheduling it.

[redacted], MD
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

-----Original Message-----
From: [redacted]@CDCR
Sent: Wednesday, August 15, 2018 10:17 AM
To: Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>
Subject: RE: Dr. [redacted] Patient

[redacted] saw Dr. [redacted] on 8/1/18 (day of discharge) and is scheduled for his next MHMD appointment today at 11:45. He was transferred from CCCMS to EOP on 8/8/18. MH Master Treatment Plan dated 8/8/18 states "The IP is unable to function at LOC: Yes". I can't tell from the treatment plan what occurred during the patient's 8/8/18 IDTT, so it's unclear whether transferring to EOP was the psychiatrist's idea or the PC's, or everyone just agreed that he really wasn't properly placed in CCCMS. I will check back later today to see if the MHMD appointment occurred.

[redacted], MD
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]
Cell phone: [redacted]

-----Original Message-----
From: Golding, Michael@CDCR
Sent: Tuesday, August 14, 2018 8:38 PM
To: [redacted]@CDCR [redacted]@cdcr.ca.gov>
Subject: Dr. [redacted] Patient

Could you look up when Dr. [redacted] patient, discharged against his advice, was scheduled to see the psychiatrist next, at his CCC (I) level of care?

Michael

Sent from my iPhone

EXHIBIT TT
(2018-08-15-1352hrs)

CDCR Mental Health Performance Report for 5/1/18 to 5/31/18

8_15_18_1552 WS

(1)

Performance Improvement Priorities

Timely MH Referrals [1]	Appointments Cancelled Due to Custody [2]	Primary clinician continuity of care	Psychiatrist continuity of care
92% (15,724) ↔	2% (461,238) ↔	83% 1,589,344) ↔	85% (344,552) ↔

Treatment plans with satisfactory documentation	Discharges from MHCB with clinician review of d/c summary	Diagnostic Monitoring [3]	Polypharmacy Medication Review
67% (33) ↔	100% (3) ↔	95% (126) ↔	97% (6,120) ↔

Effective Communication Achieved	Discharge FollowUps	Timely PC Contacts [4]	Timely Psychiatry Contacts [5]
96% (148,106) ↔	93% (5,397) ↔	97% (294,708) ↔	93% (257,390) ↔

Mental Health Crisis Bed

DSH/PIP physical discharges within timeframes	Timely admission to MHCB	MHCB clinical stays within timeframes	MHCB physical discharges within timeframes
77% (176) ↔	86% (845) ↔	90% (803) ↔	95% (674) ↔

Suicide Prevention

Suicide Risk Evaluation	Discharge FollowUps	SREs that met all audit criteria	Suicide Count
92% (5,557) ↔	93% (5,397) ↔	79% (34) ↔	1 (1) ▼

Access to Care

Timely MH Referrals	Timely IDTTs	Timely PC Contacts	Timely Psychiatry Contacts
92% (15,724) ↔	98% (130,055) ↔	97% (294,708) ↔	93% (257,390) ↔

Treatment Scheduled	Effective Communication Achieved	all IDTTs observed in which a health record and C-file are available	Adequate IDTT space
92% (25,973) ▲	96% (148,106) ↔	100% (22) ↔	100% (3) ↔

Mental Health Screens
93% (7,412) ↔

1. Timely MH Referrals only measures the percentage of *ordered* referrals that were completed on time. Ordered referrals are much more likely to be completed than referrals that should have been ordered but weren't (e.g. most med refusal referrals), thus leading to inflated compliance.
2. For an appointment to be measured as "Cancelled due to custody" the provider must first choose "cancelled", and then give custody as the reason. Most cancelled appointments are labeled as "CancelledUnspecified", because the provider did not choose a cancellation reason.
3. Diagnostic monitoring appears to be measuring MAPIP compliance, but it is unclear how they achieved the above percentage, as MAPIP compliance is nowhere near that value.
4. Timely PC Contacts are measured in patient-weeks, and when a patient transfers institutions the clock resets.
5. Timely Psychiatry Contacts are measured in patient-weeks, when a patient transfers institutions the clock resets, and the indicator only looks at whether an appointment occurred within the maximum allowed period per the Program Guide rules, not whether it occurred within the period ordered by the psychiatrist, per their clinical judgment.

DCR Mental Health Performance Report for 5/1/18 to 5/31/18

(2) 8_15_B;1352hrs

[redacted]

MCB and DSH discharges not readmitted within 30 days

79% (14,851) ↔

SREs that met all audit criteria

79% (34) ↔

Non-Formulary by Psychiatrist

4% (58,470) ↔

Appointments seen as scheduled 6

92% (10,592,353) ↔

Timely IDTTs

98% (130,055) ↔

[redacted]

5 day follow-ups with documentation of current suicidality

93% (14) ▲

[redacted]

Treatment Offered

87% (25,973) ▲

Treatment Attended

56% (25,973) ↔

MHSDS patient transfers out of desert institutions

82% (11) ▼

Timely transfers to CCCMS/EOP

61% (1,066) ↔

6. The denominator is defined as "All scheduled appointments", however QM excludes all cancelled appointments, except those cancelled due to ProviderUnavailable, TechnicalDifficulties, or ModifiedProgram. Approximately half of all scheduled appointments are cancelled due to a reason that is not included by this indicator, which makes the true Appointments seen as scheduled percentage closer to 50%, not 90+%.

DCR Mental Health Performance Report for 5/1/18 to 5/31/18

8_15_18 Dkt 5245

(3)

Quality of Care

IDTT Staffing
87% (11,985) ↔

IDTTS in which PC intake evals were completed prior to initial
100% (18) ▲

IDTTS in which psychiatry intake evals were completed prior to initial
95% (22) ▲

Psychiatrist continuity of care
85% (344,552) ↔

MH documentation of consultation from medical staff
100% (1) ▲

Discharges from MHCB with clinician review of d/c summary
100% (3) ↔

IDTTs meeting all audit criteria
68% (22) ▼

Treatment plans with satisfactory documentation
67% (33) ↔

Group treatment in a confidential setting 7
97% (160,153) ↔

Inmate-patients without conflicting diagnoses
77% (13) ▼

Treatment plans with reason for refusal and intervention documented for high refusers
100% (6) ▲

Treatment plans with documented and implemented pre-release plans
0% (4) ▼

RVR MH assessments where the patient was informed of the limits of confidentiality. (Beta)
80% (20) ▲

Average PHQ-9 Score (Beta)
10.9 (270) ▲

Utilization and Resource Management

Treatment Cancelled 8
19% (25,973) ▼

Treatment Refused 9
24% (25,973) ↔

Appointments Cancelled Due to Custody
2% (461,238) ↔

Appointments seen as scheduled
92% (10,592,353) ↔

DSH/PIP physical discharges within timeframes
77% (176) ↔

MHCB clinical stays within timeframes
90% (803) ↔

MHCB physical discharges within timeframes
95% (674) ↔

Segregated Housing

ICCS with MH clinican presence and relevant information provided
60% (5) ▼

Placement of ASU EOPs in appropriate housing within timeframes
90% (144) ↔

Placement of ASU/SHU CCCMS in STRH/LTRH within timeframes
67% (191) ▲

Timely transfer of MHSDS out Standalone ASU
63% (16) ▲

7. There is an indicator for group treatment being conducted in a confidential setting, but not for psychiatry appointments being conducted in a confidential setting.

8. Instead of giving a straight-forward percentage of the treatment that is cancelled (e.g. if there are 100 appointments, and 30 were cancelled, this indicator would show 30%), the numerator is defined as "Number of patient-weeks included in denominator during which the following number of hours of treatment were cancelled: More than 3 for ASU EOP Hub, PSU-EOP, and ML-EOP; More than 1.5 for RC-EOP and ASU EOP non hub; More than 1.0 for SRH/LRH CCCMS."

9. Instead of giving a straight-forward percentage of the treatment that is refused (e.g. if there are 100 appointments, and 40 were refused, this indicator would show 40%), the numerator is defined as "Number of patient-weeks included in denominator during which over 50% of all offered treatment was refused AND less than the following hours of treatment were attended: less than 5 for ASU EOP Hub, PSU-EOP, and ML-EOP; less than 2.5 for RC-EOP and ASU EOP non hub; less than 1.0 for STRH CCCMS and LTRH CCCMS.

DCR Mental Health Performance Report for 5/1/18 to 5/31/18

8_CB_1352hs
(4)

DSH Discharges with Clinican to Clinician Contact within 5 days

100% (1) ↔

MHPS meeting audit criteria

100% (2) ↔

EOP IDTTs discussion of clinical appropriateness for work, educ, accommodation addressed

90% (21) ↔

Primary clinician continuity of care

83% 1,589,344) ↔

Interventions for high utilizers tailored to decrease risk

67% (3) ▲

RVR assessments where all documentation requirements were met (Beta)

70% (20) ↔

Alternative Housing Stays

91% (775) ↔

MCB and DSH discharges not readmitted within 30 days

79% (14,851) ↔

of

CR Mental Health Performance Report for 5/1/18 to 5/31/18

8-15CR-13525
(5)

Data Entry

Appointment Closure Lag
1% (2,166,879) ↔

MH referral resolved before it was received
1,977 (1,977) ▲

Seen/Refused MH appointment duration greater than 4 hours
542 (542) ▲

MHI change during in-transit/temp departure
56 (56) ▲

Patients in CDCR over 30 days with no MHI entry since admission
3 (3) ▲

MH referral date(s) in the future
13 (13) ▲

MH referral received date later than data entry date
1,267 (1,267) ▲

Unresolved pending appointments
195 (195) ▲

CR Mental Health Performance Report for 5/1/18 to 5/31/18

Program/subprogram changes during in-transit/temp departure

6 (6) ▲

Use of DSH MHI

10 (10) ▲

Inpatient MHI errors

40 (40) ▼

MH Milestones Over/Under Awarded

92% (291,011) ▲

EXHIBIT UU
(2018-08-22-0900hrs)

Report

Date Range: February
Trendline: No
Colors: Green, Yellow, Red, Other
New page each group: No

Find | Next

ance Report for 2/1/18 to 2/28/18

8-22-18 29 pgs pg 1

All of

Data last refreshed: 8/14/2018 8:29:00 PM

Page 1 of 1

CCC Feb 2018

95% vs 42%

MentalHealthKpisDrilldown - Report Viewer - Internet Explorer

1 of 1 | 100% | Find | Next

⊞ ML		93% (n=325,338)	Heat Map
	Feb	95% (n=2,496,313)	Heat Map
	Jan	95% (n=2,176,863)	Heat Map
	Dec	93% (n=1,309,996)	Heat Map
	Nov	93% (n=730,459)	Heat Map
	Oct	94% (n=587,142)	Heat Map
	Sep	93% (n=1,747,885)	Heat Map
	Aug	94% (n=3,546,098)	Heat Map
⊟ ML CCCMS			
	Jul	94% (n=4,537,306)	Heat Map
	Jun	94% (n=6,260,954)	Heat Map
	May	94% (n=7,171,698)	Heat Map
	Apr	94% (n=5,086,891)	Heat Map
	Mar	95% (n=4,272,789)	Heat Map
	Feb	95% (n=2,391,974)	Heat Map
	Jan	94% (n=1,325,139)	Heat Map

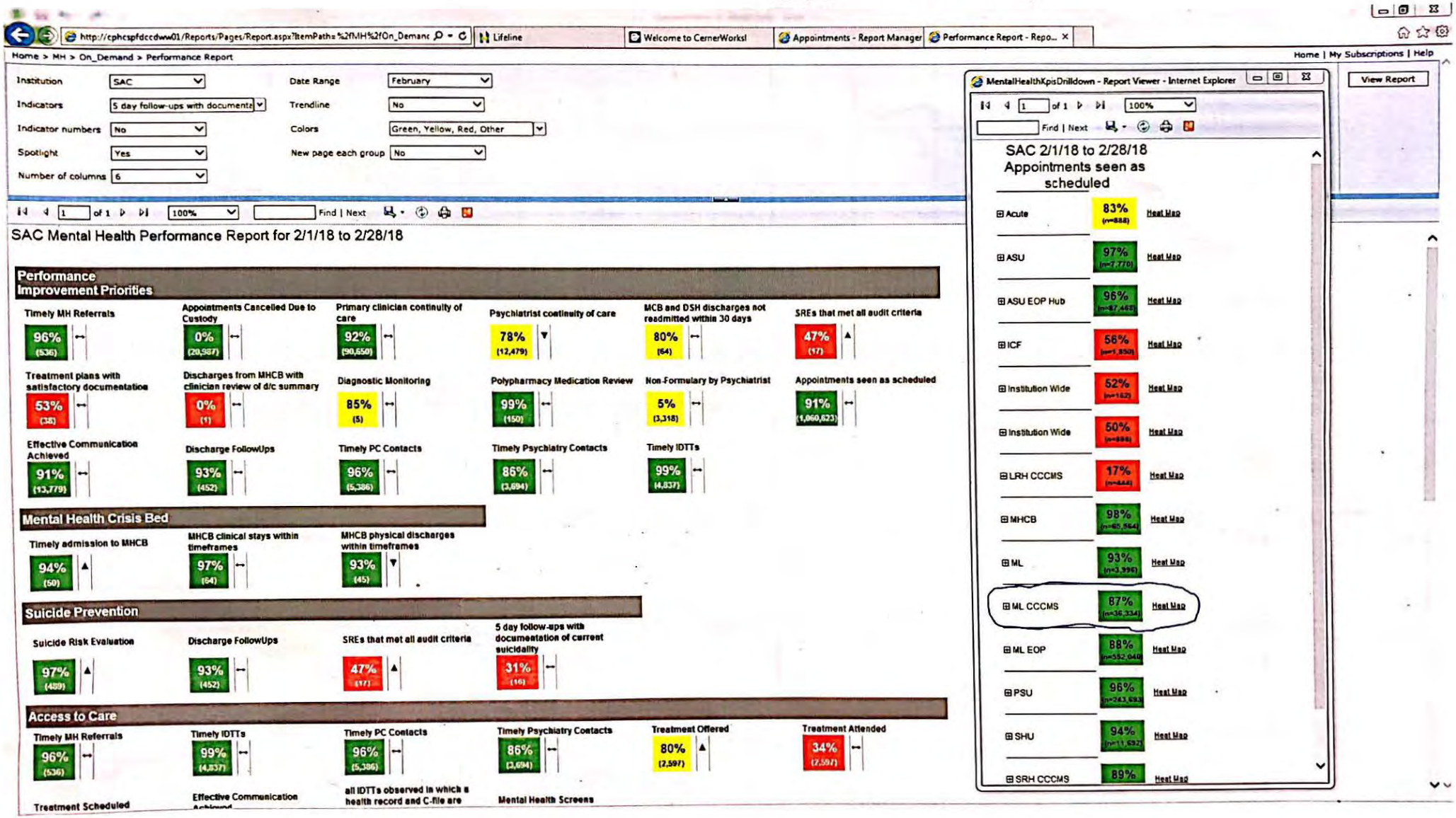
Appointments seen as scheduled indicator reports that 95% of mainline CCCMS appointments in CMCR in February 2018 were seen as scheduled MH

Actually 42% 35,642 appointments / 84,120 appointments

All of CCC All Dists February 2018

8_2218_0100MS pg 2

SAC ccc Feb



SAC P19...

8-22-18_0900hrs_PJS SAC CCCMS Appts Feb 2018 8-22-18_0900hrs_pjs

Inst	CDCR	Offender ID	Current Cell Bed	Appt Program	Appt Sub Program	Appt MHI	Appt Date	Min	Provider Type	Provider Name	Type	Reason	Outcome Type	Status Reason	Modality
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/21/2018 11:00:00 AM	30	SPS	[redacted]	PSY_CONTACT	ML CCCMS Continuing Primary Psychiatrist	Completed	Seen	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/16/2018 10:00:00 AM	30	CLIN_SOC_WORK_SAF		PC_CONTACT	ML CCCMS Continuing Primary Clinician Co	Cancelled	CancelledUnspecified	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/5/2018 10:14:00 AM	42	CLIN_SOC_WORK_SAF		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/20/2018 1:15:00 PM	60			PC_CONTACT	EOP PC Caseload Group	Cancelled	CancelledUnspecified	
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/6/2018 1:15:00 PM	60			PC_CONTACT	EOP PC Caseload Group	Cancelled	CancelledUnspecified	
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/2/2018 1:15:00 PM	120			GROUP_TREATMENT	Leisure activities	Cancelled	CancelledUnspecified	
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/14/2018 8:15:00 AM	15	PSYCHOLOGY_STUDENT		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/16/2018 11:30:00 AM	30	SPS		PSY_CONTACT	ML CCCMS Continuing Primary Psychiatrist	Completed	Seen	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/20/2018 9:54:00 AM	9	CLIN_SOC_WORK_SAF		PC_CONTACT	ML CCCMS Continuing Primary Clinician Co	Completed	Seen	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/2/2018 2:15:00 PM	10	CLIN_SOC_WORK_SAF		PC_CONTACT	ML CCCMS Continuing Primary Clinician Co	Completed	Seen	CellFront (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/14/2018 8:30:00 AM	15	PSYCH_CLINIC_CF		IDTT	IDTTRoutine	Cancelled	Scheduling Error	Standard
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/1/2018 9:50:00 AM	20	CLIN_SOC_WORK_SAF		PC_CONTACT	ML CCCMS Continuing Primary Clinician Co	Completed	Seen	Standard (Standard)
SAC	[redacted]	[redacted]	[redacted]	ML	GP	CCCMS	2/12/2018 9:15:00 AM	15	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	Scheduling Error	

8.22.18.0100-pg4 CDCR CCCMS Appts Feb 2018 8.22.18.0900-pg4

nL	CDCR#	OffenderID	CurrentCel	Program	SubProgran	MHI	StartDate	Duration	ProviderTy	ProviderName	TypeCodeValue	ReasonCodeValue	StatusCodeValue	StatusReasonCodeValue	Modality1
				ML	SNY	CCCMS	2/1/2018 0:00	30	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	Standard (Standard)
C				ML	GP	CCCMS	2/1/2018 0:00	60	CLIN_SOC_		PC_CONTACT	PC-Initial	Cancelled	CancelledUnspecified	Standard (Standard)
CRC				ML	GP	CCCMS	2/1/2018 0:00	60	PSYCH_CLI		PC_CONTACT	PC-Initial	Cancelled	CancelledUnspecified	Standard (Standard)
RJD				ML	GP	CCCMS	2/1/2018 0:00	30	OTHER_IN		OTHER_CLINICAL	PRE_RELEASE	Cancelled	ProviderUnavailable	CellFront (Standard)
RJD				ML	SNY	CCCMS	2/1/2018 0:00	15	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	ProviderUnavailable	Standard (Standard)
CCWF				ML	CTC	CCCMS	2/1/2018 0:00	600	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
CCWF				ML	CTC	CCCMS	2/1/2018 0:00	575	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
RJD				ML	GP	CCCMS	2/1/2018 2:15	15	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	Standard (Standard)
SAC				ML	GP	CCCMS	2/1/2018 6:00	30	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	
SAC				ML	EOP	CCCMS	2/1/2018 6:15	15	SR_PSYCH_		OTHER_CLINICAL	RVR Evaluation	Completed	Seen	TherapeuticModule (Standard)
SQ				ML	DR	CCCMS	2/1/2018 6:45	15	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Completed	Seen	CellFront (Standard)
CRC				ML	GP	CCCMS	2/1/2018 6:59	1	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
SATF				ML	CTC	CCCMS	2/1/2018 7:00	30	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
SQ				ML	DR	CCCMS	2/1/2018 7:00	75			GROUP_TREATMENT	Specific Mental Health Issues	Cancelled	Auto Canceled	
DVI				ML	SNY	CCCMS	2/1/2018 7:00	30	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	AutoCancellation	
SATF				ML	SNY	CCCMS	2/1/2018 7:00	60			PC_CONTACT	EOP PC Caseload Group	Cancelled	CancelledUnspecified	
RJD				ML	SNY	CCCMS	2/1/2018 7:00	60			PC_CONTACT	PC-Initial	Cancelled	CancelledUnspecified	
RJD				ML	SNY	CCCMS	2/1/2018 7:00	30	PSYCHOLO		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	
KVSP				ML	EOP	CCCMS	2/1/2018 7:00	120			GROUP_TREATMENT	Recreation Therapy	Cancelled	CancelledUnspecified	
KVSP				ML	EOP	CCCMS	2/1/2018 7:00	120			GROUP_TREATMENT	Recreation Therapy	Cancelled	CancelledUnspecified	
RJD				ML	SNY	CCCMS	2/1/2018 7:00	30	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	ProviderUnavailable	Standard (Standard)
CCI				ML	SNY	CCCMS	2/1/2018 7:00	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	Standard (Standard)
SQ				ML	DR	CCCMS	2/1/2018 7:00	120	MH HPS		GROUP_TREATMENT	Specific Mental Health Issues	Completed	Seen	Standard (Standard)
SQ				ML	DR	CCCMS	2/1/2018 7:00	120	MH HPS		GROUP_TREATMENT	Specific Mental Health Issues	Completed	Seen	Standard (Standard)
SQ				ML	DR	CCCMS	2/1/2018 7:00	120	MH HPS		GROUP_TREATMENT	Specific Mental Health Issues	Completed	Seen	Standard (Standard)
HDSP				ML	SNY	CCCMS	2/1/2018 7:10	20	CLIN_SOC_		DC_FU	ML CCCMS 5 Day Follow Up	Completed	Seen	Standard (Standard)
CRC				ML	SNY	CCCMS	2/1/2018 7:15	60	PSYCH_CLI		PC_CONTACT	PC-Initial	Cancelled	CancelledUnspecified	Standard (Standard)
CRC				ML	SNY	CCCMS	2/1/2018 7:15	60	PSYCH_CLI		PC_CONTACT	PC-Initial	Cancelled	CancelledUnspecified	Standard (Standard)
CCI				ML	SNY	CCCMS	43132.30208	60	PSYCH_CLI		PC_CONTACT	PC-Initial	Cancelled	SchedulingConflict	Standard (Standard)
HDSP				ML	SNY	CCCMS	43132.30347	11	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
HDSP				ML	SNY	CCCMS	43132.30903	38	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
SQ				ML	GP	CCCMS	43132.3125	45	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	Auto Canceled	
COR				ML	SEO	CCCMS	43132.3125	15	SOCIAL_W		PC_CONTACT	PC_ROUTINE	Cancelled	CancelledUnspecified	Standard (Standard)
CCI				ML	SNY	CCCMS	43132.3125	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	Standard (Standard)
CCI				ML	SNY	CCCMS	43132.3125	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	
CCI				ML	SNY	CCCMS	43132.3125	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	
CCI				ML	SNY	CCCMS	43132.3125	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	Standard (Standard)
HDSP				ML	SNY	CCCMS	43132.3125	25	CLIN_SOC_		PC_CONTACT	MHPC Consult Routine	Completed	Seen	Standard (Standard)
WSP				ML	SNY	CCCMS	43132.32292	15	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
WSP				ML	SNY	CCCMS	43132.32292	15	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
CTF				ML	GP	CCCMS	43132.32292	15	PSYCH_CLI		IDTT	IDTT-Initial	Cancelled	CancelledUnspecified	Standard (Standard)
CCI				ML	SNY	CCCMS	43132.32292	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	
CCI				ML	SNY	CCCMS	43132.32292	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	SchedulingConflict	Standard (Standard)
SQ				ML	GP	CCCMS	43132.32292	25	SPS		PSY_CONTACT	PSY_ROUTINE	Completed	Seen	Standard (Standard)
HDSP				ML	SNY	CCCMS	43132.32708	29	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Completed	Seen	Standard (Standard)
HDSP				ML	SNY	CCCMS	43132.32917	31	PSYCH_CLI		DC_FU	ML CCCMS 5 Day Follow Up	Completed	Seen	Standard (Standard)
SATF				ML	SNY	CCCMS	43132.32986	28	SPS		PSY_CONTACT	PSY_ROUTINE	Completed	Seen	Standard (Standard)
CMC				ML	GP	CCCMS	43132.32986	11	PSYCH_CLI		PC_CONTACT	ML CCCMS Continuing Primary Clin	Completed	Seen	Standard (Standard)
SATF				ML	SNY	CCCMS	43132.33333	60			GROUP_TREATMENT	Coping	Cancelled	Auto Canceled	
SQ				ML	SNY	CCCMS	43132.33333	75			GROUP_TREATMENT	Other Therapeutic Activities	Cancelled	Auto Canceled	
CHCF				ML	OHU	CCCMS	43132.33333	30	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
CMC				ML	GP	CCCMS	43132.33333	30	PSYCH_CLI		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
SATF				ML	SNY	CCCMS	43132.33333	60			GROUP_TREATMENT	Coping	Cancelled	Auto Canceled	
SATF				ML	SNY	CCCMS	43132.33333	60			GROUP_TREATMENT	Coping	Cancelled	Auto Canceled	
SAC				ML	GP	CCCMS	43132.33333	120			GROUP_TREATMENT	Health Issues	Cancelled	Auto Canceled	
SATF				ML	SNY	CCCMS	43132.33333	60			GROUP_TREATMENT	Coping	Cancelled	Auto Canceled	
CMC				ML	GP	CCCMS	43132.33333	30	PHYSICIAN		PSY_CONTACT	PSY_ROUTINE	Cancelled	Auto Canceled	
COR				ML	SNY	CCCMS	43132.33333	15	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
CHCF				ML	CTC	CCCMS	43132.33333	45	PSYCH_CLI		OTHER_CLINICAL	SRE	Cancelled	Auto Canceled	
DVI				ML	SNY	CCCMS	43132.33333	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	Auto Canceled	
SQ				ML	SNY	CCCMS	43132.33333	75			GROUP_TREATMENT	Other Therapeutic Activities	Cancelled	Auto Canceled	
COR				ML	SNY	CCCMS	43132.33333	15	PSYCH_CLI		DC_FU	ML CCCMS 5 Day Follow Up	Cancelled	Auto Canceled	
DVI				ML	CTC	CCCMS	43132.33333	60	SPS		PSY_CONTACT	PSY-Initial	Cancelled	Auto Canceled	
SQ				ML	SNY	CCCMS	43132.33333	75			GROUP_TREATMENT	Other Therapeutic Activities	Cancelled	Auto Canceled	
COR				ML	GP	CCCMS	43132.33333	15	CLIN_SOC_		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
COR				ML	GP	CCCMS	43132.33333	15	PSYCHOLO		PC_CONTACT	PC_ROUTINE	Cancelled	Auto Canceled	
SQ				ML	SNY	CCCMS	43132.33333	30	SPS		PSY_CONTACT	PSY_ROUTINE	Cancelled	Auto Canceled	

EXHIBIT VV
(2018-08-23)

Aug 23, 2018 (1)

Timely Psychiatry Contacts from 10/01/17 thru 3/31/18
Mainline CCCMS

	Measurements	Avg Days Overdue	Compliance
Timely Psychiatry Contacts	321011	2.6	94%
Initial	4239	2.7	91%
Routine	316772	2.6	94%

Aug 23 2018 (2)

Psychiatry Contacts
10/01/17-03/31/18

# of Psy_Contact	Column Labels			Avg per	Avg EOP	
Institutions	EOP ML	EOPMod	Total	30 days	ML Pop	Rate
ASP	12		12	2	1	2.00
CAL	1		1	0	-	N/A
CCI	33		33	6	5	1.10
CCWF	1,059	14	1,073	179	131	1.37
CEN	2		2	0	-	N/A
CHCF	2,269	488	2,757	460	575	0.80
CIM	11		11	2	-	N/A
CIW	701	58	759	127	84	1.51
CMC	3,786	15	3,801	634	541	1.17
CMF	2,456	122	2,578	430	445	0.97
COR	2,490	185	2,675	446	585	0.76
CRC	5		5	1	1	0.83
CTF	11		11	2	2	0.92
DVI	2		2	0	-	N/A
FSP	32		32	5	3	1.78
HDSP	9		9	2	4	0.38
ISP	1		1	0	1	0.17
KVSP	1,148	288	1,436	239	217	1.10
LAC	3,745	479	4,224	704	667	1.06
MCSP	3,595	344	3,939	657	663	0.99
NKSP	10	1	11	2	-	N/A
PBSP	10		10	2	2	0.83
PVSP	3		3	1	1	0.50
RJD	4,047	325	4,372	729	831	0.88
SAC	2,336	8	2,344	391	509	0.77
SATF	3,409	105	3,514	586	642	0.91
SCC	7		7	1	1	1.17
SOL	19		19	3	4	0.79
SQ	549	64	613	102	59	1.75
SVSP	2,907	18	2,925	488	587	0.83
VSP	1,757	59	1,816	303	354	0.85
WSP	10	1	11	2	-	N/A
Total	36,432	2,574	39,006	6,501	6,915	0.94

in 6 months

in 6-months

EXHIBIT WW
(2018-08-23-1207hrs)

Aug 23, 2018 12:07 PM

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Thursday, August 23, 2018 12:07 PM
To: [redacted]@CDCR; [redacted]@CDCR
Subject: [redacted] Case No. [redacted]

Psychiatry Our Headquarters team can't search database unless Dr. [redacted] has time.

Hi [redacted]
With your permission, can [redacted] take a look at this very high profile case for us?
Michael

[redacted] Case No. [redacted]
Hi [redacted]
This is an extremely high profile case.
Can you search the database to figure out his medication history and whether he is a Clozapine candidate?
He apparently lacks competency.
Obviously issues of voluntary blood draw and voluntary taking-of-medications would be appropriate

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

EXHIBIT XX
(2018-08-28)

8/28/18

Physical Health Monitoring for Psychotropic Medication (not High Dose)

NHS

This guidance has been developed using BNF and summary of product characteristics for essential monitoring for psychotropic medication in Adult Mental Health. Annual health check is recommended.

Medication	Frequency	BMI/Weight	TFTs	U&Es/ eGFR	ECG	Li levels	FBC	HbA1c Glucose	LFTs	BP	Lipids
Lithium*	initiation/dose change		√	√	B	weekly until stable					
	3 monthly					√ for 1st year or risk					
	6 monthly		√	√	B	√ after 1st year					
	annually										
Valproate	initiation						C		A		
	annually										
Lamotrigine	Initiation skin reaction advice						C				
Venlafaxine	initiation									√	
	post dose increase									√	
	6 monthly									√	
Citalopram	initiation				B						
Escitalopram	initiation				B						
Tricyclics	initiation			D	X						
Antipsychotics (for the most recent info check SPC for the specific drug)	initiation	√		√	B		√	√	√	√	√
	post dose increase									√	
	After 1 month	√						olanzapine			
	3 months	√									√
	6 months	olanzapine						√			olanzapine
	9 months	olanzapine									olanzapine
	annually	√		√	B		√	√	√		√

A = before therapy and during first six months
B = only if suspected or existing cardiac problem
C = recognise signs of blood disorders (anaemia/bruising - info for patients). Check before surgery
D = to rule out hypokalaemia if using clomipramine
X = avoid if pre-existing cardiac disease as can be harmful even at clinical doses
Clozapine - see separate guidance (sign post to...)
HDAT (High Dose Antipsychotic Therapy) = majority monitoring in secondary care. See separate guidance...

Risk Groups with Lithium Therapy*
- Older people
- Concurrent interacting drugs (NSAIDs, ACEIs, diuretics)
- At risk of renal or thyroid dysfunction, pregnancy, Ca etc.
- Significant disease or change in fluid/food intake
- Poor adherence or symptom control

Created by Southern Health NHS Foundation Trust | Agreed by all clinical commissioning groups across Hampshire and Southampton.

EXHIBIT YY
(2018-08-31-0242hrs)

8-31-18-024 DLS (1)

Medication Non-Compliance Appointments at CHCF

There were 17 medication non-compliance appointments scheduled at CHCF for the month of August.

10 were "completed": 8 on-time, 2 refused

7 were cancelled: 5 as CancelledUnspecified, 1 as SchedulingError, 1 as SchedulingConflict

Thus CHCF appears to be 59% compliant with completing medication non-compliance appointments, since refused appointments are counted as completed. The percentage of scheduled medication non-compliance appointments that were seen on time was 47% (8 divided by 17). The Performance Report shows 100% compliance for medication non-compliance consults completed within 7 days. [1]

It is important to note that the Timely MH Referrals report excludes cancelled appointments. Appointments are frequently cancelled on the day of the appointment, often due to the patient refusing to attend or not showing up, and these are sometimes coded as CancelledUnspecified due to the provider not giving an appointment cancellation reason. In the case of the medication non-compliance appointments, these are patients who have been flagged as medication non-compliant and require an appointment with a psychiatrist within 7 days, per policy. Many, but not all, of these cancelled appointments are rescheduled, but the patients who do not have their appointment rescheduled do not receive their required medication non-compliance appointment. By removing cancelled appointments from the calculations, this indicator ignores these patients, and reports a falsely elevated timely completion rate.

One might argue that this is an indicator for *timeliness* of referrals, and thus should only include referrals that were completed. However, if a referral is required by policy, but is never done, that required referral is not timely, and this deficiency needs to be recorded. An indicator that only reports on the timeliness of completed consults, and excludes all consults that were cancelled or never occurred despite being required, is not very helpful, and is incredibly misleading. Plus, the definition of the Timely MH Referrals denominator is "Number of Routine, Urgent, Emergent, Med Refusal, and RVR MHA referrals that either came due or were completed during the reporting period." Thus even though these cancelled appointments were not completed, they *came due* during the reporting period and should be included in the compliance statistics.

More concerning, per the Huddle Report on 8/3/18, for that ONE day, 225 patients were flagged as psychiatric medication non-compliant (had refused 50+% of their psychiatric medication doses in a week, or refused three consecutive days of psychiatric medication, or refused one dose of a critical psychiatric medication). To get this number I had to open the Huddle Report for each Care Team (e.g. D5B, D6A – each entry with a number listed below is a separate Care Team), scroll down to the section titled "EHRS Institutions Only: Patients with Medication Administration Policy Alerts (All Medication Admin Alerts):", and sort through to find the psychiatric medication refusals. Many of the patients only had medical medications listed, so those patients were excluded. Additionally, many patients had medications listed that could have been prescribed by either Medical or Psychiatry – if there were no other psychiatric medications listed for that patient, I excluded the patient and assumed the medication was prescribed by Medical, thus 225 is likely lower than the real total.

1. This number was obtained by excluding the cancelled appointments from the denominator, counting the refusals as timely completions, including one of the cancelled appointments as completed, and counting one of the completed appointments twice.

(2)

Although it would have taken minutes to get the above data if I had access to the database and could run a query for CHCF patients who were flagged as non-compliant with psychiatric medication, compiling this information manually took me over 3 hours.

Please note, 225 is the number of patients flagged on one day. If we were to extremely conservatively estimate that those 225 patients are the only patients at CHCF who were flagged as psychiatric medication non-compliant for the whole month of August, then 8 of the 225 (3.6%) patients actually received their required appointment. It is highly likely that there were more patients flagged as psychiatric medication non-compliant if the whole month of August were included, not just a single day, in which case this percentage would be lower.

Additionally, the Timely MH Referrals indicator reported 291 MH referrals at CHCF during the month of August. This figure only includes the 12 previously mentioned medication non-compliance appointments. If every patient who required a medication non-compliance appointment had one scheduled for them, at the very least there would be 213 (225 minus 12) additional MH referrals, for a total of 504 MH referrals during the month of August. Using this more accurate, but still extremely conservative, figure, the percentage of MH referrals completed on-time would be 55%, not 96% as is reported in the Performance Report.

Number of patients who were flagged as psychiatric medication non-compliant on 8/3/2018 in the CHCF Mental Health Huddle Report, listed by Care Team:

A1A	5
A1B	3
A2A	5
A2B	4
B1A	2
B1B	3
B2A	0
B3A	1
B3B	2
B4A	5
B4B	1
B5A	6
B5B	4
B6A	4
B6B	3

(3)

B7A	2
B7B	4
B8A	0
B8B	3
C1A	1
C1B	1
C2A	0
C2B	1
C3A	0
C3B	1
C4A	0
C4B	2
C5A	1
C5B	0
C6A	1
C6B	1
D1A	1
D1B	2
D2A	0
D2B	1
D3A	1
D3B	1
D4A	0
D4B	1
D5A	0
D5B	0
D6A	1
D6B	0
D7A	0

(4)

E 01-25	32
E 26-50	23
E 51-75	42
E 76-00	34
E1A 01-25	2
E1A 26-50	1
E1A 51-75	3
E1A 76-00	2
Work Crew	11

Total = 225 patients (not medications) were flagged as non-compliant with their psychiatric medication at CHCF on 8/3/18. This only includes the patients who: 1) refused 3 consecutive days of psychiatric medication; or 2) refused 50% or more of their psychiatric medication doses in a week; or 3) refused one dose of a critical psychiatric medication.

PCP:Lenoir, Pierrette PS | MH LOC/DDP:EOP/Pass - NCF | Allergies: egg-containing compound | Loc:CHCF
NCM:Christine Escobar,RN/__MHPC:Deanne Welch,Psychologist | Code: | Hold:Non
MHMD:Jinge Su,Psychiatrist/__DEN:Sam Tan,Dentist | History Of Suicide Attempts: 3/DPC:5-(05/16/2018) | EPRD

Appointments

8/3/18 02:42

5

CDCR #: [redacted]

1

Cancelations by Patient: 5
Other Cancelations: 278

Reschedules by Patient: 2
Other Reschedules: 30

No Shows: 3

ments

	Duration	State	Apportment Type	Apportment Reason	Primary Resource	Location
W	60	Confirmed	Leisure Activities (CHCF)		Leisure Activities (CHCF)	CHCF E Clinic
M	30	Confirmed	ML EOP Continuing Primary Clinician Contact		[redacted] PC	CHCF E Clinic
W	60	Canceled	Leisure Activities (CHCF)		Leisure Activities (CHCF)	CHCF E Clinic
M	60	Confirmed	Leisure Activities (CHCF)		Leisure Activities (CHCF)	CHCF E Clinic

ents

	Duration	State	Apportment Type	Apportment Reason	Primary Resource	Location
AM	60	Canceled	Leisure Activities (CHCF)		Leisure Activities (CHCF)	CHCF E Clinic
PM	60	Canceled	Social Skills Communication (CHCF)		Social Skills Communication (CHCF)	CHCF E Clinic
[redacted]						
W	60	Canceled	Leisure Activities (CHCF)		Leisure Activities (CHCF)	CHCF E Clinic

Even if pts who
1. were mod non-compliant
2. were scheduled for an appointment
3. Did not refuse (as recorded)
4. But the appointment was cancelled

then this pt. still counted as Compliant!

Most cancelled appointments were simply excluded which prevents non-compliance, This pt was somehow affirmatively counted! (no note in chart)

6

So medication non-compliant

Reports are said to be seen 100% of the time. Actually < 3.7%

< 3.7% vs 100% at CHCF

http://cphcspfdccdww01/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand

Home > MH > On_Demand > Performance Report

Institution	CHCF	Date Range	August
Indicators	Timely MH Referrals	Trendline	No
Indicator Numbers	No	Colors	Green, Yellow, Red, Other
Spotlight	Yes	New page each group	No
Number of Columns	6		

1 of 1 100% Find | Next

CHCF Mental Health Performance Report for 8/1/18 to 8/31/18

Performance Improvement Priorities

Timely MH Referrals

96% (29/1)

Access to Care

Timely MH Referrals

96% (29/1)

Report run on: 8/31/2018 8:36:50 AM Data last refreshed: 8/30/2018 8:06:00 PM Page

/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand%2fPerformance+Report

MentalHealthKpisPopup - Report Viewer - Internet Explorer

1 of 1 100% Find | Next

Quick List: CHCF
Timely MH Referrals from 8/01/18 thru 8/31/18
Placement: ALL
Data last refreshed 8/30/2018 8:06:00 PM

96% Timely MH Referrals

100%!

	Measurements	Avg Time Overdue	Compliance
Timely MH Referrals	291	0.1	96%
CompletedMHMDConsultEmergent in 4 Hours	2	25.0	0%
CompletedMHPCConsultUrgent in 24 Hours	27	0.9	93%
CompletedMHMDConsultRoutine in 5 WorkDays	16	0.1	94%
CompletedMHPCConsultRoutine in 5 WorkDays	183	0.0	97%
CompletedMHPCConsultEmergent in 4 Hours	51	0.0	98%
CompletedMedNonComplianceConsult in 7 Days	12	0.0	100%

Details

Timeframe	Placement	Inst	CDCR#	Name	Date	Time Overdue	Details
CompletedMedNonComplianceConsult in 7 Days (12)	ML EOP	CHCF	[redacted]		8/21/2018 11:59:00 PM	0	Initiated on Aug 14 2018 8:48AM Due Aug 21 2018 11:59PM Completed on Aug 20 2018 8:51AM
	ML EOP	CHCF	[redacted]		8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM Due Aug 17 2018 11:59PM Completed on Aug 15 2018 8:25AM
	ML CCCMS	CHCF	[redacted]		8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:13PM Due Aug 9 2018 11:59PM Completed on Aug 9 2018 2:35PM
	ML EOP	CHCF	[redacted]		8/29/2018 11:59:00 PM	0	Initiated on Aug 22 2018 7:33AM Due Aug 29 2018 11:59PM Completed on Aug 22 2018 7:58AM
	ML CCCMS	CHCF	[redacted]		8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:07PM Due Aug 9 2018 11:59PM Completed on Aug 9 2018 2:45PM
	ML CCCMS	CHCF	[redacted]		8/16/2018 11:59:00 PM	0	Initiated on Aug 9 2018 2:47PM Due Aug 16 2018 11:59PM Completed on Aug 16 2018 7:34AM
	ML EOP	CHCF	[redacted]		8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM Due Aug 17 2018 11:59PM Completed on Aug 17 2018 1:00PM
	ML CCCMS	CHCF	[redacted]		8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:21PM Due Aug 9 2018 11:59PM Completed on Aug 9 2018 1:40PM
	ML CCCMS	CHCF	[redacted]		8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:15PM Due Aug 9 2018 11:59PM Completed on Aug 7 2018 7:18AM
	ML CCCMS	CHCF	[redacted]		8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:03PM Due Aug 9 2018 11:59PM Completed on Aug 8 2018 10:00AM
	ML CCCMS	CHCF	[redacted]		8/14/2018 11:59:00 PM	0	Initiated on Aug 7 2018 8:37PM Due Aug 14 2018 11:59PM Completed on Aug 8 2018 10:00AM
	ML EOP	CHCF	[redacted]		8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM Due Aug 17 2018 11:59PM Completed on Aug 15 2018 10:00AM

EXHIBIT ZZ
(2018-09-01-0900hrs)

Sept 9 L 16 0900hrs

Psychiatry Contacts
10/01/17-03/31/18

# of Psy_Contact Column Labels

Institutions	EOP ML	EOPMod	Total	Avg per 30 days	Avg EOP ML Pop	Rate
ASP	12		12	2	1	2.00
CAL	1		1	0	-	N/A
CCI	33		33	6	5	1.10
CCWF	1,059	14	1,073	179	131	1.37
CEN	2		2	0	-	N/A
CHCF	2,269	488	2,757	460	575	0.80
CIM	11		11	2	-	N/A
CIW	701	58	759	127	84	1.51
CMC	3,786	15	3,801	634	541	1.17
CMF	2,456	122	2,578	430	445	0.97
COR	2,490	185	2,675	446	585	0.76
CRC	5		5	1	1	0.83
CTF	11		11	2	2	0.92
DVI	2		2	0	-	N/A
FSP	32		32	5	3	1.78
HDSP	9		9	2	4	0.38
ISP	1		1	0	1	0.17
KVSP	1,148	288	1,436	239	217	1.10
LAC	3,745	479	4,224	704	667	1.06
MCSP	3,595	344	3,939	657	663	0.99
NKSP	10	1	11	2	-	N/A
PBSP	10		10	2	2	0.83
PVSP	3		3	1	1	0.50
RJD	4,047	325	4,372	729	831	0.88
SAC	2,336	8	2,344	391	509	0.77
SATF	3,409	105	3,514	586	642	0.91
SCC	7		7	1	1	1.17
SOL	19		19	3	4	0.79
SQ	549	64	613	102	59	1.75
SVSP	2,907	18	2,925	488	587	0.83
VSP	1,757	59	1,816	303	354	0.85
WSP	10	1	11	2	-	N/A
Total	36,432	2,574	39,006	6,501	6,915	0.94

EXHIBIT AAA
(2018-09-04-1500hrs)

9-4-18 15:00 (1)

Medication Non-Compliance Appointments at CHCF

There were 17 medication non-compliance appointments scheduled at CHCF for the month of August.

10 were "completed": 8 on-time, 2 refused

7 were cancelled: 5 as CancelledUnspecified, 1 as SchedulingError, 1 as SchedulingConflict

not entirely of the 100's who were not scheduled!

Thus CHCF appears to be 59% compliant with completing medication non-compliance appointments, since refused appointments are counted as completed. The percentage of scheduled medication non-compliance appointments that were seen on time was 47% (8 divided by 17). The Performance Report shows 100% compliance for medication non-compliance consults completed within 7 days. [1]

It is important to note that the Timely MH Referrals report excludes cancelled appointments. Appointments are frequently cancelled on the day of the appointment, often due to the patient refusing to attend or not showing up, and these are sometimes coded as CancelledUnspecified due to the provider not giving an appointment cancellation reason. In the case of the medication non-compliance appointments, these are patients who have been flagged as medication non-compliant and require an appointment with a psychiatrist within 7 days, per policy. Many, but not all, of these cancelled appointments are rescheduled, but the patients who do not have their appointment rescheduled do not receive their required medication non-compliance appointment. By removing cancelled appointments from the calculations, this indicator ignores these patients, and reports a falsely elevated timely completion rate.

One might argue that this is an indicator for *timeliness* of referrals, and thus should only include referrals that were completed. However, if a referral is required by policy, but is never done, that required referral is not timely, and this deficiency needs to be recorded. An indicator that only reports on the timeliness of completed consults, and excludes all consults that were cancelled or never occurred despite being required, is not very helpful, and is incredibly misleading. Plus, the definition of the Timely MH Referrals denominator is "Number of Routine, Urgent, Emergent, Med Refusal, and RVR MHA referrals that either came due or were completed during the reporting period." Thus even though these cancelled appointments were not completed, they *came due* during the reporting period and should be included in the compliance statistics.

More concerning, per the Huddle Report on 8/3/18, for that ONE day, 225 patients were flagged as psychiatric medication non-compliant (had refused 50+% of their psychiatric medication doses in a week, or refused three consecutive days of psychiatric medication, or refused one dose of a critical psychiatric medication). To get this number I had to open the Huddle Report for each Care Team (e.g. D5B, D6A – each entry with a number listed below is a separate Care Team), scroll down to the section titled **"EHRS Institutions Only: Patients with Medication Administration Policy Alerts (All Medication Admin Alerts):"**, and sort through to find the psychiatric medication refusals. Many of the patients only had medical medications listed, so those patients were excluded. Additionally, many patients had medications listed that could have been prescribed by either Medical or Psychiatry – if there were no other psychiatric medications listed for that patient, I excluded the patient and assumed the medication was prescribed by Medical, thus 225 is likely lower than the real total.

1. This number was obtained by excluding the cancelled appointments from the denominator, counting the refusals as timely completions, including one of the cancelled appointments as completed, and counting one of the *completed appointments* twice.

9418 15.00 (2)

Although it would have taken minutes to get the above data if I had access to the database and could run a query for CHCF patients who were flagged as non-compliant with psychiatric medication, compiling this information manually took me over 3 hours.

Please note, 225 is the number of patients flagged on one day. If we were to extremely conservatively estimate that those 225 patients are the only patients at CHCF who were flagged as psychiatric medication non-compliant for the whole month of August, then 8 of the 225 (3.6%) patients actually received their required appointment. It is highly likely that there were more patients flagged as psychiatric medication non-compliant if the whole month of August were included, not just a single day, in which case this percentage would be lower.

Additionally, the Timely MH Referrals indicator reported 291 MH referrals at CHCF during the month of August. This figure only includes the 12 previously mentioned medication non-compliance appointments. If every patient who required a medication non-compliance appointment had one scheduled for them, at the very least there would be 213 (225 minus 12) additional MH referrals, for a total of 504 MH referrals during the month of August. Using this more accurate, but still extremely conservative, figure, the percentage of MH referrals completed on-time would be 55%, not 96% as is reported in the Performance Report.

Number of patients who were flagged as psychiatric medication non-compliant on 8/3/2018 in the CHCF Mental Health Huddle Report, listed by Care Team:

A1A	5
A1B	3
A2A	5
A2B	4
B1A	2
B1B	3
B2A	0
B3A	1
B3B	2
B4A	5
B4B	1
B5A	6
B5B	4
B6A	4
B6B	3

9-4-18: 15,003

B7A	2
B7B	4
B8A	0
B8B	3
C1A	1
C1B	1
C2A	0
C2B	1
C3A	0
C3B	1
C4A	0
C4B	2
C5A	1
C5B	0
C6A	1
C6B	1
D1A	1
D1B	2
D2A	0
D2B	1
D3A	1
D3B	1
D4A	0
D4B	1
D5A	0
D5B	0
D6A	1
D6B	0
D7A	0

9-4-18 15:00 (4)

D7B 1

E 01-25	32
E 26-50	23
E 51-75	42
E 76-00	34
E1A 01-25	2
E1A 26-50	1
E1A 51-75	3
E1A 76-00	2
Work Crew	11

Total = 225 patients (not medications) were flagged as non-compliant with their psychiatric medication at CHCF on 8/3/18. This only includes the patients who: 1) refused 3 consecutive days of psychiatric medication; or 2) refused 50% or more of their psychiatric medication doses in a week; or 3) refused one dose of a critical psychiatric medication.

EXHIBIT BBB
(2018-09-04-1600hrs)

2018-09-04-1600hrs 9_4_18 16:00

Psychiatry Indicators and Biases

(1)

Timely Psychiatry Contacts

1. Biases due to measurement:
    a. Measured in weeks, rather than on-time versus late. This causes significant bias towards inflating compliance.
        i. E.g. an Enhanced Outpatient Program (EOP) patient had a psychiatry appointment on Monday, 8/13/18, and their next appointment wasn't until Friday, 9/21/18. They were due to be seen by 9/12/18 (per Program Guide rules), so are 9 days late, but due to compliance being measured by weeks, there are four weeks of compliance and one week of non-compliance, which is then reported as 80% compliant. If you have 100 patients, 50 of whom are seen on time, and 50 of whom are seen late by one week, the reported Timely Psychiatry Contacts compliance rate will be 90%. It would be very easy to think that the 90% compliance rate meant that 90% of the patients were seen on time, when in actuality only 50% were.
    b. The clock resets when patients transfer.
        i. E.g. a Correctional Clinical Case Management System (CCCMS) patient had a psychiatry appointment on 3/5/18, and was due to been seen again by 6/3/18 (90 days later). However, the patient transferred to a different CCCMS institution on 5/25/18. Instead of requiring that the patient still be seen by 6/3/18 (to comply with the Program Guide rules), and reporting it as late if it occurs after 6/3/18, this indicator resets the clock to the date of transfer, and only reports the appointment as late if it occurs more than 90 days after transfer. In this example, the patient could go 172 days (from 3/5/18 to 8/23/18) without seeing a psychiatrist, and still be counted as compliant.
    c. Physician orders for follow-ups prior to maximum time per Program Guide are ignored by this indicator.
        i. E.g. a CCCMS patient has a psychiatry appointment on 3/5/18, and the psychiatrist is concerned about him, so orders a follow-up appointment for three weeks later. This appointment was scheduled but cancelled due to custody, or was refused, or did not occur for any number of reasons, and the patient was not seen again until 6/2/18. This indicator counts that appointment as compliant, because it occurred within 90 days, despite the appointment being 68 days late based on the psychiatrist's clinical judgment, and order, that the patient needed follow-up within three weeks.
    d. Sixty percent of psychiatry supervisors see patients (per our polling data), due to staffing shortages. The compliance numbers in this indicator are presented as having been obtained by line staff alone, and are used to determine psychiatry staffing needs. This both results in an underestimate of staffing needs, and in supervisors being unable to do necessary supervisory work due to having to compensate for the line staff shortage.
    e. In December 2016 the indicator was inexplicably changed to count EOP appointments as timely if they occurred within 45 days of the prior appointment, despite the Program Guide rule that EOP psychiatry appointments must occur at least monthly. This

9-4-18 6:00 2

significantly inflated the compliance percentages statewide, and allowed for an inaccurately favorable report to the court in March 2017. The indicator was not fixed until this change was discovered by the psychiatry team in March 2017.

Appointments seen as scheduled

1. Biases due to measurement:
    a. The definition of this indicator states that it measures "All scheduled appointments", but in actuality it only includes appointments that are coded as Seen, Cancelled due to ProviderUnavailable, Cancelled due to ModifiedProgram, or Cancelled due to TechnicalDifficulties (see snip titled Appointments seen as scheduled). It excludes Refusals, No Shows, and all other cancelled appointments, which account for approximately half of all scheduled appointments.
        i. E.g. the Appointments seen as scheduled indicator reports that 95% of mainline CCCMS appointments in CDCR in February 2018 were seen as scheduled. (see attachment CDCR CCCMS appointments seen as scheduled) However, per the Appointments report, in February 2018 in mainline CCCMS, there were 84,120 mental health appointments, 35,642 of which were seen (see Excel spreadsheets titled CDCR CCCMS all appointments in February 2018 and CDCR CCCMS completed appointments in February 2018). Thus the percentage of appointments that were seen as scheduled was 42%, not 95%.

Timely MH Referrals

1. Biases due to measurement:
    a. Only measures the referrals that were ordered, not all of the referrals that occurred, *or should have occurred*. Ordered referrals are much more likely to be completed and done on time than are referrals that should have been ordered but weren't.
        i. E.g. on 8/3/18 at CHCF, 225 patients were flagged as non-compliant with their psychiatric medication (meaning they refused 50% or more of their psychiatric medication in a week, or refused three consecutive days of psychiatric medication, or refused one dose of a critical psychiatric medication). Each of these patients is supposed to be seen by a psychiatrist to discuss their medication non-compliance within seven days, or within one day for refusal of a critical medication. However, during the entire month of August, there were only 17 medication non-compliance appointments scheduled at CHCF – 10 were seen, 7 were cancelled. The cancelled appointments were excluded from the Timely MH Referrals measurement, with the exception of one cancelled appointment that was counted as completed, despite never having occurred. Additionally, two refused appointments were counted as completed, and one seen appointment was counted twice, so the compliance was recorded as 12/12, or 100% for the month of August (see CHCF August Timely MH referrals screenshot). In actuality, 225 patients required follow-up for medication non-

(16)
100's of patients med non-compliant
Not scheduled so not med-non-compliant.
17 scheduled
8 seen
2 Refused
7 cancelled
8/17 seen

2 refused → 8 seen / 15 → 6 cancelled → 8/9 → 1 cancelled → is seen → 9/10 → 2 refused counted as seen → 11/12
1000%
12/12 ← one cancelled seen

9418
16:00 (3)

compliance on a single day in August, and only 8 patients (12 minus the appointment that was counted twice, minus the cancelled appointment that was counted as completed, and minus the two refused appointments) in the whole month of August had a completed medication non-compliance consult. If we use these numbers (8 out of 225), the compliance percentage is 3.6%. However, if the entire month of August is included – not just a single day – this compliance percentage would be much lower.

ii. E.g. for the month of July at CSP-Sacramento, there was one urgent MHMD consult, two emergent MHMD consults, and three routine MHMD consults (see snip titled SAC Timely MH referrals). It is unlikely that there were truly only three routine MHMD consults in a month at an institution with such a large mental health population. The far more likely scenario is that most routine MHMD consults were "ordered" by psychologists or social workers via stopping by the psychiatrist's desk, calling them on the phone, or emailing them, rather than placing an official order (see email from Dr. Golding titled "FW: MHMD emergent consults"). This prevents an institution from having a low compliance rate despite insufficient psychiatry staffing to complete these consults, because these consults will not be measured by the indicator. Compare this to an institution with sufficient psychiatry staffing – at San Quentin during the same month there were 32 routine, 11 urgent, and one emergent MHMD consults (see snip titled SQ Timely MH Referrals).

b. Excludes most cancelled appointments, and counts refusals as "completed". As described in "Appointments seen as scheduled 1 a" above, all cancelled appointments, except those coded as ProviderUnavailable, TechnicalDifficulties, and ModifiedProgram are also excluded from this indicator's calculations.

2. Biases due to lack of knowledge:
   a. Many psychiatrists appear to not know about the medication non-compliance appointment order in EHRS, or are not aware of the requirement to see patients who have been flagged for medication non-compliance. If all psychiatrists had this knowledge, and placed a medication non-compliance appointment order for every patient flagged as non-compliant, there would be thousands of medication non-compliance appointments statewide per month. Psychiatry staffing is not sufficient to complete all, or even most, of these appointments, so the percentage of MH referrals completed on time would significantly decrease.
3. Biases due to random error:
   a. Medication non-compliance appointments may be ordered erroneously as a psychiatry follow-up appointment, and thus not captured by this indicator. Also, as mentioned above, mental health referrals may be communicated to the requested provider verbally and an order never placed in EHRS, despite knowledge of the process and intention to place an order. In both of these examples the appointment is less likely to occur when there is no official order, due to a number of factors, including the increased likelihood of the provider forgetting, the provider having limited time and triaging some of these appointments as less important, and there being less pressure from supervisors on the

9418 16:00
4

provider to complete the appointment in a timely manner to improve the indicator results.

Appointment confidentiality: There is an indicator for "Group treatment in a confidential setting", but not for psychiatry appointment in a confidential setting. However, this is an important indicator of quality care, and should be one of the measured indicators. Currently, there is no easy way to determine the percentage of psychiatry appointments at a given institution or level of care that were confidential, but it is possible to use the Appointments report to check on whether individual appointments were recorded as confidential or non-confidential, count all of the confidential appointments in the population of interest, then divide by the total number of appointments in order to get a percentage. This is time-consuming, but more importantly it is inaccurate, due to the following biases.

1. Biases due to measurement: In the Electronic Health Record System (EHRS), confidentiality is recorded in a drop-down menu on the appointment check-out screen. The default value is "Confidential", thus if the provider does not change this selection, all appointments are recorded as confidential. If an accurate measure of confidentiality was desired, this drop-down menu would default to NULL (no selection), and it would require the provider to change the selection to either confidential or non-confidential.
2. Biases due to lack of knowledge: If a provider does not know how to record an appointment as non-confidential, it is recorded as confidential (due to #1 above).
    a. E.g. in the MHCB at CCWF, the psychiatrists reported that all routine psychiatry appointments are conducted in the patient's cell, not in a confidential treatment room, thus 100% of the routine appointments are non-confidential. All of the psychiatrists stated they did not know how to record an appointment as non-confidential. Per the Appointments report, there were 96 completed psychiatry appointments in CCWF MHCB in May 2018, 100% of which were recorded as confidential.
3. Biases due to random error: Even if a provider knows how to record an appointment as non-confidential, if they forget, or are in too much of a hurry, to change the drop-down menu to non-confidential, it is recorded as confidential.
    a. E.g. in the MHCB at CHCF, the psychiatrists reported that all routine psychiatry appointments are conducted cell-front, not in a confidential treatment room, so 100% of the routine appointments are non-confidential. All of the psychiatrists stated they knew how to record an appointment as non-confidential. Per the Appointments report, there were 289 completed routine psychiatry appointments in CHCF MHCB in May 2018, 31% of which were recorded as confidential.

Diagnostic Monitoring (Medication Administration Process Improvement Program)

1. Biases due to measurement:
    a. Until June 2018, this indicator ONLY measured whether annual labs and tests were done. MAPIP guidelines mandate obtaining baseline, 3 month, and annual labs for antipsychotics (except Clozapine) and mood stabilizers, obtaining labs within 14 days of increasing the dose of mood stabilizers, and obtaining baseline, 3 month, and annual

9418
16.05

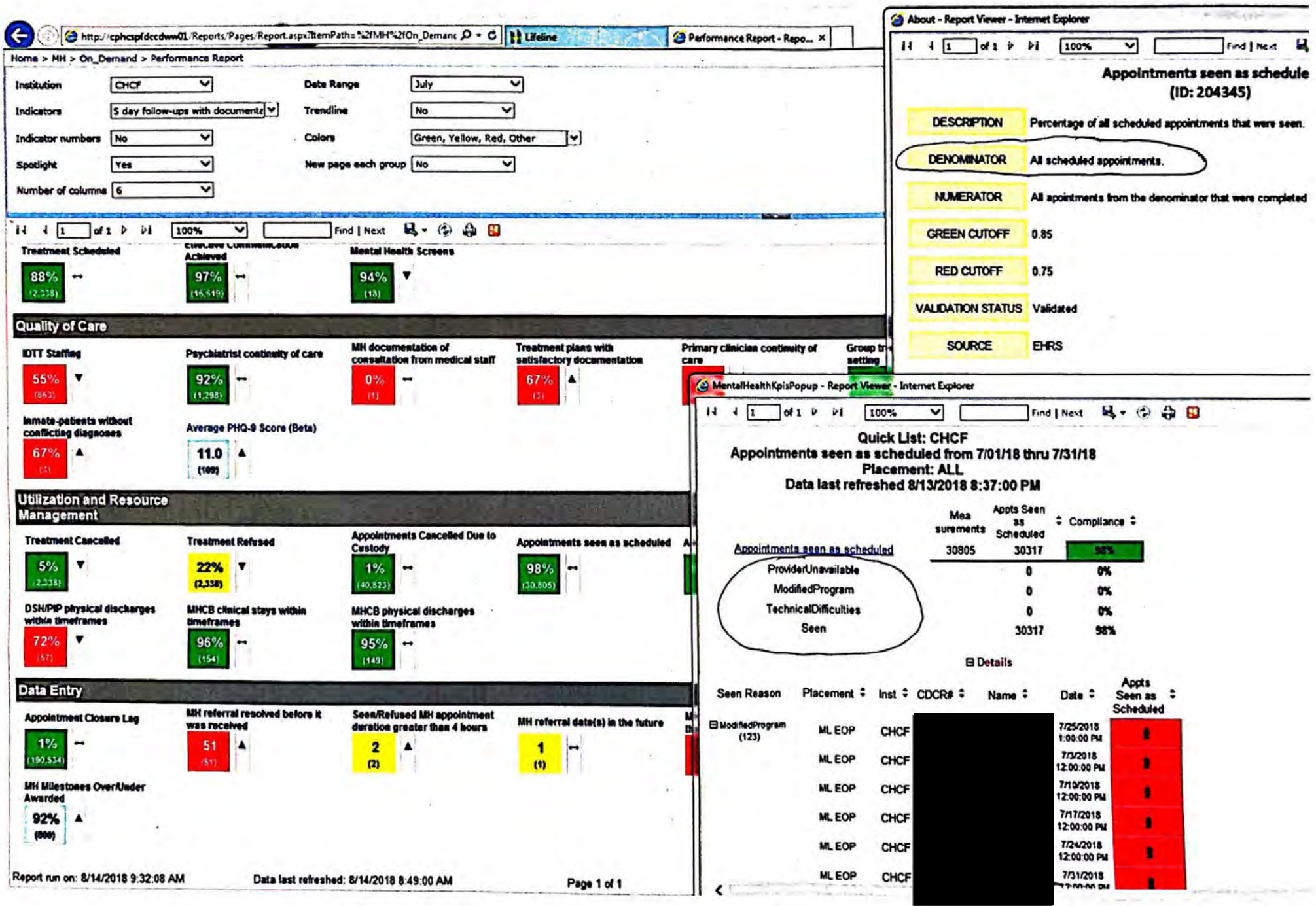
weight/height and blood pressure for antipsychotics and Clozapine. However, until June 2018, the indicator monitoring compliance with these guidelines did not even measure whether baseline, 3 month, or dose increase labs and tests were done. It only checked to see if annual labs and tests were done, and reported 100% compliance if the annual lab draw and tests occurred (see Memorandum dated 7/3/2018).

i. E.g. A patient is prescribed an antipsychotic, and has labs, a blood pressure measurement, and his weight obtained 8 months after starting the medication, but had no tests or labs done at baseline or 3 months. This indicator reports that this patient is 100% compliant with MAPIP, despite being only 33% compliant. This is very misleading, but more importantly it is *dangerous* and poor care. If his blood pressure is elevated, he is morbidly obese, and his fasting lipid levels are critically high at 8 months, we have no idea whether those problems were all present prior to starting the antipsychotic – in which case we likely would not have started the medication – or occurred within the first few months after starting the medication – in which case we would likely have stopped it after obtaining the 3 month test results. Failing to obtain these labs and tests can lead to permanent organ damage or death.

b. Until June 2018, it counted annual labs and tests as completed if the patient had the relevant labs and tests done at any point within a year of starting the medication. Since June 2018, it still counts annual labs and tests as completed if the patient had the relevant labs and tests done between 91 and 365 days after starting the medication. The baseline, 3 month, annual, and after dose increase criteria for obtaining labs and tests is not arbitrary. It was created by physicians, per their clinical judgment of the minimum monitoring necessary to maximize patient safety. Therefore, measuring whether the required tests were done at any point within a year or at any point from 91 to 365 days after starting the medication – not within limited periods around the baseline, 3 month, annual, and dose increase time points – is inappropriate, and leads to falsely elevated compliance.

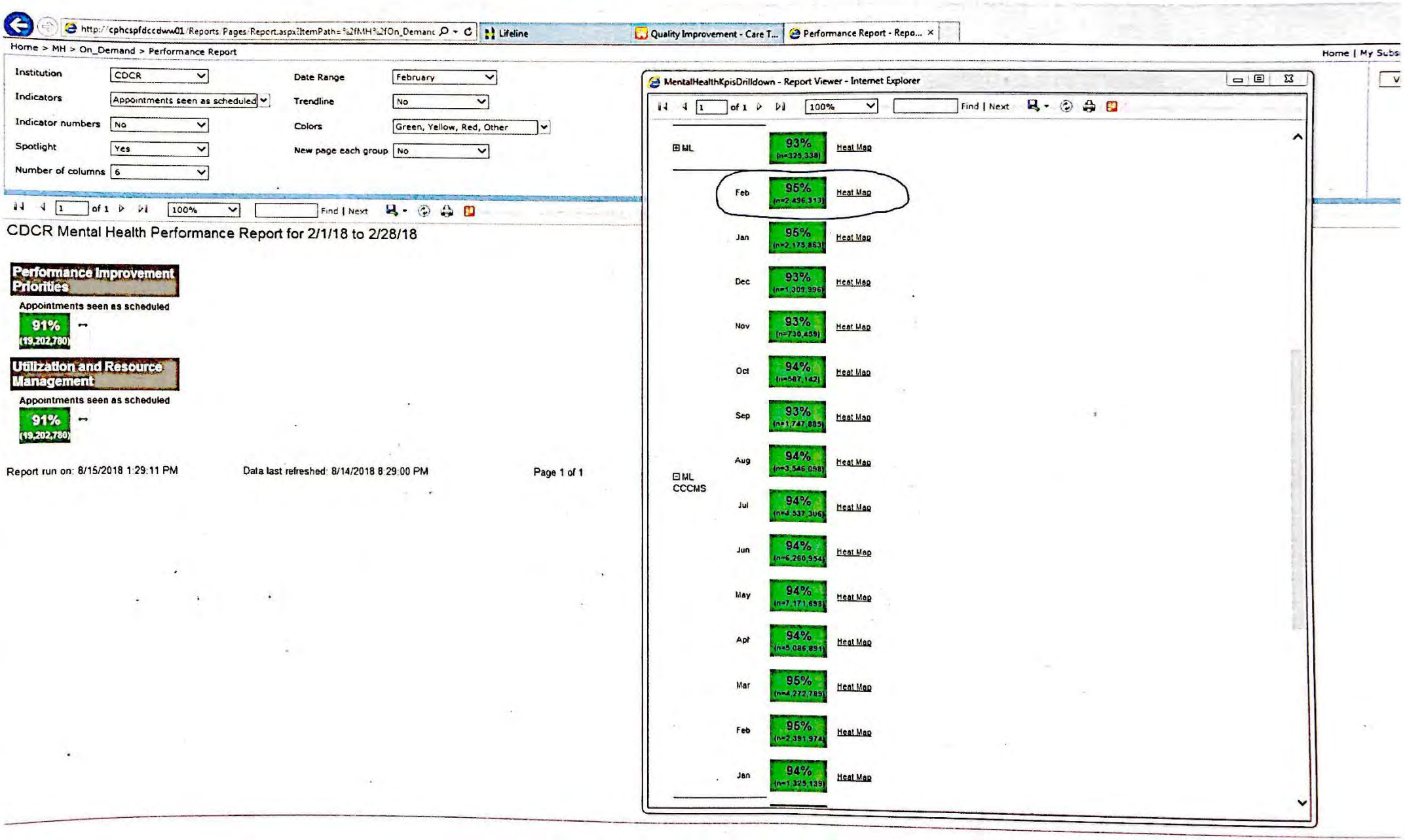
c. Until June 2018, it excluded patients who were not on the same medication class for the whole year. This inflated MAPIP compliance, because these patients were less likely to have had the required labs and tests, due to the provider not having had an entire year during which to have ordered labs and tests.

Appointments Seen As Scheduled
CHCF



9-4-18 16:00 7

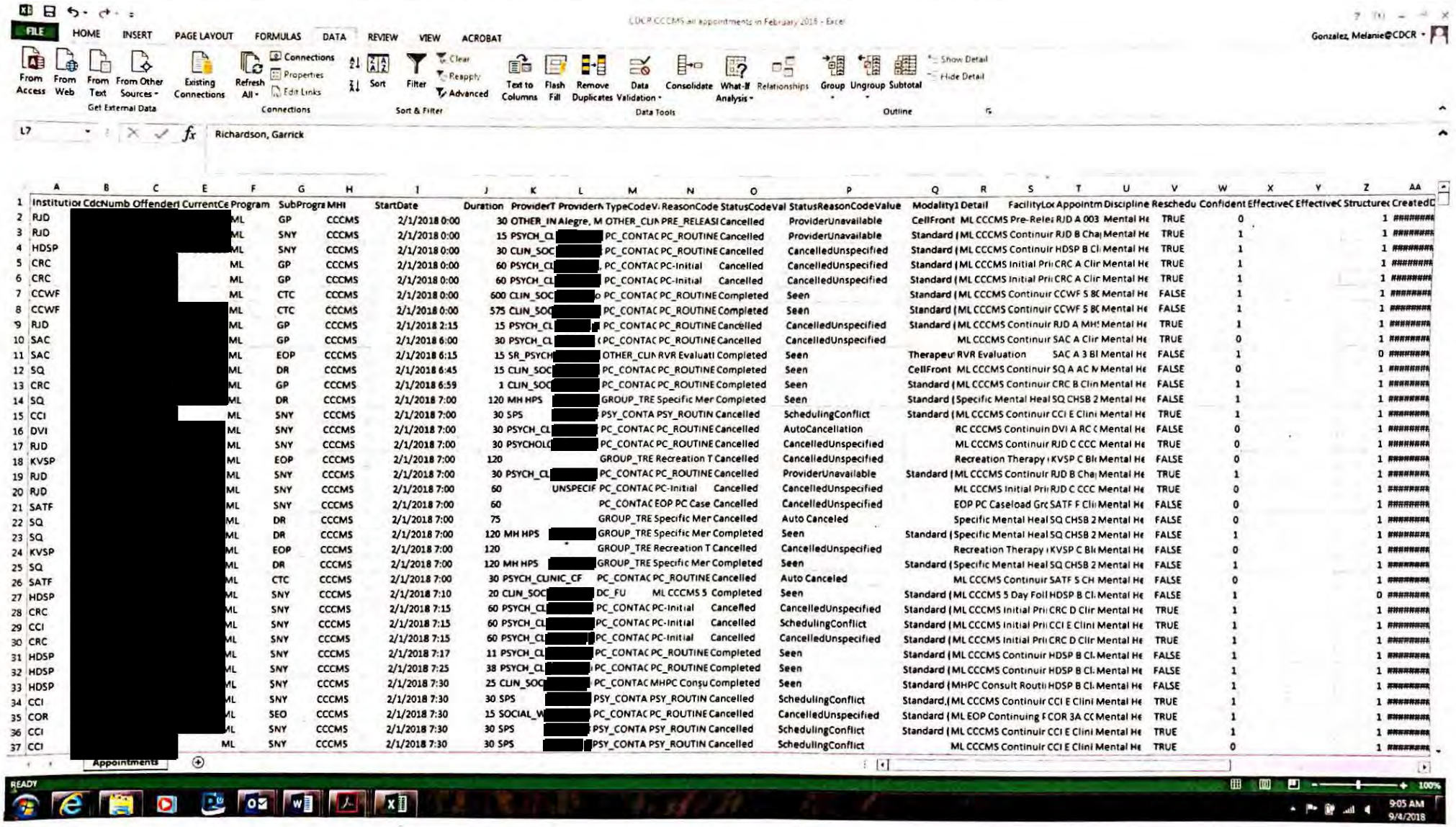
CDCR CCCMS appointments seen as scheduled by all provider types



9-4-18 16:08

CDCR CCCMS all appointments in February 2018

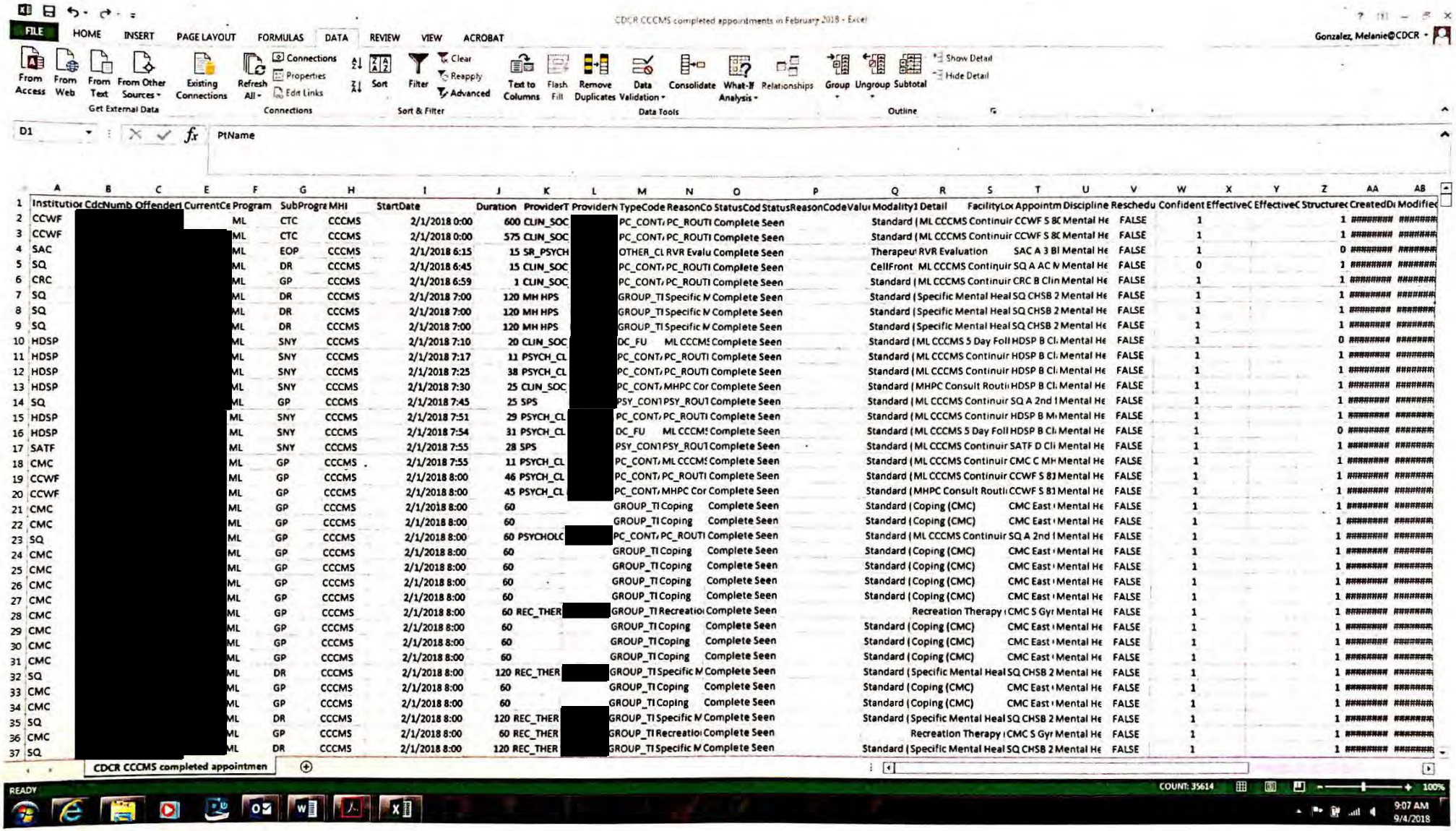
(screenshot of Excel file. If printed from Excel it is 8,950 pages)



9-4-18 16:009

CDCR CCCMS completed appointments in February

(screenshot of Excel file. If printed from Excel it is 3,795 pages)



9-4-18 6:00 to

CHCF August Timely MH referrals

http://cphcspfdccdww01/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand Appointments

Home > MH > On_Demand > Performance Report

Institution	CHCF	Date Range	August
Indicators	Timely MH Referrals	Trendline	No
Indicator Numbers	No	Colors	Green, Yellow, Red, Other
Spotlight	Yes	New page each group	No
Number of Columns	6		

1 of 1 100% Find | Next

CHCF Mental Health Performance Report for 8/1/18 to 8/31/18

Performance Improvement Priorities

Timely MH Referrals

96% (291) --

Access to Care

Timely MH Referrals

96% (291) --

Report run on: 8/31/2018 8:36:50 AM Data last refreshed: 8/30/2018 8:06:00 PM Page

http://cphcspfdccdww01/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand%2fPerformance+Report

MentalHealthKpisPopup - Report Viewer - Internet Explorer

1 of 1 100% Find | Next

Quick List: CHCF
Timely MH Referrals from 8/01/18 thru 8/31/18
Placement: ALL
Data last refreshed 8/30/2018 8:06:00 PM

	Measurements	Avg Time Overdue	Compliance
Timely MH Referrals	291	0.1	96%
CompletedMHMDConsultEmergent in 4 Hours	2	25.0	0%
CompletedMHPCConsultUrgent in 24 Hours	27	0.9	93%
CompletedMHMDConsultRoutine in 5 WorkDays	16	0.1	94%
CompletedMHPCConsultRoutine in 5 WorkDays	183	0.0	97%
CompletedMHPCConsultEmergent in 4 Hours	51	0.0	88%
CompletedMedNonComplianceConsult in 7 Days	12	0.0	100%

⊟ Details

Timeframe	Placement	Inst	CDCR#	Name	Date	Time Overdue	Details	
⊟ CompletedMedNonComplianceConsult in 7 Days (12)	ML EOP	CHCF	[redacted]		8/21/2018 11:59:00 PM	0	Initiated on Aug 14 2018 8:48AM. Due Aug 21 2018 11:59PM. Completed on Aug 20 2018 8:51AM	
	ML EOP	CHCF			8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM. Due Aug 17 2018 11:59PM. Completed on Aug 15 2018 8:25AM	
	ML CCCMS	CHCF			8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:13PM. Due Aug 9 2018 11:59PM. Completed on Aug 9 2018 2:35PM	Refused
	ML EOP	CHCF			8/29/2018 11:59:00 PM	0	Initiated on Aug 22 2018 7:33AM. Due Aug 29 2018 11:59PM. Completed on Aug 22 2018 7:56AM	Cancelled
	ML CCCMS	CHCF			8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:07PM. Due Aug 9 2018 11:59PM. Completed on Aug 9 2018 2:45PM	Refused
	ML CCCMS	CHCF			8/16/2018 11:59:00 PM	0	Initiated on Aug 9 2018 2:47PM. Due Aug 16 2018 11:59PM. Completed on Aug 10 2018 7:34AM	
	ML EOP	CHCF			8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM. Due Aug 17 2018 11:59PM. Completed on Aug 17 2018 1:00PM	
	ML CCCMS	CHCF			8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:21PM. Due Aug 9 2018 11:59PM. Completed on Aug 9 2018 1:40PM	
	ML CCCMS	CHCF			8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:15PM. Due Aug 9 2018 11:59PM. Completed on Aug 7 2018 7:18AM	
	ML CCCMS	CHCF			8/9/2018 11:59:00 PM	0	Initiated on Aug 2 2018 4:03PM. Due Aug 9 2018 11:59PM. Completed on Aug 8 2018 10:00AM	} Counted twice
	ML CCCMS	CHCF			8/14/2018 11:59:00 PM	0	Initiated on Aug 7 2018 6:37PM. Due Aug 14 2018 11:59PM. Completed on Aug 8 2018 10:00AM	
	ML EOP	CHCF			8/17/2018 11:59:00 PM	0	Initiated on Aug 10 2018 12:01AM. Due Aug 17 2018 11:59PM. Completed on Aug 15 2018 10:00AM	

SAC Timely MH referrals

http://cphcspfdccdww01/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demanc | Quality Improvement - Care T... | Performance Report - Repo... | Calculate Duration Between T... | Appointments - Report Mana

Home > MH > On_Demand > Performance Report

Institution	SAC	Date Range	July
Indicators	Timely MH Referrals	Trendline	No
Indicator numbers	No	Colors	
Spotlight	Yes	New page each gr	
Number of columns	6		

1 of 1 | 100% | Find | Next

SAC Mental Health Performance Report for 7/1/18 to 7/3

Performance Improvement Priorities

Timely MH Referrals

95% (621)

Access to Care

Timely MH Referrals

95% (621)

Report run on: 8/16/2018 2:43:49 PM

Data last refreshed: 8/15/2018

MentalHealthKpisPopup - Report Viewer - Internet Explorer

1 of 1 | 100% | Find | Next

Quick List: SAC
Timely MH Referrals from 7/01/18 thru 7/31/18
Placement: ALL
Data last refreshed 8/15/2018 8:28:00 PM

	Measurements	Avg Time Overdue	Compliance
Timely MH Referrals	621	1.4	95%
CompletedMHMDConsultEmergent in 4 Hours	2	7.0	50%
CompletedMHMDConsultRoutine in 5 WorkDays	3	1.0	67%
CompletedMedNonComplianceConsult in 7 Days	34	2.1	85%
CompletedMHPCConsultUrgent in 24 Hours	21	7.6	86%
CompletedMHPCConsultEmergent in 4 Hours	294	2.3	95%
CompletedMHPCConsultRoutine in 5 WorkDays	266	0.0	98%
CompletedMHMDConsultUrgent in 24 Hours	1	0.0	100%

⊟ Details

Timeframe	Placement	Inst	CDCR#	Name	Date	Time Overdue	Details
⊟ CompletedMedNonComplianceConsult in 7 Days (34)	ML CCCMS	SAC	[redacted]		7/3/2018 11:59:00 PM	34	Initiated on Jun 26 2018 12:47PM. D 2018 11:59PM. Completed on Aug 11:00AM
	ML CCCMS	SAC	[redacted]		7/5/2018 11:59:00 PM	26	Initiated on Jun 28 2018 6:33AM. D 2018 11:59PM. Completed on Aug 8:45AM

FW: MHMD emergent consults

[redacted]@CDCR 9:4-18 6:02 12

From: Golding, Michael@CDCR
Sent: Thursday, August 16, 2018 4:35 PM
To: [redacted]@CDCR
Subject: FW: MHMD emergent consults

Hmm
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Thursday, August 16, 2018 4:17 PM
To: [redacted]@CDCR
Cc: [redacted] [redacted]@CDCR; Golding, Michael@CDCR; [redacted]@CDCR; [redacted]@CDCR
Subject: RE: MHMD emergent consults

That is fantastic news!
Thank you so much.

[redacted], cchp, Ph.D.
[redacted]
Statewide Mental Health Program
[redacted]

From: [redacted]@CDCR
Sent: Tuesday, August 07, 2018 2:24 PM
To: [redacted]@CDCR [redacted]@cdcr.ca.gov>
Cc: [redacted] @CDCR [redacted]@cdcr.ca.gov>; Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>; [redacted] @CDCR [redacted]@cdcr.ca.gov> [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: RE: MHMD emergent consults

9-4-18_16:00
(12)

Good Afternoon, Dr. [redacted]-

I believe that your emergent MHMD consult statistic for NKSP is accurate.

One likely reason for this is that inmate-patients requiring Mental Health Alternative Housing very rarely receive an emergent MHMD consult; the process is mostly handled by the primary clinicians on the Crisis Team. While true that after-hours placements of inmate-patients into MHAH usually involve a nurse calling the on-call psychiatrist, our process here at NKSP does not generate an emergent MHMD consult since technically that would require the on-call psychiatrist to complete a face-to-face examination of the patient within the emergent four-hour window (possibly in the middle of the night).

Another reason for our low number of emergent MHMD consults is that we encourage health care staff members to communicate their patient care concerns directly to our psychiatrists who are very responsive overall. For example, if a patient is experiencing a side effect from a medication, the primary clinician, nurse, medical provider, etc. may directly contact the treating psychiatrist who will triage each problem to determine whether this matter can wait until next week; wait until tomorrow; or need to be addressed immediately. This is much preferred to the practice of reflexively ordering an emergent MHMD consult for "side effects."

Finally, I would hope that the relatively low number of emergent MHMD consults at NKSP is an indication that we have things running fairly smoothly here; I certainly am not hoping for more psychiatric emergencies at NKSP!

Please contact me if you have further questions/concerns about this matter.

[redacted], MD
SENIOR PSYCHIATRIST SUPERVISOR
NORTH KERN STATE PRISON
[redacted]
[redacted] (CELL)

From: [redacted] @CDCR
Sent: Tuesday, August 07, 2018 11:57 AM
To: [redacted] @CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: MHMD emergent consults

Hi, did you see this? The one emergent consult was for [redacted] on 7/19.
I think it is best if you respond to this.

Thanks.

[redacted], Ph.D.

From: [redacted] @CDCR
Sent: Thursday, July 26, 2018 1:29 PM
To: [redacted] @CDCR [redacted]@cdcr.ca.gov>; [redacted] @CDCR <[redacted]@cdcr.ca.gov>

9-4-18-16;00 17

Cc: Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>; [redacted]@CDCR [redacted]@cdcr.ca.gov>; [redacted]@CDCR [redacted]@cdcr.ca.gov>
Subject: MHMD emergent consults

Hi,

At our HQ monthly MHPS meeting, NKSP's timeliness with consults was reviewed. We noticed there was only one emergent MHMD consults for the month of July. While that would be great if it were true that there were that few emergencies, it seems very low. Can you verify that these consults are being ordered?

Thank You,

[redacted], cchp, Ph.D.
[redacted]
Statewide Mental Health Program
[redacted]

9-4-18 16:00 (5)

SQ Timely MH Referrals

http://cphcspfdccdww01/Reports/Pages/Report.aspx?ItemPath=%2fMH%2fOn_Demand

Quality Improvement - Care T... | Performance Report - Repo... | Calculate Duration Between T... | Appointments - Report M...

Home > MH > On_Demand > Performance Report

Institution	SQ	Date Range	July
Indicators	Timely MH Referrals	Trendline	No
Indicator numbers	No	Colors	
Spotlight	Yes	New page each g	
Number of columns	6		

1 of 1 | 100% | Find | Next

SQ Mental Health Performance Report for 7/1/18 to 7/31

Performance Improvement Priorities

Timely MH Referrals

97% (425)

Access to Care

Timely MH Referrals

97% (425)

Report run on: 8/16/2018 2:43:04 PM

Data last refreshed: 8/15/2018

MentalHealthKpisPopup - Report Viewer - Internet Explorer

1 of 1 | 100% | Find | Next

Quick List: SQ
Timely MH Referrals from 7/01/18 thru 7/31/18
Placement: ALL
Data last refreshed 8/15/2018 8:28:00 PM

	Measurements	Avg Time Overdue	Compliance
Timely MH Referrals	425	0.1	97%
CompletedMHMDConsultRoutine in 5 WorkDays	32	0.1	94%
CompletedMHPCConsultRoutine in 5 WorkDays	192	0.1	94%
CompletedMHPCConsultEmergent in 4 Hours	82	0.1	99%
CompletedMHMDConsultUrgent in 24 Hours	11	0.0	100%
CompletedMHPCConsultUrgent in 24 Hours	107	0.0	100%
CompletedMHMDConsultEmergent in 4 Hours	1	0.0	100%

Details

Timeframe	Placement	Inst	CDCR#	Name	Date	Time Overdue	Details
CompletedMHMDConsultEmergent in 4 Hours (1)	RC	SQ	[redacted]		7/24/2018 3:00:00 PM	0	Initiated on Jul 24 2018 10:45AM. Du 2018 3:00PM. Completed on Jul 24 10:50AM
CompletedMHMDConsultRoutine in 5 WorkDays (32)	ML CCCMS	SQ			7/20/2018 11:59:00 PM	6	Initiated on Jul 14 2018 8:28AM. Du 2018 11:59PM. Completed on Jul 2 12:21PM
	RC	SQ			7/10/2018 11:59:00 PM	0	Initiated on Jul 2 2018 9:43AM. Due 2018 11:59PM. Completed on Jul 1 10:30AM

9-4-18 16:00 1

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date	:	July 3, 2018
To	:	All Healthcare Staff
From	:	Headquarters Mental Health
Subject	:	CCHCS Healthcare Dashboard Diagnostic Monitoring Methodology Change and Mental Health Registry Enhancements

Beginning June 2018, the Diagnostic Monitoring measures on the Statewide Dashboard will adopt the new performance measurement methodology included in the new MAPIP Measure Summary. This update also aligns the Dashboard methodology with the current Psychotropic Medication Monitoring Requirements adopted by Mental Health in September 2015 (memo). Various additions and enhancements were also made to the Mental Health Registries to support Institutions in improving patient care following this performance measurement overhaul.

Dashboard Methodology Explained

The new dashboard specification documents can be found here and will be added to the PDF version of the dashboard specifications in July. The old specification documents will be stored here for comparison purposes. Although there is some variation between each of the 41 dashboard measures, the table below gives a general overview of how the methodologies differ across most of these measures. As you will see, the new methodology will require a greater level of diligence to achieve higher performance scores on the dashboard.

	Old Methodology	New Methodology
Numerator	All patients who received appropriate psychotropic monitoring screening / test within the past 12 months.	Received appropriate psychotropic monitoring screening / test within the compliance timeframe*: **Baseline*: Completed within 90 days before the medication start date and 14 days after* **3 Month*: Completed between 15 and 90 days after the start date* **Annual*: Completed between 91 and 365 days after the start date*
Denominator	Only Patients prescribed the same psychotropic class of medication every month for the past 12 months.	Patients prescribed a psychotropic class of medication with a compliance date that came due* during the measurement period. **Baseline*: 14 days after the medication start date* **3 Month*: 90 days after the medication start date* **Annual*: 365 days after the medication start date*

Patients are considered to be consistently on a psychotropic medication class (i.e. Antipsychotics, Lithium, etc.) as long as they do not have a gap of more than 45 days between prescriptions. Switching between different antipsychotic medications does not impact the medication start date.

9418 16:00 ET

HEALTH CARE SERVICES

Enhancements to the Mental Health Registries

In order to support improvement efforts in these new dashboard performance measures, the Mental Health registries have been updated with new fields, filter options, and alert rules. Institutions can now use these registries to proactively track and monitor patients with labs or charting requirements that are due soon and take action before falling out of compliance, effectively improving future performance.

MENTAL HEALTH – MASTER REGISTRY

The Mental Health Master Registry still exists as a tool for users to quickly find all patients in the Mental Health program at any institution. Users can then navigate to any Sub-Registry (i.e. Anti-Depressants, Clozapine, etc.) by simply clicking on the column header (outlined in yellow above). Three new data points were also added to the report (outlined in red above):

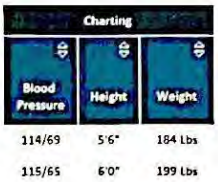
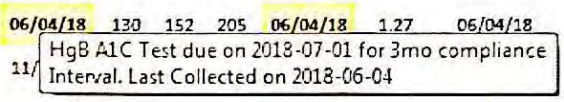
- Expired Psych Meds: Shows the count of a patient's psychotropic medication expired in the past 3 days or expiring in the next 3 days (hover for details).
- Psych Med Admin Alert: Displays a check mark if a patient missed any High Alert or PC2602 medication, 50% or more of administrations within the past 7 days, or 3 consecutive days of any one medication (Psychotropic Medications only- hover for details).
- Psych Drug-Drug Alerts: Displays the highest level of drug interaction, if one exists, between active psychotropic medications and any other active prescription. Users can hover over the interaction for more details or click to access the Drug-Drug Alerts report.

MENTAL HEALTH – SUB-REGISTRIES

All 6 of the Mental Health Sub-Registries will look and act similar to their prior versions but have significantly enhanced functionality outlined below. In addition, all flagging rules have been updated to match the new Diagnostic Monitoring performance measurement methodology.

9-4-18 1600

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Description	Example
All Sub-Registries now include each patient's most recent Height, Weight, and Blood pressure	
Hovering over any flag in the registries will show the reason for the flag, the compliance interval (i.e. baseline, 3 month, annual), and the last date the lab / charting was completed.	
New filter options allow users to quickly find all patients with a lab or charting requirement due within the next 30 days.	

ACCESS AND TRAINING

REPORT ACCESS

Click *here* to access the QM Portal Care Team Tools & Operational Reports page; you will find the enhanced Mental Health Registries under the "Behavioral Health" section. A Definitions document that provides detailed information about report features and data sources is linked on the top right corner of each registry.

TRAINING

Quality Management will hold a training on the MAPIP Measure Summary and Mental health Registry updates at the next two QM Webinars (July 11th and 18th), held every Wednesday from 1-3 pm. Please click here for more details.

Questions?

Please direct any questions to the appropriate group below:

Mental Health Policies and Procedures: MHPolicyUnit@cdcr.ca.gov
Data Issues: QMStaff@cdcr.ca.gov

EXHIBIT CCC
(2018-09-04-1700hrs)

DASHBOARD 5.0

9_4_18_17:00 (1)

Specifications

Domain	Population Health Management
Measure	Antipsychotics - Lipid Monitoring

Definition	Percentage of patients prescribed Antipsychotics who received appropriate Lipid Profile monitoring that came due* within the measurement period.
Denominator	Patients prescribed Antipsychotics** with a baseline, 3 month, or annual Lipid Profile test that came due* during the measurement period. **For specific requirements for patients to be considered on Antipsychotics: Click Here for Internal HCS Users Click Here for Public Internet Users *Baseline: 14 days after the medication start date *3 Month: 90 days after the medication start date *Annual (Year 1): 365 days after the medication start date *Annual (Year 2+): 365 days from the last Annual Lipid profile test *A patient is considered to be consistently on antipsychotics as long as they do not have a gap of more than 45 days since their last prescription. Switching between different antipsychotic medications does not impact the medication start date
Numerator	Patients in the denominator who received a Lipid Profile test within the compliance range. Baseline: Completed within 90 days before the start date and 14 days after 3 Month: Completed between 15 and 90 days after the start date Annual (Year 1): Completed between 91 and 365 days after the start date Annual (Year 2+): Completed within 365 days since the last Lipid Profile Test
Rate Calculation	**Statewide:** Percentage is the sum of the numerators divided by the sum of the denominators times 100. **Institution:** Percentage is the numerator divided by the denominator times 100. **Care Team:** Percentage is the numerator divided by the denominator times 100.
Data Source(s)	Electronic Health Record System (EHRS)
Reporting Frequency	Monthly
Background	Health Care Services Performance Improvement Plan (PIP) Objective:

DASHBOARD 5.0

Specifications

9/4/18 17:00 (2)

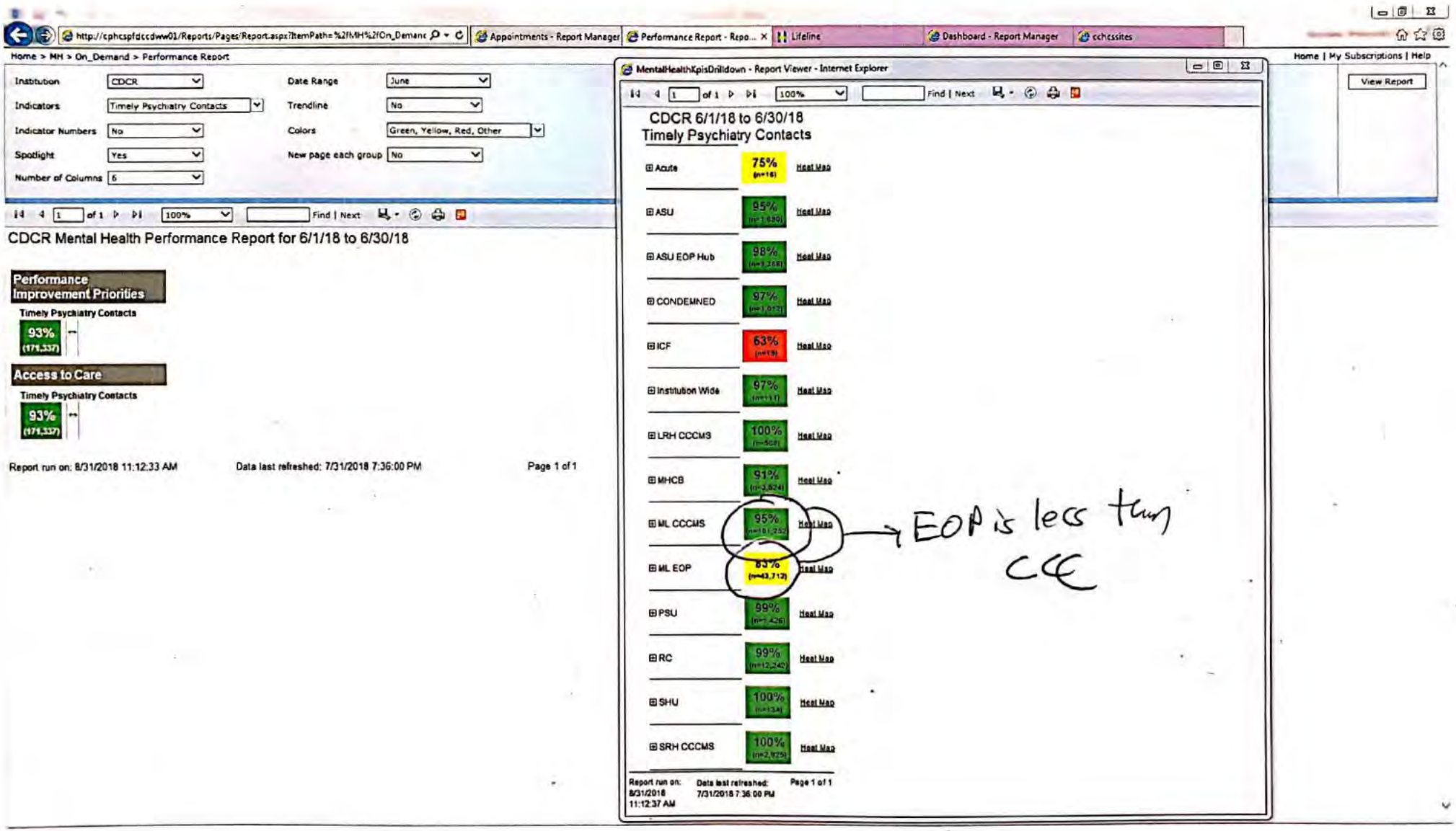
Domain	Population Health Management
Measure	Antipsychotics - Lipid Monitoring
	By December 31, 2016, 90% or more of patients prescribed select high risk medications will have appropriate diagnostic monitoring.
Goal/Ranking	High > = 90% Moderate 75% - 89% Low < 75%
Comments	This measure is a component of the Diagnostic Monitoring composite measure shown on the Dashboard.
Last Revised	20180601 SDP

Click Here to: Return to Composite

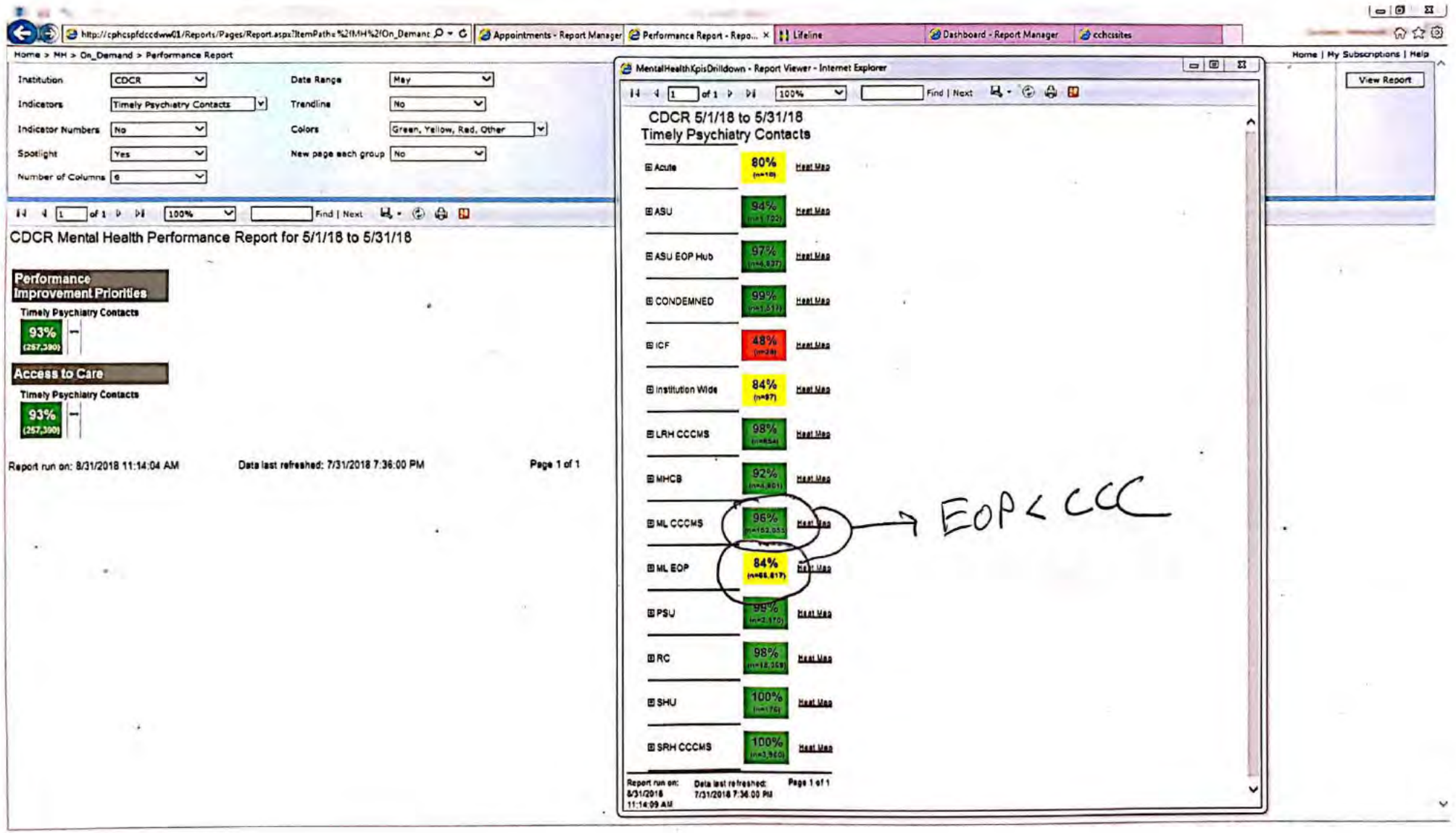
Click Here to: Return to Home

EXHIBIT DDD
(2018-09-04-1830hrs)

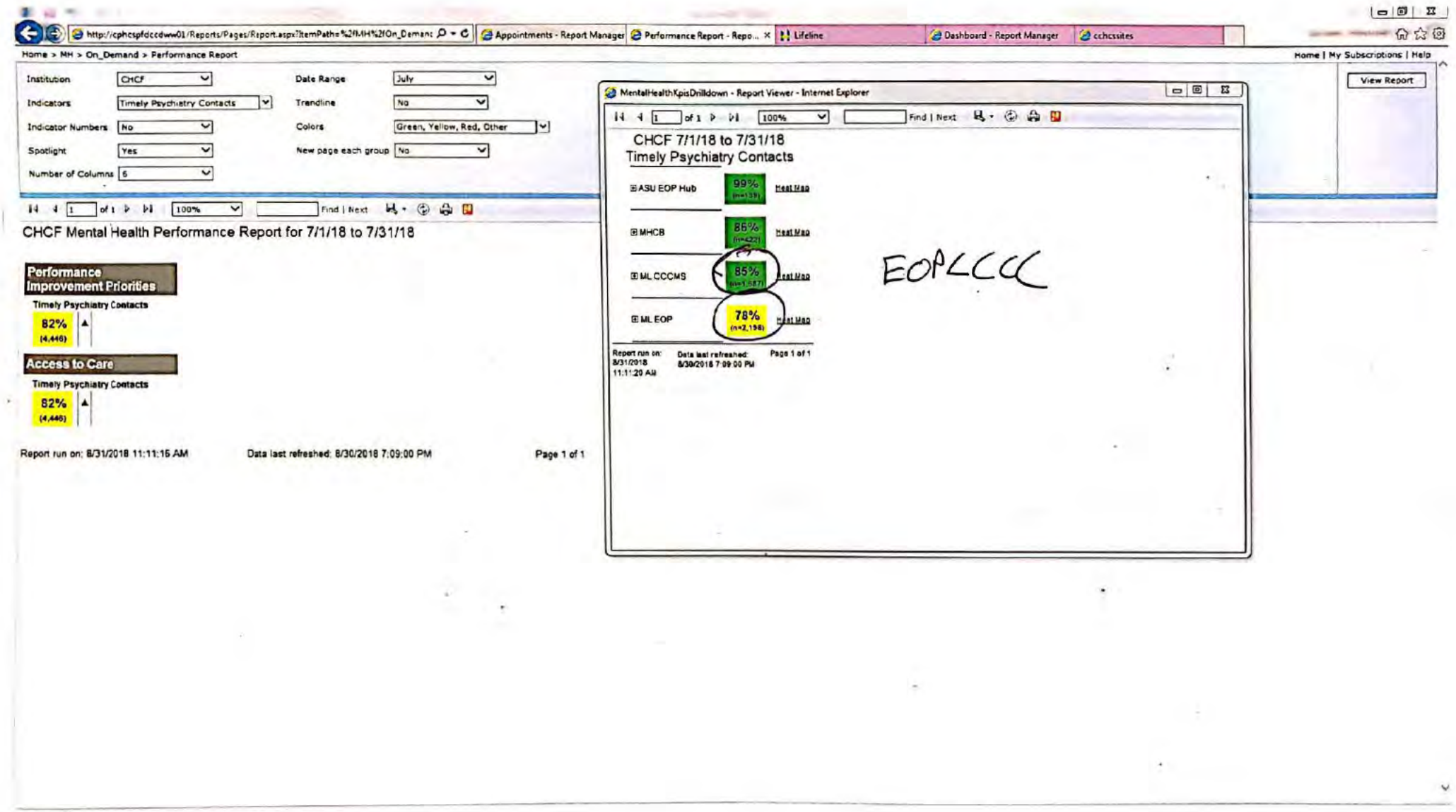
9/4/18 PST 18:30



9/4/18 pg 2


Home > MH > On_Demand > Performance Report
Institution CDCR
Indicators Timely Psychiatry Contacts
Indicator Numbers No
Spotlight Yes
Number of Columns 6
Date Range May
Trendline No
Colors Green, Yellow, Red, Other
New page each group No
CDCR Mental Health Performance Report for 5/1/18 to 5/31/18
Performance Improvement Priorities
Timely Psychiatry Contacts
93%
Access to Care
Timely Psychiatry Contacts
93%
Report run on: 8/31/2018 11:14:04 AM
Data last refreshed: 7/31/2018 7:36:00 PM
Page 1 of 1
MentalHealthKpisDrilldown - Report Viewer - Internet Explorer
CDCR 5/1/18 to 5/31/18
Timely Psychiatry Contacts
Acute 80%
ASU 94%
ASU EOP Hub 97%
CONDEMNED 99%
ICF 48%
Institution Wide 84%
LRH CCCMS 98%
MHCB 92%
ML CCCMS 96%
ML EOP 84%
PSU 99%
RC 98%
SHU 100%
SRH CCCMS 100%
Heat Map
Report run on: 8/31/2018 11:14:09 AM
Data last refreshed: 7/31/2018 7:36:00 PM
Page 1 of 1
EOP < CCC

9/4/18 pg 3


Home > MH > On_Demand > Performance Report
Home | My Subscriptions | Help
Institution CHCF
Indicators Timely Psychiatry Contacts
Indicator Numbers No
Spotlight Yes
Number of Columns 6
Date Range July
Trendline No
Colors Green, Yellow, Red, Other
New page each group No
View Report
CHCF Mental Health Performance Report for 7/1/18 to 7/31/18
Performance Improvement Priorities
Timely Psychiatry Contacts
82%
(4,446)
Access to Care
Timely Psychiatry Contacts
82%
(4,446)
Report run on: 8/31/2018 11:11:16 AM
Data last refreshed: 8/30/2018 7:09:00 PM
Page 1 of 1
MentalHealthKpisDrilldown - Report Viewer - Internet Explorer
CHCF 7/1/18 to 7/31/18
Timely Psychiatry Contacts
ASU EOP Hub 99%
MHCB 86%
ML CCCMS 85%
ML EOP 78% (n=2,198)
Heat Map
Report run on: 8/31/2018 11:11:20 AM
Data last refreshed: 8/30/2018 7:09:00 PM
Page 1 of 1
EOP<CCC

9/4/18 pg 4

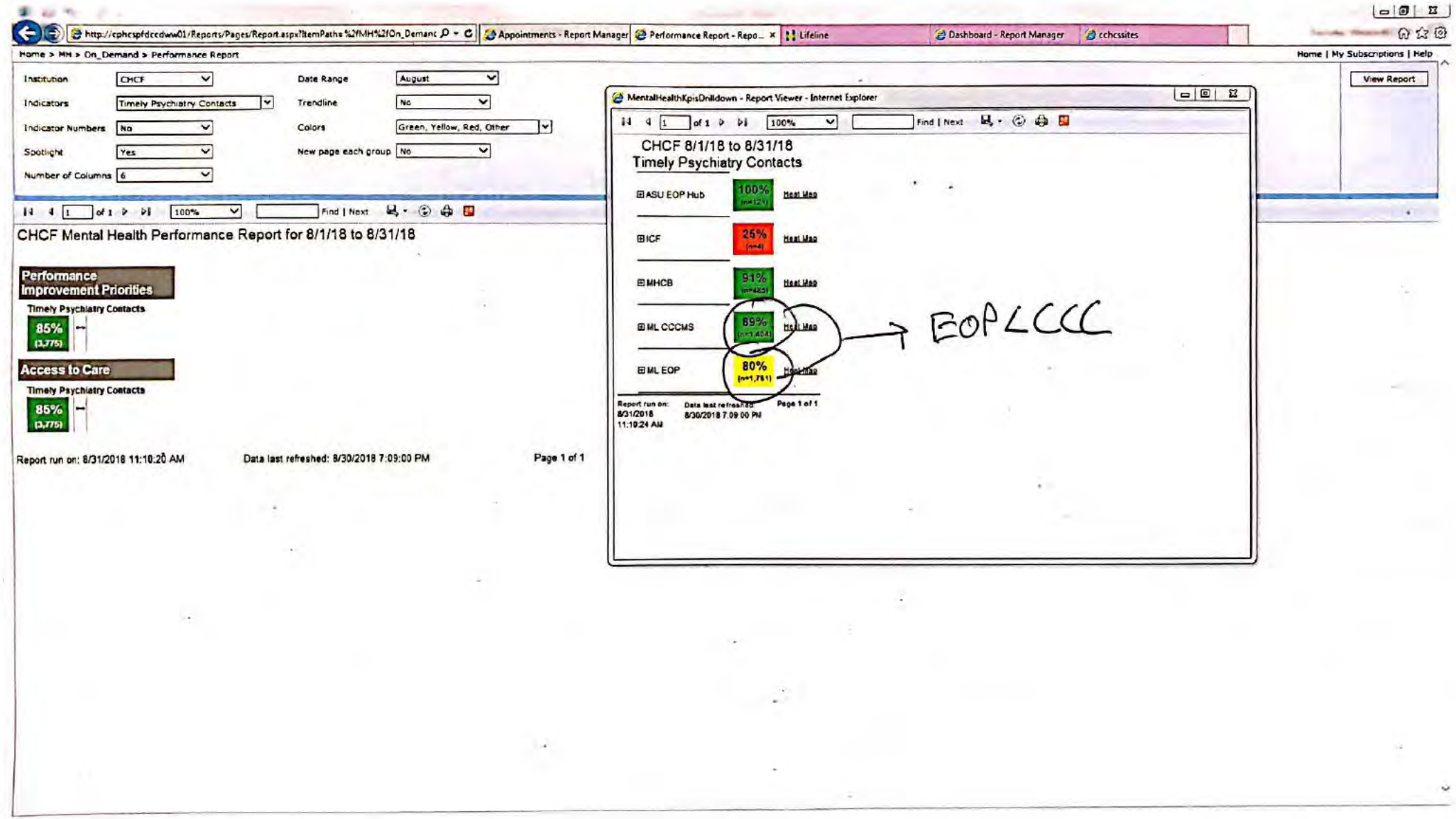

Home > MH > On_Demand > Performance Report
Home | My Subscriptions | Help
Institution CHCF
Indicators Timely Psychiatry Contacts
Indicator Numbers No
Spotlight Yes
Number of Columns 6
Date Range August
Trendline No
Colors Green, Yellow, Red, Other
New page each group No
View Report
CHCF Mental Health Performance Report for 8/1/18 to 8/31/18
Performance Improvement Priorities
Timely Psychiatry Contacts
85%
Access to Care
Timely Psychiatry Contacts
85%
Report run on: 8/31/2018 11:10:20 AM
Data last refreshed: 8/30/2018 7:09:00 PM
Page 1 of 1
MentalHealthKpisDrilldown - Report Viewer - Internet Explorer
CHCF 8/1/18 to 8/31/18
Timely Psychiatry Contacts
ASU EOP Hub 100%
ICF 25%
MHCB 91%
ML CCCMS 89%
ML EOP 80%
Heat Map
Report run on: 8/31/2018 11:10:24 AM
Data last refreshed: 8/30/2018 7:09:00 PM
Page 1 of 1
EOP < CCC

EXHIBIT EEE
(2018-09-05-1700hrs)

Sept 5, 2018
17:00

Definitions - Internet Explorer

Seen as Scheduled

Measure Definition
Percentage of dental, medical, and mental health appointments seen as scheduled (i.e., without being rescheduled). Excludes appointments not seen as scheduled due to patient refusal or similar patient-controlled factors; scheduling error; patient transfer; lay-in; out to court/medical; pending or "to be scheduled" appointments; walk-ins; and appointments scheduled to be seen during the reporting period but not yet closed. Data sources: Dental Scheduling and Tracking System, Medical Scheduling and Tracking System, and Mental Health Tracking System.

For detailed specifications, please visit the Dashboard Glossary

EXHIBIT FFF
(2018-09-18-1619hrs)

From: "Golding, Michael@CDCR" <Michael.Golding@cdcr.ca.gov>
Date: September 18, 2018 at 4:19:06 PM PDT
To: "[redacted]@CDCR" <[redacted]@cdcr.ca.gov>
Subject: Re: MH Memorandum: Updated MHCB Referral, Referral Rescission, and Discharge Policy and Procedures

Hi,

A significant change seems to be that the decision for discharge is made by the primary clinician (the psychologist) OR the IDTT. That's what the memo says.
"Clinical discharge means the primary clinician OR treatment team has determined that a patient requires a different level of care"

So verbal assent even by the psychiatrist is no longer needed, it seems because the primary clinician can now make the decision, per the memo, without even the IDTT.

If the primary clinician needed to consult the treatment team before a discharge decision was made it would've said the primary clinician "AND" the IDTT.

Our psychiatrists noticed this change immediately. It was pointed out to me.

Best,
Michael

Sent from my iPhone

On Sep 18, 2018, at 4:04 PM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

This is just the policy that finally made it through the negotiation with the union.

As we have discussed several times, I have sought legal clarification of discharge requirements.

The language in the attached memo is not a change of the policy. The change had mostly to do with the medical hold issue, which is highlighted and captured in the email below.

Sent from my iPhone

On Sep 18, 2018, at 3:52 PM, Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov> wrote:

"Clinical discharge means the primary clinician or treatment team has determined that a patient requires a different level of care and discharge orders are placed and the

inmate/patient can be moved."

Hi,

Is this the clarification of the policy that was elevated twice to deal with the need for psychiatric clearance when a patient leaves a crisis bed to go to a lower level of care?

Or is there something else?

Best,
Michael

Sent from my iPhone

Begin forwarded message:

From: "CDCR MHPolicyUnit@CDCR" <m_MHPolicyUnit@cdcr.ca.gov>
Date: September 18, 2018 at 2:25:18 PM PDT
Cc: '[redacted]@CDCR" <[redacted]@cdcr.ca.gov>, '[redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, "Golding, Michael@CDCR" <Michael.Golding@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted] (HCS)@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted]@CDCR" <[redacted].[redacted]l@cdcr.ca.gov>, '[redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>, '[redacted] [redacted]@CDCR" <[redacted].[redacted]@cdcr.ca.gov>
Subject: MH Memorandum: Updated MHCB Referral, Referral Rescission, and

Discharge Policy and Procedures

Sent on behalf of [redacted]

Please review the attached memorandum and associated policy and disseminate as appropriate. The official implementation date of this memorandum and policy and procedures is **October 15, 2018**. Local Operating Procedures (LOP) shall be updated to reflect these changes no later than **October 1, 2018**. Forward copies of the amended LOP to the following email address: CDCR MHPolicyUnit@CDCR.

To ensure staff awareness of these policy changes, Wardens and Chief Executive Officers shall ensure mandatory training on this memorandum and LOP is completed. In-Service Training Managers shall ensure all Correctional Counselors, C&PR/Assistant C&PR, Sergeants, Lieutenants, Captains, Associate Wardens and MHCB Clinical Staff receive On-the-Job Training on this memorandum and LOP. Wardens and CEO's shall ensure staff training is completed and submit a proof of practice memorandum to their respective mission's Associate Director by **October 1, 2018**.

Key Revisions

This policy and procedure includes several significant changes to the MHCB referral requirements including but not limited to:

- Medical clearance prior to transfer no longer required unless patients are on medical hold
- Escalation process for delays in clinician to clinician contact (report delays to CMH, and then to CEO)

If you have questions or require additional information related to this memorandum, you may contact the Mental Health Policy Unit by email: CDCR MHPolicyUnit@CDCR.

(Sent to CEOs, Chiefs of Mental Health, Regional Mental Health

Administrators, Regional Health Care Executives, Associate Directors Division of Adult Institutions, Wardens, Correctional Counselors III, Classification Staff Representatives and Classification and Parole Representatives)

<Updated MHCB Referral Referral Rescission and Discharge Memorandum and Policy and Procedures.pdf>

EXHIBIT GGG
(2018-09-18-memo)

HEALTH CARE SERVICES

MEMORANDUM

Date: September 18, 2018

To: **See Distribution List**

From: [redacted]

[redacted]
Statewide Mental Health Program

[redacted]
Division of Adult Institutions

[redacted]
California Correctional Health Care Services

[redacted]
California Correctional Health Care Services

[redacted]

Subject: **UPDATED MENTAL HEALTH CRISIS BED - REFERRAL, REFERRAL RESCISSION, AND DISCHARGE POLICY AND PROCEDURES**

This memorandum and the attached revised policies, provides guidance for custody and clinical staff regarding Mental Health Crisis Bed (MHCB) referral and transfer requirements. It also announces updates to the MHCB Referral, Referral Rescission, and Discharge policy (12.05.200) and procedures (12.05.200.P1) (Attached) and provides a summary of the policy and procedural changes for Mental Health staff. Staff shall reference the attached policy and procedures for specific requirements. These changes do <u>not</u> apply to Intermediate and Acute referrals.

To ensure compliance with MHCB transfer timelines and up to a maximum of ten day length of stay guidelines, the following policy updates have been made:

1. **Medical clearance is no longer required, prior to patient transfer for MHCB referrals, unless a medical hold is present or there are concerns raised by any clinician during the referral period regarding a patient's ability to transfer safely.**
    - **Patients with <u>no</u> medical hold shall transport without medical clearance unless there are concerns raised by any clinician during the referral period regarding a patient's ability to transfer safely.**
    - **Patients with a medical hold will require an evaluation by a Primary Care Provider as part of the referral documentation. If it is determined a patient is unsafe to transfer, a medical hold will be ordered consistent with Inmate Medical Services Policies and Procedures 12.3.1, *Health Care Transfer Policy*.**

- In such cases where a medical clearance is required, the Chief Executive Officer shall ensure the clearances are prioritized and completed within an hour of bed assignment.

2. A facility escalation process for delayed clinician to clinician contact has been added to address delays in obtaining MHCB transfer approvals.
3. To ensure admission as soon as possible and never to exceed the 24 hours mandated by the Mental Health Services Delivery System (MHSDS) Program Guide (2009 Revision), the following processes shall be followed:

    a. For external transfers (patients required to travel to another institution), it is expected that the patient will be in transit in sufficient time to allow the patient to be assigned a bed and housed in the MHCB within 24 hours. Institutions shall contact the Statewide Transportation Unit to check if there is a transport team available to transfer the patient. If a transport team is not available, the referring institution is required to provide their staff to conduct the transfer. However, for trips expected to exceed 10 hours round trip, institutions should arrange for their transportation teams to meet partway in order to reduce travel time. Institutions shall redirect staff and/or utilize overtime as necessary to ensure these timelines are met. Should custody overtime be required for MHCB transports, please ensure staff use the Psychiatric Transport Inmate (PTI) code in Telestaff for the proper tracking of these expenditures. It is understood that the redirection of staff to facilitate transports may result in yard and/or other program closures.

    b. Transfers within the same institution (internal transfers) shall occur within two hours of bed assignment. Institutions shall not delay facilitating movement to wait for medical clearance or clinician acceptance. Once the bed is assigned, custody staff shall escort the patient to the MHCB unit immediately.

    c. When patients are clinically discharged from crisis beds or inpatient beds, they shall be moved from the bed to their assigned institution in an expeditious manner to ensure bed availability for patients awaiting MHCB placement. Per the MHSDS Program Guide (2009 Revision), patients who have been clinically discharged from MHCB shall be transferred as soon as possible and not to exceed 72 hours. However, it is the expectation that patients transfer occur the following calendar day. Institutions shall contact the Statewide Transportation Unit to check if there is a transport team available to transfer the patient. If a transport team is not available, the referring institution is required to provide their staff to conduct the transfer. However, for trips expected to exceed 10 hours round trip, institutions should arrange for their transportation teams to meet partway in order to reduce travel time. Institutions shall redirect staff and/or utilize overtime as necessary to ensure these timelines are met. Should custody overtime be required for MHCB transports, please ensure staff use the Psychiatric Transport Inmate (PTI) code in Telestaff for the proper tracking of

these expenditures. If no transport is required (internal transfer), the patient shall be returned to housing within two hours of clinical discharge.

- Clinical discharge means the primary clinician or treatment team has determined that a patient requires a different level of care and discharge orders are placed and the inmate/patient can be moved. There will be instances where time frames are not met due to extenuating circumstances such as the patient refusing to exit the cell and the de-escalation process commences, or inclement weather. When a patient refuses to vacate the cell, the institution clinical staff shall order a refusal order and document consistent with the attached policy and controlled use of force policy per Department Operations Manual, Section 51020.12. For all delays, the Classification and Parole Representative (C&PR) or designee shall document the information in the Case Notes section of the Strategic Offender Management System.

d. Patients that cannot be returned to their originating institution shall be referred to Health Care Placement Oversight Program for a "Re-Direct" endorsement. It is understood that these patients may not be moved in the time frames identified in section 4.c above. The patient should be transported by the following calendar day. If the patient is endorsed to the MHCB institution where currently housed, the patient shall be moved within two hours of endorsement notification.

e. Clinical staff shall communicate to custody staff immediately when patients are being discharged to eliminate unnecessary discharge delays. Staff shall not wait until all Interdisciplinary Treatment Teams (IDTT) are completed to communicate discharges. Discharge orders shall be written immediately upon discharge and verbal or email communication to designated custody staff shall occur immediately after each individual patient's discharge.

f. Existing policy requires correctional counselor participation in the IDTT process. When a patient is being discharged from an MHCB, the assigned counselor shall make contact with the C&PR's office, as well as the Watch Commander, and provide the CDCR number and name of the pending discharged patient to allow preparation for transport to begin. If counseling staff are not present during the IDTT, Mental Health staff shall make contact with the C&PR's office, as well as the Watch Commander, and provide the CDCR number and name of the pending discharged patient. This communication may also allow multiple patients to be scheduled on a single transport.

g. Typically when patients are discharged from an MHCB or inpatient bed, the patient's "home" institution is responsible for picking up the patient upon discharge. The expectation for institutions with 30 or more MHCBs or inpatient beds is that they should arrange for the delivery of the patient back to their home institution via Statewide Transportation or if unavailable, their own transportation teams. For trips expected to exceed 10 hours round trip,

institutions should arrange for their transportation teams to meet partway in order to reduce travel time. This will allow multiple patients to be placed on a transport and the bed to be vacated sooner and thus allow the bed to be backfilled expeditiously. Institutions with 30 or more MHCBs include the following institutions:

- California Health Care Facility
- California Medical Facility
- Salinas Valley State Prison
- California Men's Colony
- California Institution for Men
- California State Prison, Sacramento

The following steps shall be taken to ensure patients are not typically retained past ten days without an Intermediate Care Facility (ICF) or Acute referral in place:

1. Start Discharge Planning, including a detailed Safety Plan, on day one of the MHCB stay.
2. Consider referring to a higher level of care at any time, if it is clinically warranted. This includes day one of MHCB placement.
3. Determine if the patient is likely to require further treatment at the MHCB level of care past seven days, and document the consultation within 72 hours of MHCB placement.
4. Do not wait until day ten to refer if either ICF or Acute level of care are warranted. Hold a special IDTT meeting as necessary to refer when clinically indicated.
5. Custody and Mental Health shall address any issues relative to safety concerns or secondary gain issues (e.g. property, bed moves, etc.) at the initial IDTT. Any action should be documented in the Initial Treatment Plan, when a patient is admitted to MHCB for clinical issues that were exacerbated by Safety Reasons. The treatment team shall contact the sending facility's custody, nursing, medical or mental health staff to help address the patient's needs/concerns and avoid an unnecessary readmission.
6. Initiate the Penal Code (PC) 2602 if a patient meets criteria for a PC 2602, move up the hearing if possible, and if the patient transfers to a higher level of care, a phone testimony may be appropriate.
7. There will be rare exceptions where a length of stay beyond 10 days is justified and appropriate. Per the Mental Health Services Delivery System Program Guide (2009) when the treatment team believes a patient requires length of stay beyond 10 days, the Chief Psychiatrist or designee shall be provided justification and approve the extended stay. These extensions shall be rare and will be monitored. CDCR Headquarters Inpatient Referral Unit may also be utilized as a resource for consultation and discharge planning, and can be contacted at cdcrdchcsdmhreferupdate@cdcr.ca.gov.

The official implementation date of this memorandum and policy and procedures is October 15, 2018. Local Operating Procedures (LOP) shall be updated to reflect these changes no later than October 1, 2018. Forward copies of the amended Local Operating Procedures to the following email address: CDCR MHPolicyUnit@CDCR. For custody, transfer, or other

MEMORANDUM

operational questions, contact the Mental Health Compliance Team at DAI-MHCompliance@cdcr.ca.gov.

To ensure staff awareness of these policy changes, Wardens and Chief Executive Officers shall ensure mandatory training on this memorandum and LOP is completed. In-Service Training Managers shall ensure all Correctional Counselors, C&PR/Assistant C&PR, Sergeants, Lieutenants, Captains, Associate Wardens and MHCB Clinical Staff receive On-the-Job Training on this memorandum and LOP. Wardens and CEO's shall ensure staff training is completed and submit a proof of practice memorandum to their respective mission's Associate Director by October 1, 2018.

Attachments

cc: [redacted], Esq.
[redacted]
[redacted]
[redacted], M.D.

Distribution List:

[redacted]
[redacted]
Associate Directors, Division of Adult Institutions
Wardens
[redacted]
[redacted]
[redacted]
[redacted]
[redacted], Psy.D., MBA
[redacted]
[redacted], Ph.D.
[redacted], Ph.D.
[redacted], Ph.D.
[redacted]. M.D.
[redacted], M.D.
[redacted], Psy.D.
[redacted], Ph.D.
[redacted], Ph.D.
Regional Mental Health Administrators
Regional Healthcare Executives
Chief Executive Officers
Chiefs of Mental Health

MEMORANDUM

[redacted]

Correctional Counselors III, Reception Centers
Classification Staff Representatives
Classification and Parole Representatives

VOLUME 12: MENTAL HEALTH SERVICES	Effective Date:	October 15, 2018
CHAPTER 05: INPATIENT SERVICES	Revision Date(s):	
	Supersedes Memoranda dated:	9/8/2009; 5/23/02; 9/06/05;12/20/02
12.05.200 MENTAL HEALTH CRISIS BED- REFERRAL, REFERRAL RESCISSION, AND DISCHARGE POLICY	Attachments:	Yes ☐ No ☒
	Director Approval:	[redacted]

Policy

A patient suffering from an acute, serious mental disorder resulting in serious functional disabilities or who is a danger to self or others as a consequence of a serious mental disorder shall be referred to a Mental Health Crisis Bed (MHCB). All patient placements into an MHCB shall require authorization from the Health Care Placement Oversight Program (HCPOP) prior to placement. This includes internal placements made by institutions with vacant MHCBs. All MHCB referrals shall be processed with urgency, shall leave the referring facility as soon as possible, and shall be completed within 24 hours.

Transfer Delays

In some cases, a patient may refuse to transfer to an MHCB. If a patient refuses to transfer, clinical staff shall document the date and time the patient became unavailable to transfer, the reason for the delay, and the resolution date and time of the delay reason in the healthcare record. When transfer is delayed due to transfer to court or outside medical, follow up documentation shall occur immediately upon the patient's return, or on the date of expected return, whichever comes first.

Per existing policy, temporary departures shall be documented in the Strategic Offender Management System (SOMS).

If an MHCB is not available and a bed is occupied by a patient for medical reasons, the medical leadership at the referring institution, in consultation with Utilization Management, may direct the movement of the medical placement to an outside hospital or other appropriate medical placement.

All patients clinically discharged from an MHCB must be transferred as soon as possible and not to exceed 72 hours.

Out to Court

During the referral process, if a patient is physically unavailable for transfer to an MHCB due to an order to appear in state or federal court, necessitating transfer out of the institution or to an institution nearest the court, HCPOP shall be notified immediately upon the patient's return to the California Department of Corrections and Rehabilitation (CDCR) and shall place the patient in the next available bed. The patient shall be transferred to the next available bed as expeditiously as possible.

Out to Hospital and Medical Conditions

If a patient is out to hospital or on a medical hold due to a medical condition that cannot be treated at an MHCB and that is deemed more urgent than the mental health treatment

need at or after the time of the referral, the most urgent clinical needs shall be attended to first.

If the medical condition is deemed more urgent than the mental health treatment need, as determined by a joint team of medical and mental health clinicians, a medical hold shall be ordered in accordance with current policy. The relative urgency of the medical and mental health needs shall be continually monitored by the joint team, and mental health staff shall document the reasons that the medical need continues to outweigh the mental health need as dictated by the patient's condition. If resolution of the medical issue delays CDCR's ability to transfer the patient to the MHCB within the transfer timelines, upon clearance for transfer and acceptance to an MHCB, the patient shall be transferred to the next available bed as expeditiously as possible.

Transfer Refusal

If a patient refuses to transfer, every effort shall be made by the treating clinician to encourage the patient to vacate the cell voluntarily for transfer. The clinician responding to the patient's cell to discuss the refusal shall enter the *MHCB Refusal to Transfer* order in the electronic healthcare record immediately. When the patient vacates the cell for transport, the order shall be immediately discontinued. If the patient continues to refuse to vacate the cell within 48 hours and still requires inpatient care, the controlled Use of Force policy shall be initiated.

Purpose

To ensure the effective management of statewide MHCB resources and ensure timely and equal access to care.

Definitions

Transfer – Starts at the day/time the patient's level of care is changed to MHCB (the patient is referred) within the healthcare record and ends upon arrival to the MHCB, according to the SOMS departure date/time.

Clinical Discharge – When the primary clinician or treatment team determines that a patient requires a different level of care and discharge orders are placed and the patient can be moved.

Compliance Indicators

MHCBs operate 24 hours a day, seven days a week. To be in compliance with this policy, the following requirements shall be met:

1. HCPOP shall be contacted immediately and not to exceed one hour of clinical determination that a patient requires placement in an MHCB and/or prior to a patient's placement into alternative housing (MH Policy *12.05.301 Housing of Inmate-Patients Pending Mental Health Crisis Bed Transfer*).
2. HCPOP shall determine bed availability and notify the referring clinician of the bed assignment.
3. HCPOP shall monitor SOMS for vacant MHCBs. Patient movement out of an MHCB shall be entered into SOMS immediately and reflect physical transfer date and time.
4. Upon receipt of the Clinical Director's or designee's approval to transfer the patient to the receiving institution's MHCB, the Chief of Mental Health or designee at the receiving institution shall complete the Acceptance Phase within the electronic healthcare record, which notifies the Classification and Parole Representative (C&PR) at the sending institution of acceptance and approval to transport. Within one hour, the C&PR/Watch Commander at the sending institution shall ensure the C&PR/Watch Commander at the receiving institution is provided the notice of the acceptance and transfer. HCPOP and respective custodial staff (i.e., C&PR/Watch

Commander) are notified within one hour by the referring clinician or designee when a referral is rescinded (See Procedure *12.05.200.P2 Mental Health Crisis Bed: Rescinding a Referral*).

5. All patients referred to an MHCB, who are being transferred, shall leave the referring institution for transport to the MHCB as soon as possible to ensure the patient is housed in the receiving MHCB within 24 hours.

Compliance Indicators continued

6. All patients referred to an MHCB are admitted within 24 hours of referral to an MHCB unless the MHCB referral is rescinded. All failures to complete an MHCB transfer within 24 hours of the MHCB referral are reported by HCPOP to the Deputy Director, Statewide Mental Health Program via a daily MHCB transfer report. The institution and headquarters Quality Improvement Units shall monitor missed timeframes, review reasons for delays, and implement process improvement plans to address missed timelines.

7. The treating clinician or designee shall immediately notify HCPOP of any MHCB clinical discharges that occur throughout the day. The treating clinician or designee shall immediately notify the respective C&PR or designee for placement determination of a patient discharged from MHCB.

8. Patients are returned to the sending institution unless the sending institution is not designated to provide for their mental health level of care or unless the patient was placed on Clozapine and the sending institution is not a Clozapine institution.

9. No patients are transferred, upon clinical discharge, to an institution that is not designated to provide for their mental health level of care.

10. Per the Mental Health Program Guide (2009) patients who have been clinically discharged from MHCB shall be transferred as soon as possible and not to exceed 72 hours. However, it is the expectation that patients transport shall occur the following calendar day. If no transport is required, the patient shall be returned to housing within two hours of clinical discharge.

    Patients that cannot be returned to their originating institution shall be referred to HCPOP for a "Re-Direct" endorsement. The transport should occur by the following calendar day. If the patient is endorsed to the MHCB institution where currently housed, the patient shall be moved to the endorsed housing within two hours of endorsement notification.

11. A local operating procedure, consistent with all requirements of the statewide MHCB Referral, Referral Rescission, and Discharge policy and procedure, shall be developed.

Retaining Beds for MHCB Cases

Staff shall retain a patient bed/cell for a minimum of ten days if the patient is moved/transferred to an MHCB. This applies to intra-institutional moves as well as inter-institutional transfers.

References

California Code of Regulations (CCR) Title 22, Section 79789. Patient Transfers, licensing standards provide that a patient shall not be transferred unless and until the receiving facility has consented to accept the patient. Specifically, the CCR provides, in part, that no patient shall be transferred, or discharged for purposes of transferring, unless arrangements have been made in advance for admission to a health facility.

Division of Correctional Health Care Services, *Mental Health Services Delivery System Program Guide,* Rev, 2009, Chapter 5, "Mental Health Crisis Bed."

Department Operations Manual, Section 62080.17. Emergency Medical Transfers.

Department Operations Manual, Section 51020.12. Controlled Use of Force General Requirements.

September 8, 2009, *Procedures for Transfer of Inmate-Patients After Discharge from Mental Health Crisis Bed and Department of Mental Health Treatment.*

June 17, 2008, *Primary and Alternate Hub Designations for Placement of Inmates who Require Administrative Segregation Placement and Mental Health Services.*

December 20, 2002, *Retaining Beds for Mental Health Crisis Bed and Outpatient Housing Unit Cases*,

October 9, 2013 MH Policy 12.05.301 *Housing of Inmate-Patients Pending Mental Health Crisis Bed Transfer.*

Inmate Medical Services Policies and Procedures (IMSP&P), Volume 4, Chapters 29, Medical Classification System Policy, and 29.1, Medical Classification System Procedure

Questions

If you have any questions or need any additional information related to this policy, you may contact the policy unit via e-mail at: CDCR MHPolicyUnit@CDCR.

VOLUME 12: MENTAL HEALTH SERVICES	Effective Date:	October 15, 2018
CHAPTER 05: INPATIENT SERVICES	Revision Date(s):	
	Supersedes:	
PROCEDURE 12.05.200.P1: MENTAL HEALTH CRISIS BED: REFERRAL PROCEDURE	Attachments:	Yes☐ No☒

[redacted]

12.05.200.P1 Mental Health Crisis Bed: Referral Procedure

Discussion

This document describes the steps required for submitting a Mental Health Crisis Bed (MHCB) referral.

Throughout the referral process, the referring clinician, receiving Clinical Director, and referring and receiving Classification and Parole Representatives (C&PR)/Watch Commanders communicate with each other to ensure all health care, classification, and transportation issues are addressed.

STEP	PROCESS
1	A referring clinician or interdisciplinary treatment team determines a patient requires MHCB level of care (LOC). - Referring clinician: Completes the consult appointment, according to the healthcare record workflow, the orders, and documentation required for admission to Mental Health Crisis Bed (Policy 12.05.601, *Documentation Required for Referral to Mental Health Crisis Bed*). - For physician on call evaluations, the orders and referral documentation may be completed the following morning; however, the Health Care Placement Oversight Program notification noted in step three (3) must be completed at the time of evaluation.
2	Patients with **no** medical hold shall transport without medical clearance, with the following exception: - Concerns are raised by any clinician during the referral period regarding a patient's ability to transfer safely. This exception will require an evaluation by a Primary Care Provider as part of the referral documentation. If it is determined a patient is unsafe to transfer, a medical hold will be ordered consistent with IMSP&P 12.3.1, *Health Care Transfer Policy*. - In such cases where a medical clearance is required, the Chief Executive Officer shall ensure that the clearances are prioritized and completed within an hour of bed assignment.
3	**The referring clinician:** - Contacts HCPOP within one hour of clinical determination that a patient requires placement in an MHCB and prior to placement in alternative housing.

	- In conjunction with custodial staff, consults policy 12.05.301, *Housing of Patients Pending Mental Health Crisis Bed Transfer,* when the patient requires alternative housing pending transfer to an MHCB. - Completes the Referring Admin Phase of the MHCB PowerPlan within the electronic healthcare record. - Ensures all referral documentation in accordance with MH Policy 12.05.601, *Documentation Required for Referral to Mental Health Crisis Bed is completed.* **HCPOP**: - Places the patient on the MHCB pending list upon notification of referral. - Locates and secures an MHCB for the patient in the following order: MHCB availability at referring institution, within region, or adjacent region. No patient is placed ahead of another (without Mental Health Regional Administrator [MHRA] approval) with the caveat that HCPOP is expected to take time and distance into consideration. HCPOP uses discretion to balance placements in order to use MHCBs as efficiently as possible based on the overall needs of the Department. - Directs the receiving MHCB Clinical Director or designee to hold the available MHCB. - Upon chronological review of the MHCB pending list, immediately contacts the referring clinician or designee with the MHCB bed location and provides the receiving MHCB clinical staff contact information once a vacant MHCB is located. <u>MHCB Referral With Subsequent Order To Appear</u> 1. If in close proximity to the court, MHRA approval to retain at current institution and/or approval to place at the "top" of the list shall be obtained by the institution's Mental Health (MH) leadership. HCPOP shall be informed of the approval by the MHRA. If an MHCB becomes available, HCPOP shall assign immediately or place the patient in a vacant bed once the patient reaches the top of the list. 2. If not in close proximity to the court, the referring institution's MH leadership shall request approval from their MHRA and the MHRA for the receiving institution in closer proximity to the court to facilitate the court appearance. HCPOP shall be informed upon Regional approvals and assign an MHCB accordingly. <u>MHCB Referral And Subsequent Order to Appear After Being Placed in an MHCB</u> 1. If in close proximity to the court, the patient shall be retained at the local institution. The MHCB pending list will be back filled to further alleviate waitlist. 2. If not in close proximity to the court, the institution's MH leadership shall request approval from their MHRA and the MHRA for the receiving institution in closer proximity to the court to facilitate the court appearance. <u>MHCB Referred Patient Return From OTC</u> - HCPOP shall be informed of all retuning MHCB patients by the receiving institution via the referral process. HCPOP shall assign the patient to the next available bed.
4	**Clinician to Clinician Contact** Shall be initiated between the referring and receiving institutions. Each institution shall institute a local operating procedure in which the institution's Chief of Mental Health, and then the Chief Executive Officer, is engaged when clinician to clinician contact is delayed more than 30 minutes. In all cases, clinician to clinician contact shall occur within one hour of bed assignment notification. Once clinician to clinician contact has been completed, the

	receiving clinician should mark the MH Clinician to Clinician order as complete in the healthcare record within the Acceptance Phase of the MHCB PowerPlan. - **Referring Clinician**: Upon notification by HCPOP of bed availability, the referring clinician immediately calls the receiving Clinical Director or designee. The call must be completed immediately and never to exceed one hour of bed assignment. - **Receiving Clinical Director or designee**: Immediately upon notice of bed assignment and not to exceed one hour after referral receipt, the receiving clinician reviews the referral information in the health care record, conducts the pre-admission screening to determine if the patient is appropriate for MHCB placement, and completes the Acceptance Phase of the MHCB PowerPlan in the electronic health care record.
5	The following table describes the steps required based on the pre-admission review by the receiving Clinical Director or designee.

If the patient is …	**then …**
Accepted*	**Chief of Mental Health or Designee at the Receiving Institution:** 1. Completes the Acceptance Phase of the MHCB PowerPlan in the electronic health care record. **Chief of Mental Health or Designee at the Sending Institution:** 1. Ensures the sending C&PR/Watch Commander received the acceptance. 2. If the Acceptance Phase of the MHCB PowerPlan has not been initiated within one hour of HCPOP notice of bed assignment, the Chief Executive Officer at the referring institution will contact the Chief Executive Officer at the receiving facility to secure admission approval.
Denied; however, the referring clinician believes the clinical need for transfer remains	The case shall be referred to the MHRA for resolution. If an agreement cannot be reached, the patient shall be admitted and evaluated.
Denied and clinician does not believe the need for transfer remains	Patient is not transferred. Referral is rescinded; HCPOP is notified of rescinded referral (refer to Chapter 05: Inpatient Services, Procedure 12.05.200-P2, *Rescinding a Referral*) immediately, but not to exceed one hour after the decision to rescind.

	***Note:** Before the patient can be admitted, the receiving inpatient clinician orders acceptance (California Code of Regulations (CCR) Title 22, Section 79743) by completing the Acceptance Phase of the MHCB PowerPlan or provides just cause for the denial.
6	The patient is transferred to an MHCB within 24 hours of referral. Please note: transfer timelines start at the time of MHCB referral (Mental Health Identifier change to MHCB) and ends when the patient has arrived at the receiving MHCB and the bed is assigned in the Strategic Offender Management System.

	- **Referring clinical staff**: Contacts HCPOP immediately if any barriers to the transfer process are identified. - **Receiving clinical staff**: Completes the required evaluations according to the *Mental Health Services Delivery System Program Guide*. - **Referring clinical staff**: If applicable, notifies HCPOP and the MHRA as soon as possible, but no later than the next business day, of the specific reason(s) which delayed the transfer of a patient to the MHCB institution within 24 hours of referral. - If transfer is delayed due to patient refusal, the clinician responding to the patient's cell to discuss the refusal shall enter the *MHCB Refusal to Transfer* order in the healthcare record immediately. When the patient vacates the cell for transport, the order shall be immediately discontinued.

VOLUME 12: MENTAL HEALTH SERVICES	Effective Date:	October 15, 2018
CHAPTER 05: INPATIENT SERVICES	Revision Date(s):	
	Supersedes Policy:	August 2014
POLICY 12.05.601 DOCUMENTATION REQUIRED FOR REFERRAL TO MENTAL HEALTH CRISIS BED	Attachments:	Yes ☐ No ☒
	Director Approval:	[redacted]

Policy

For all Mental Health Crisis Bed (MHCB) referrals, the referring/sending institution shall complete the required documentation and orders as described in this policy.

Purpose

To standardize MHCB referral documentation; clarify the expectations between the sending and receiving institutions; improve the efficiency in generating the documentation to provide timely access to care; and ensure that the receiving MHCB staff has the necessary information to admit the patient.

Discussion

Prior to acceptance into an MHCB, the referring/sending institution's mental health staff shall complete the required documentation and orders. While the receiving MHCB staff may request additional documentation beyond what is required, the only documentation and orders required for the referral and acceptance into the MHCB are listed in this policy. Each document shall be dated within the specified period of time indicated for the purpose of the MHCB referral documentation.

Compliance Indicators

To be in compliance with this policy, the following orders and documentation are required:

1. Referral to MHCB: initiated by the "MH Place In" order (using the default order sentence) in the Referring Admin phase of the MHCB PowerPlan.
2. "MH Notify HCPOP Send" order: initiated and signed upon initiation of the Referring Admin phase of the MHCB PowerPlan.
3. "128C-3" order (*Medical Classification order)*: per the medical classification policy (Inmate Medical Services Policies and Procedures (IMSP&P), Volume 4, Chapters 29, Medical Classification System Policy, and 29.1, Medical Classification System Procedure).
4. "Consult to Primary Care Provider" order: requests the "MH Medically Stable for Transport" review by medical personnel for patients on medical hold only.
5. "MH Medically Stable for Transport" order: only patients with a medical hold will require an evaluation by a psychiatrist, who has competence in performing medical assessments, or primary care physician, must check either "Yes or No" and select the appropriate transport needs (required fields) with a corresponding progress note dated within 48 hours of the documented date of referral.
6. Dynamic Documentation Notes – *Interdisciplinary Notes* (Including but not limited to PC 2602 history) associated with healthcare appointments dated

within seven (7) days of the documented date of referral.

7. "Mental Health Primary Clinician (MHPC) Initial Assessment":
   - If an "MHPC Initial Assessment" was completed more than seven (7) days prior to referral, no update of the "MHPC Initial Assessment" is required.
   - If an "MHPC Initial Assessment" is not available or the most recent document is available but is not complete or accurate, a full "MHPC Initial Assessment" must be completed by the referring clinician or the Primary Clinician at the time of referral.
8. "Suicide Risk Assessment and Self-harm Evaluation" (SRASHE): dated within seven (7) days of the documented date of referral.
   - The referring clinician is to complete the SRASHE if the patient is referred for suicidal ideation, a suicide attempt, or any type of self-harm.
   - The receiving team may, upon clinical discretion, complete the SRASHE if the patient is referred for any other reason.
9. "Acceptance" phase of the MHCB PowerPlan initiated and signed which includes the "MH Admit to", "MH Clinician to Clinician Contact", and the "MH Notify C&PR" Orders.

References

Inmate Medical Services Policies and Procedures (IMSP&P), Volume 4, Chapters 29, Medical Classification System Policy, and 29.1, Medical Classification System Procedure

Division of Health Care Services (DHCS), Mental Health Services Delivery System (MHSDS) Program Guide, 2009 Revision, Chapter 5, Mental Health Crisis Bed, p. 12-5-11.

Questions

If you have any questions or need any additional information related to this policy, you may contact the policy unit via e-mail at: CDCR MHPolicyUnit@CDCR

EXHIBIT HHH
(2018-09-19-report)

Psychiatry QM

Timely Psychiatry Contacts – measured in weeks, only checked once a week on Sunday, clock resets when patient transfers, physician orders for follow-ups prior to maximum time per program guide are often ignored (especially if the patient transfers institutions).

Routine

Initial

After transfer

After leaving MHCB/PIP

Medication non-compliance – these appointments are only measured if the physician puts in a scheduling order for a medication non-compliance appointment. The appointments that are ordered are *far* more likely to be completed. To accurately capture the percentage of medication non-compliance appointments that are occurring when they should, the denominator needs to be the number of patients who are flagged as medication non-compliant, and the numerator needs to be the number of medication non-compliant patients who are seen within the specified program guide timeframe.

Timely MH Referrals: Denominator = Number of Routine, Urgent, Emergent, Med Refusal, and RVR MHA referrals that either came due or were completed during the reporting period. Due dates determined using the timeframes delineated in the Compliance Rules grid.. This has the same problem as the appointments for medication non-compliance – the denominator is only capturing the referrals that were ordered, not all of the referrals that occurred. Unlike medication non-compliance appointments, there is not an easy way to make the denominator more accurate. Per the CLAC workflows for MH Consults, the staff member who wants the referral is supposed to put in an order (or submit an MH-5 if they do not have EHRS access), and then call the provider if it is an urgent or emergent consult. The scheduler is then supposed to schedule the consult in a timely fashion. If this always occurred, the denominator would be accurate, and the issue would then become the numerator (since it would be measuring the completed consults, which means the psychiatrist would have to have EHRS access, which is not possible outside of business hours), but there are clearly many consults occurring without an order.

Emergent consult

Urgent consult

Routine consult

Psychiatrist continuity of care: "Percentage of psychiatrist contacts seen by the most frequent provider." Denominator = All psychiatry contacts seen in person during the 5 months before the start of the reporting period through the end of the reporting period (6 months total) for any patient who has been EOP in the same housing program at the same institution, without interruption, for the past six months.

Confidential vs. Non-confidential – this is not an indicator, but it is important to note that the check out screen defaults to confidential, so unless a psychiatrist knows how to change it to Non-confidential, and they take the time to change it, all appointments will be recorded as confidential.

Appointments seen as scheduled – The denominator is "All scheduled appointments", and the numerator is "All appointments from the denominator that were completed as seen", but this may not be the case. The percentage for Appointments seen as scheduled is surprisingly high, and the drill down for this indicator only shows appointments that were Seen, Cancelled due to ProviderUnavailable, Cancelled due to ModifiedProgram, or Cancelled due to TechnicalDifficulties. It is unclear why IP Refusals, No Shows, and other cancelled appointments do not appear here.

Encounters Per Psychiatrist (on the Dashboard) – "Average number of patient encounters completed per psychiatrist per workday. Excludes encounters completed by Chief Psychiatrist." This number is extremely low, and doesn't match what we see in the field. Kevin said he has had meetings with Mike Selby and others to fix this indicator, because it is obviously inaccurate, but no changes have been implemented yet.

Non-Formulary by Psychiatrist

Diagnostic Monitoring: "Percentage of patients prescribed select high risk medications who received appropriate diagnostic monitoring consistent with clinical guidelines. This measure is a composite of 29 measures that assess whether patients on medications that meet specified high risk criteria are receiving appropriate monitoring. Data sources: Electronic Unit Health Record, Guardian Pharmacy Database, Quest Diagnostics Laboratory Database, Strategic Offender Management System. The number displayed at each institution each month is the number of measurements (usually 4 or 5). *Need to investigate further to see how many patients are included.*

<u>Under Data Entry Indicators:</u>

Continuity of Meds 1) Upon Arrival at RCs; 2) Upon Inter-Institutional Transfer at R&R; 3) with Intra-Institutional Transfers to ASU/SHU/PSU; 4) Discharge/Transfer from a Community Hospital and/or DSH; 5) Mental Health Crisis Bed (MHCB) Transfers; 6) Continuity of NA/DOT Meds with Intra-Institutional Transfers (Excluding ASU/SHU/PSU)

Diagnostic Monitoring

Diagnostic Monitoring Antidepressants

Diagnostic Monitoring Antipsychotics

Diagnostic Monitoring Clozapine

Diagnostic Monitoring Mood Stabilizers

Diagnostic Monitoring QT Prolongation EKG 12 Months

IDTTs in which psychiatry intake evals were completed prior to initial

MAPIP M12: Non-Adherence PC2602 Meds

MAPIP Medication Administration

MAPIP Medication Continuity-Transfer

Medication Admin: Chronic Care Medications Historical Administration (Psychiatrist)

Medication Admin: Outpatient Provider New Medication Orders (Psychiatrist)

Medication Compliance with PC 2602, Involuntary Meds: Court Order

Medication Compliance with PC 2602, Involuntary Meds: Med Order

Polypharmacy Medication Review

There is an indicator for "Group treatment in a confidential setting", but not for psychiatry appointment in a confidential setting.

EXHIBIT III

Golding, Michael@CDCR

DPC 18,2017 P

From: Golding, Michael@CDCR
Sent: Monday, December 18, 2017 7:34 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR
Subject: RCA.docx
Attachments: RCA.docx

HI,

I received a long analysis of an RCA done on patient [redacted] by Dr. [redacted] the [redacted] at CIW. The patient enucleated her left eye after 4-hours of documented "screaming" and "yelling" in a psychotic state, while in a cell in the CIW TTA. Orders had been written for a licensed MHCB admission, but the beds were full and so the patient could not be housed there.

Obviously you can feel free to read the entire attached document or not. My very brief and therefore very incomplete summary of the problems she mentions is as follows.

1. **The psychologist did not contact the psychiatrist on admission:** A psychologist was admitting a patient who was documented to be psychotic and screaming for hours and the psychologist did not feel it necessary to call the psychiatrist during the admission process.
    a. **Psychologist thought the patient would not take meds:** According to the [redacted] the admitting psychologist said to her that the reason he did not call the psychiatrist is that he did not think the patient would take meds. If true, that suggests that the psychologist made a determination about whether a 2602 (forced med order from the court which can allow immediate forced mediation administration) should be utilized. Determinations about whether medications or forced medications were needed should have been made by the psychiatrist.
    b. **Psychologist Culture at CIW is biased against calling psychiatrists for sick patients:** According to Dr. [redacted] the CTC psychiatrist Dr. [redacted] stated that he has not been contacted by the psychologists who are admitting patients (even once in the last two years.) If true, CIW culture does not encourage psychologist to contact psychiatrists who may need medications when admitting psychiatric patients in need of hospitalization, including screaming psychotic patients who can then enucleate their eye. It should be stated that nurses will call the psychiatrist to review medications once the patient is already housed and admitted, but that process occurs too late to be useful when there is acuity.
2. **Root Cause Analysis Excluded Psychiatrist Opinions:** There were no psychiatrists other than Dr. [redacted] involved with creating the key "Fishbone" part of the RCA document. But Dr. [redacted] (and virtually all psychiatrists who have subsequently reviewed the case at HQ) suggested that there was clear indication for emergency psychiatric medications. Dr. [redacted] wanted to include in the RCA the medical indication for psychiatric medications in a patient in that state and therefore the need for the psychiatrist to have been contacted to make sure the patient got the medications.
    a. **Any psychiatrist's opinion about need for emergency psychiatric medications was not utilized:** Dr. [redacted] includes an email from the local Senior Psychologist who lead the RCA committee stating that an HQ psychologist helped edit the RCA. Dr. [redacted] medical opinion that patients like this should be given forced medications was overruled by non-medical personnel with no apparent knowledge about how to make these determinations.
    b. **Statewide Chief Psychiatrist Could Not Intervene:** When Dr. [redacted] contacted me, I tried to intervene with non-medical HQ representatives to add that I agreed that there was a clear indication for emergency psychiatric medications and therefore forced medications. I therefore suggested that the psychologist should have called the psychiatrist in that emergency situation to help the patient. My suggestion was not utilized, either.

c. **Policy indicates the psychiatrist should be contacted:** Vol 13 Chapter 6 states, "Admitting Psychologists must contact a Psychiatrist for completion of admission process." Dec18,2017 2

3. **A sampling of other concerns of Dr. [redacted]**
   a. **Lack of admitting privileges of the psychologist:** The psychologist doing the admission did not have admitting privileges.
   b. **Failure to Train on Policy:** Psychologists are not trained on 2C above
   c. **Confusion in roles:** There is confusion between psychologists and psychiatrists (psychologists were ordering urine tox screens in crisis beds [I think against the law], the psychologist who did the admit is listed on the CTC census form as the admitting *physician*.)
   d. **The event was not reported to MHCB licensing:** The patient was ordered (medical order by a psychologist) to have a licensed admission. Since there was an inability to follow that order because of no licensed beds, it was thought that the adverse event that then occurred (in the less safe, unlicensed condition) did not need to be reported to licensing. Dr. Sepah was concerned that the absence of an ability to provide the mandated licensed (safer) conditions should not have been protection against having to report an unsafe event. The psychologist running the RCA committee was concerned that reporting the event to licensing "could adversely affect our relationship with licensing or conflict with some policy or directive from HQ." Dr. [redacted] seemed to be aware that whether the event should be reported to licensing or not was a legal decision.

I am not sure what can be done at this point. I happen to agree and other HQ psychiatrists agree (as well) that given the documentation available, that psychiatric medications were indicated and that therefore the psychologist should have called the psychiatrist. The fact that the psychologist who did the admission and those writing the RCA did not think it necessary to include the absence of acute medications as a root cause of the problem also suggests that the psychologists did not think medications in that scenario were relevant. The fact that the psychologists, doing hospital admissions at CIW, have not called the CTC psychiatrist for two years during an admission (or at least do not call psychiatrist's much during admissions), suggests that they do not believe medical consultation is needed when admitting mentally ill patients who are acutely ill.

Even in retrospect, the opinion of the only medical professional on the RCA committee who understands indications for psychiatric medications (the Institutional Chief Psychiatrist) was ignored. Also interestingly, the opinion of an outside reviewer (the Statewide Chief Psychiatrist [this commentator]) was ignored about the need for psychiatric medications. These issues suggest substantial cultural problems at CIW with enabling patients to be helped to utilize medical/psychiatric interventions.

I know that Dr. [redacted] is leaving that institution for many reasons, but also because she is concerned about the ability of psychiatrist to be allowed to help determine care for mentally ill patients in her institution. Psychologists who will not allow a psychiatrist to state and record in an RCA that a medication was needed acutely (after a devastating event) and who did not call the psychiatrist for help before the event suggest that at least some of her observations are accurate.

Best,
Michael

7/26/18 9:48 (1)

Golding, Michael@CDCR

Subject: FW: Z9 Patient follow- ups and possible MHCB referrals

From: [redacted]@CDCR
Sent: Thursday, July 26, 2018 9:48 AM
To: [redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Re: Z9 Patient follow- ups and possible MHCB referrals

I forwarded your email to Dr. [redacted].

From: [redacted]
Sent: Wednesday, July 25, 2018 4:45:05 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: RE: Z9 Patient follow- ups and possible MHCB referrals

Again, my advice is for him to go immediately to crisis bed for safety and stabilization. It is possible he might be a candidate for emergent PC2602 and this can only be done in crisis bed. I will make a note in the chart to this effect.

From: [redacted]@CDCR
Sent: Wednesday, July 25, 2018 4:38 PM
To: [redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: Re: Z9 Patient follow- ups and possible MHCB referrals

Yes, I agree but they said no. Instead, they said he wants a change in housing and should remain in ASU. He has been off all week. I have been encouraging him to take his medications.

From: [redacted]
Sent: Wednesday, July 25, 2018 4:34:17 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR
Subject: RE: Z9 Patient follow- ups and possible MHCB referrals

If he is increasingly symptomatic, non-compliant, and suicidal, it is highly advisable that he be stabilized in crisis bed.

From: [redacted]@CDCR
Sent: Wednesday, July 25, 2018 3:59 PM
To: [redacted]@cdcr.ca.gov>
Subject: Re: Z9 Patient follow- ups and possible MHCB referrals

You are welcome, but per the PT, he has not been taking the medication and instead throws them down the sink. He also admitted that he has not been taking the medication. For the past few days he has been off - increasingly irritable and verbalizing SI. He was referred to MHCB and was not admitted or seen by psychiatry.

(4)

07/25/2018 Psychiatry Note: [redacted] was on my schedule today as an emergent consult from psychology. The consult stated that pt was "currently medication non-compliant with increasing mood symptoms - irritability, talkative, depressive symptoms." There was no mention of suicidal ideation. I checked the chart and saw that I had seen the pt on 7/12/2018 and medication compliance was an issue, we discussed it, and he agreed to take his medication. I then checked the MAR, which showed that he had been taking his medication. I informed the psychologist (Dr. [redacted] of this, but she then stated that the pt had been throwing his medication down the sink and was verbalizing suicidal ideation and had been referred to Crisis Bed but was not admitted. I informed her that this pt needed to be sent immediately to Crisis Bed for safety, stabilization and consideration for an emergent PC2602, which cannot be accomplished on ASU.

Result type: MHMD Progress Note
Result date: July 25, 2018 17:23 PDT
Result status: Auth (Verified)
Result title: Free Text Note
Performed by: [redacted] Psychiatrist on July 25, 2018 17:37 PDT
Verified by: [redacted] Psychiatrist on July 25, 2018 17:37 PDT
Encounter info: 10000001512165983BC1958, SVSP, Institutional Encounter, 06/12/18 - 08/02/18

hank you.

(2)

From: [redacted]
Sent: Wednesday, July 25, 2018 3:49:22 PM
To: [redacted]@CDCR
Subject: RE: Z9 Patient follow- ups and possible MHCB referrals

Hi [redacted] Thank you for this info! I also want to let you know that I did not see [redacted] an urgent consult you requested because of medication non-compliance and increased mood symptoms. I saw this IP on 7/12; med compliance was an issue at that time, but we discussed this issue, he agreed to be compliant, and in looking at his MAR, he has been compliant for at least the last several days.
[redacted]

From: [redacted]@CDCR
Sent: Tuesday, July 24, 2018 9:13 AM
To: [redacted]@cdcr.ca.gov>
Subject: Fw: Z9 Patient follow- ups and possible MHCB referrals

FYI

From: [redacted]@CDCR
Sent: Tuesday, July 24, 2018 9:09 AM
To: [redacted]@CDCR; [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]@CDCR; [redacted]
[redacted]@CDCR
Subject: RE: Z9 Patient follow- ups and possible MHCB referrals

[redacted] has been unclear about his motivation for the hunger strike. We recently put him in CCCMS because we thought this was part of it. Would the assigned clinician please carefully try to figure out what's motivating this behavior? Not just his speech, but what his behavior is telling us?

From: [redacted]@CDCR
Sent: Tuesday, July 24, 2018 8:52 AM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Cc: [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]
[redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]
<[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR
<[redacted]@cdcr.ca.gov>
Subject: Re: Z9 Patient follow- ups and possible MHCB referrals

Hope you feel better Dr [redacted].

Sent from my iPhone

On Jul 24, 2018, at 8:26 AM, [redacted]@CDCR <[redacted]@cdcr.ca.gov> wrote:

> Unfortunately, i am not feeling well today and will not be coming in to work. I will be monitoring my email periodically. There are two patients that require follow-up and possible intervention today. One of them is [redacted], according to Captain [redacted], he has missed 44

(3)

meals. Custody staff told us yesterday that it was just a couple of days, apparently this was not accurate. He is refusing to cooperate with medical and has not been evaluated. A referral to MHCB needs to be considered. He is reportedly doing this in an attempt to commit suicide and is not demanding anything.

The other patient is [redacted] One of the PTs is reporting that he is dehydrated and appears to be gravely disabled. This is also different than what was reported during morning huddle yesterday. Custody had reported that he was refusing medical care at CTC with the intent of going to an outside hospital. There was no mention of behavior that would suggest grave disability. His clinician needs to follow-up with this today. If, it does appear that he is gravely disabled, a referred to MHCB would be necessary.

[redacted] asks EHRS data-base access

Golding, Michael@CDCR

From: Golding, Michael@CDCR
Sent: Tuesday, October 24, 2017 5:18 PM
To: [redacted]@CDCR
Subject: FW: Follow up on Psychiatry SQL Tracking Request
Attachments: CHCF PIP Psychiatry Audit

Documents RE: access to Data for [redacted] EHRS

Hi [redacted]

[redacted] requests access to the below highlighted information from Dr. [redacted] in order to address issues that Dr. [redacted] raised with me today about the productivity of well-paid registry psychiatrists.

This is his "Short-Term" request, the details of which are listed in the highlighted information below. In a different situation, [redacted] also asked to receive this type of information in June and [redacted] had said that [redacted] would be allowed to access the data then. Unfortunately it has not been made available. In a third situation, [redacted] made a request of [redacted] to audit the CHCF PIP (information not made available again).The information was not provided..

[redacted] really should be able to directly query the data base itself to monitor psychiatric trends, which is his long-term request.

Would you be able to ask Dr. [redacted] and those who control this database to honor our short term and long term request so we can answer the questions you and [redacted] have repeatedly asked us?

Best,
Michael

[redacted] said:

- Short Term
  - To address the concerns at a certain institution, I need to know the scheduling information for certain psychiatrists, PLUS the above highlighted data
- Long Term
  - Free, unfettered, direct access to query the data base myself to determine Psychiatry trends to improve both the patient and end user experience

The ask at that time was to have data access to know what work-product Psychiatrists are producing, and not relying on what they said they did through scheduling responses. Specifically, I needed to know and need to know for [redacted] current request:

- Orders fired
- Reconciliations done
- Documents signed
- Powerplans ordered
- Medications ordered
- Messages responded to in Message Center

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

From: [redacted]@CDCR
Sent: Tuesday, October 24, 2017 4:53 PM
To: Golding, Michael@CDCR
Subject: FW: Follow up on Psychiatry SQL Tracking Request

Hi Michael,

Back in June, [redacted] was kind enough to be in a meeting with [redacted] and myself. The purpose of the meeting was to get task-based Psychiatry performance data, not scheduling data. I wanted to make sure we were not duplicating our former paper system where someone indicated they "saw a patient", yet there is no documentation or orders to prove that occurred. As you know, unfortunately, we simply made that inaccurate and uninformative paper tracking system electronic with the EHRS.

The ask at that time was to have data access to know what work-product Psychiatrists are producing, and not to rely just on what the psychiatrists said they did (i.e. their scheduling response.) Specifically, I needed to know then and I need to know now the below items These items are relevant even today to answer a question that [redacted] asked concerning the productivity of well-paid registry psychiatrists at Corcoran.

- Orders fired
- Reconciliations done
- Documents signed
- Powerplans ordered
- Medications ordered
- Messages responded to in Message Center

(All of the above broken down by provider, date and time, so that afterhours work could be assessed as well.)

I requested information a second time after [redacted] requested [redacted] and I go to CHCF PIP for an audit. That information unfortunately was not delivered either (see attached). Your request Michael is our third attempt to get this information.

I have a short term and long term request:

- Short Term
  - To address the concerns at a certain institution, I need to know the scheduling information for certain psychiatrists, PLUS the above highlighted data

- Long Term
  - Free, unfettered, direct access to query the data base myself to determine Psychiatry trends to improve both the patient and end user experience

Thanks Michael. We will get to the bottom of things and find accurate and true information.

[redacted]

[redacted] M.D.
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Correctional Health Care Services
California Department of Corrections and Rehabilitation
[redacted]

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Save Our Water

Learn easy ways to save water during California's drought at SaveOurWater.com

From: [redacted]@CDCR
Sent: Monday, July 31, 2017 11:54 AM
To: [redacted]@CDCR
Subject: RE: Follow up on Psychiatry SQL Tracking Request

Sure thing. Done!

Thanks for getting back with me.

[redacted]

From: [redacted]@CDCR
Sent: Monday, July 31, 2017 10:13 AM
To: [redacted]@CDCR
Subject: RE: Follow up on Psychiatry SQL Tracking Request

Hi [redacted],

I have not had much bandwidth to focus on this since we last spoke. It should be feasible, but my priorities continue to be evaluated. Might I suggest adding this to the newly developed QM data request site? Then you will receive automatic status updates.

Let me know if we need to meet,

[redacted]
Senior Psychologist Specialist
[redacted]

From: [redacted]@CDCR
Sent: Tuesday, July 25, 2017 2:27 PM
To: [redacted]@CDCR <[redacted]@cdcr.ca.gov>
Subject: FW: Follow up on Psychiatry SQL Tracking Request

Hey [redacted]

I know you have a million things happening right now. Just wondering if you need any additional information from me for this data dive.

I will be here this week and next, then I begin my traveling ways again.

Thanks,

[redacted]

From: [redacted]@CDCR
Sent: Wednesday, June 21, 2017 10:24 AM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: Follow up on Psychiatry SQL Tracking Request

Hi [redacted],

Just wanted to circle back around on the EHRS tracking request for psychiatry. Psychiatry needs to have a way to measure discrete tasks. Our current scheduling-based tracking system is useful, but not detailed enough. Although Lighthouse is similarly useful for an overall picture, it does not provide clear data for making critical staffing decisions.

Psychiatrists do many tasks, including:

- Completing documents
- Attending meetings
- Writing orders (labs, meds, scheduling orders)
- Performing Order Reconciliation

- Responding to Message Center requests/tasks
- Reviewing charts
- Responding to urgent business hours and afterhours requests

We need to have some way to understand what tasks a psychiatrist has completed for any patient. Ideally, we could query the database looking for the above noted tasks performed per patient, and then aggregate that per day.

It is a difficult transition from a paper tracking sheet entered into the system without regard to task completion, and moving to a task completion based model. We have many strong data analysis options now that EHRS is available. I am happy to work with you to refine this further.

Thanks for your expertise!

[redacted]

[redacted] M.D.
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Correctional Health Care Services
California Department of Corrections and Rehabilitation
[redacted]

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Learn easy ways to save water during California's drought at SaveOurWater.com

Golding, Michael@CDCR

From: [redacted]@CDCR
Sent: Thursday, October 11, 2018 8:53 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR
Subject: Re: Need a quick rule clarification

I'll look into this once I'm back on Monday, but I don't remember seeing any rules on the dashboard or On Demand about EOP overflow beds. I agree with what you said to [redacted] - if they're patients who require EOP LOC, just because we don't have an EOP bed to place them in does not mean they should get less care. Her reasoning for providing them less care ("we're not staffed for it") is completely inappropriate.

Sent from my iPhone

On Oct 11, 2018, at 6:27 PM, Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov> wrote:

> Hi,
> Here [redacted] is arguing that patients in EOP overflow beds have not been seen once per month.
>
> She says,
> "It has been that way for years"
>
> Then despite my arguing with her, she says,
> "We can leave it like it is"
>
> Definitely check out whether we have any EOP overflow beds and where they are and whether they continue to allow the patients to be seen less than once every 30-days.
>
> Michael
>
> **From:** [redacted]@CDCR
> **Sent:** Monday, December 05, 2016 6:16 PM
> **To:** Golding, Michael@CDCR <Michael.Golding@cdcr.ca.gov>
> **Cc:** [redacted]@CDCR <[redacted]@cdcr.ca.gov>; [redacted]@CDCR <[redacted]@cdcr.ca.gov>
> **Subject:** RE: Need a quick rule clarification
>
> There is no PG rule for it and there never has been. We should do what is clinically appropriate.
>
> [redacted]
> DHCS Mental Health Program
> [redacted]
>
> <image001.jpg>
>
> *CONFIDENTIALITY NOTICE: This communication and contents may have sensitive, confidential and/or legally privileged information. Any unauthorized disclosure, distribution, or action in reliance on the contents of this communication is strictly*

From: Golding, Michael@CDCR
Sent: Monday, December 05, 2016 5:43 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Need a quick rule clarification

Well///Do you really think Coleman would be OK with keeping it as it is...
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

<image002.jpg>

From: [redacted]@CDCR
Sent: Monday, December 05, 2016 3:33 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Need a quick rule clarification

We can keep it as clinically indicated if that is the right thing to do. We can leave it as is. It has been this way for years so we can keep if you think that is best.

[redacted]
DHCS Mental Health Program
[redacted]

<image001.jpg>

From: Golding, Michael@CDCR
Sent: Monday, December 05, 2016 3:27 PM
To: [redacted]@CDCR
Cc: [redacted]@CDCR; [redacted]@CDCR
Subject: RE: Need a quick rule clarification

Hi,

I would very much like to say that each decision should be made given the needs of the patient, but that is not our prerogative.

If the rule is that psychiatrists must see EOP patients every month, the fact that we also do not have enough EOP beds for patients requiring EOP levels of care, cannot reasonably be the reason why such patents require less frequent treatment by psychiatrists.

Unfortunately, I think we need to require monthly visits, to be consistent with what is required in our system for EOP patients.

Yes we are not staffed for that.

But, we make the rules and institutions (hopefully) allocate scarce resources to prevent death and morbidity, while often having to break our rules in order to do so.

Of course the situation is very much imperfect.

Best,
Michael

Michael Golding, M.D.
Statewide Chief Psychiatrist
Mental Health Support Program
California Department of Corrections and Rehabilitation

Phone: 916.662.6541
Email: michael.golding@cdcr.ca.gov

<image002.jpg>

From: [redacted]@CDCR
Sent: Monday, December 05, 2016 2:12 PM
To: Golding, Michael@CDCR
Cc: [redacted]@CDCR
Subject: FW: Need a quick rule clarification

Hi Michael,

[redacted] and I just spoke about this. How often do you think a person who is EOP level of care and prescribed psych meds be seen by a psychiatrist? There are no PG rules for people in EOP overflow waiting for transfer to an EOP program and these programs are not staffed to provide full complement of EOP care so for these I want to create a policy based upon clinical appropriateness – what do you think? Should we create a policy (and then a reporting rule) for frequency of psychiatry visits for EOP overflow patients on meds? If so what makes sense?

Thank You.

[redacted]

DHCS Mental Health Program

[redacted]

<image001.jpg>

From: [redacted]@CDCR
Sent: Monday, August 29, 2016 10:34 PM
To: [redacted]@CDCR; [redacted]@CDCR
Subject: Need a quick rule clarification

[redacted] and [redacted]

I'm in the process of streamlining our psychiatry contact rules for EOPs in all housing situations (due to a bug in one of them that needs to be fixed for PVSP's Coleman data) and I'm seeing that currently, ML EOP/EOPMods on pychiatrist-prescribed meds are only required to be seen by a psychiatrist at institutions with an EOP program. The other institutions have no ML EOP/EOPMod psychiatry requirement, *even if the patient is on psychiatrist-prescribed meds.* I'm thinking I should change the rule such that ML EOP/EOPMod patients on psychiatrist-prescribed meds at ALL institutions should be required to be seen regularly by a psychiatrist, regardless of whether or not the institution has an EOP program. Am I right on this, or do I leave the rule as is?

[redacted]

Documents which psychiatrists said what for first ~~EHRS~~ SAC report

From: [redacted]@CDCR
To: Golding, Michael@CDCR
Subject: SAC information
Date: Thursday, November 16, 2017 1:03:00 PM

Hi Michael,

Here's a synopsis of what I've found:

Dr. [redacted]

CTC: Rare custody barriers; there are a couple COs who push back when asked to bring patients they feel will be a lot of work, but overall custody is very helpful. Office space is limited, and the times available for seeing patients are short (due to breakfast, pill line, lunch, change of shift – usually they can see patients from 7:30 – 10:30, and 11 – 1:30), but the psychiatrists denied any significant problems with office availability thanks to COs bringing patients promptly and the psychiatrists and psychologists working well together. There are lots of PC 2602s to do, which somewhat decreases ability to see many patients. Biggest complaint from two of the psychiatrists was how many trainings (SRE, Columbia scale, etc) they have to do. Overall the CTC psychiatrists feel things run smoothly.

Dr. [redacted]

Dr. [redacted]

MHCBU: "All 3 or 4 custody officers will put on their sunglasses and sleep. If you ask them for patients to be pulled they'll say 'oh, he won't come out'" without even attempting to get the patient. He stated the psychologist has an office, but the psychiatrist does not have an office and has to sit in the hallway to see patients or do any work. He reported it's really noisy in the hallway, there is no privacy, and other prisoners can listen to the appointments and even see his computer/notes if they are in a nearby cell. There are lots of PC 2602s.

Dr. [redacted]

PSU A1: Approximately 70% of patients do not show up for their scheduled appointment – 50-60% of those say that they did not attend their appointment because custody never came to pick them up. Custody is mostly helpful when directly asked to do something, although a few are resistant to helping out the psychiatrist. Dr. [redacted] has forbidden patients from being taken out of groups to see the psychiatrist. The psychiatrist ends up seeing most patients cell-front, which can be time-consuming due to the psychiatrist needing to find them (the patient may be on the yard, in the law library, out to court, in group, or at a medical appointment). There are lots of PC 2602s. MAs come and go frequently – he has had 5 MAs since February – so he has to spend time to train them on expectations each time he gets a new one. Medical had priority over Psychiatry for MAs, so two of the five left because they were re-assigned to Medical.

Dr. [redacted]

PSU A2: Custody will pull patients when requested, unless the patient is in a group. He said Dr. [redacted] informed custody that groups take precedence over psychiatry appointments, and that patients are never to be taken out of a group for a psychiatry appointment. Overall custody is helpful. Patients frequently (~50%+) refuse to attend appointments, and must be seen cell-front, which can result in time spent tracking them down.

Dr. [redacted]

PSU B: They were 50% staffed in PSU B until October. No custody issues. The psychology supervisor, Dr. [redacted] did not allow psychiatrists to pull patients from groups, but she was transferred to PSU A recently, so psychiatrists are now able to pull patients from groups. 90+% of the psychiatrist's patients refuse their 1:1 appointments, largely "because they don't want to be stuck in there for an

Dr. [redacted]

hour or two" (custody transports patients in groups, so although the appointment with the psychiatrist may only be 10-15 minutes, they have to sit in the treatment center for 1-2 hours before or after the appointment waiting until custody transports the group back). The psychiatrist sees about 50% of her patients cell-side, due to them refusing both their 1:1 with her and their group. She no longer schedules appointments in advance, due to 90+% of them not coming, so all scheduling orders are placed in arrears by the MA, who places the order, schedules the appointment, and checks them in and out.

Dr. [redacted]

A3 EOP: Over 50% of patients do not show up for their scheduled appointments, which the psychiatrist believes is mostly due to them refusing, but could also be due to custody failing to bring them. He said custody is pleasant and helpful overall. He is able to pull patients out of groups without any push-back. He goes cell-front to see the patients that are not in group and that refuse their appointment, and has some difficulty tracking these patients down. There are a fair number of PC 2602s to do, which takes away from direct patient care time.

Dr. [redacted]

Dr. [redacted]

A5 Ad Seg EOP: One psychiatrist said "Custody won't bring any patients". He clarified that he has patients scheduled, they are ducated, but custody refuses to bring patients for any psychiatry appointments. He stated custody will bring patients for psychology 1:1 appointments, and for groups. He reported he tries to see his patients with the psychologist during the psychology appointment whenever possible, or pull them from group, but frequently ends up having to see patients cell-side. Often the patients aren't in their cell, and "custody says they don't know where [the inmate] is", so he has to go all over the yard trying to find his patients, which takes a significant amount of time. He noted that although he does pull patients from groups, it is "frowned on" to do so, and he has heard other psychiatrists have been told they are not allowed to do that by Dr. [redacted] Another psychiatrist stated "I cannot see the patients in a confidential setting on the block", and explained that custody will not pull patients out of their cell for a psychiatry appointment, only for groups and psychology appointments. He noted he can only see patients in a confidential setting if he pulls them out of group to see him, and said that custody is cooperative with pulling patients out of groups for him. He sees most of his patients cell-front, and denied significant problems with tracking them down, as they are usually either in their cell or on the yard.

Dr. [redacted]

A6 EOP: "Custody is very rude and there are lots of problems. When I try to see my patients they tell me they cannot bring the patient because it's yard time, shower time, they're not in their cells yet, or 'we have a shortage of staff and can't'. If you schedule 6 patients, 1 or 2 will be brought, but the others won't because custody refuses." "Two psychiatrists have left SAC because of working in A6." He reported he ends up having to see most of his patients cell-side, but this takes a lot of time because there are 3 blocks, and "custody will often refuse to even open the block for you". If he is eventually let in to the block, often the patient isn't in his cell, so he then has to try to find out where the patient is.

Dr. [redacted]

A7 EOP: 75+% of patients refuse their appointment, especially if they are scheduled for yard at the same time. He tries to see the patients who refuse cell-side, but often can't find them, and spends a lot of time checking their cells, work, yard, groups, etc, which decreases the amount of time he has available for patient care. He reported there are lots of PC 2602s to do, and in order to complete the paperwork and hearings he often has to devote one full day per week to PC 2602s.

Scheduling:

Most of the psychiatrists had more notes than scheduling orders, meaning they are forgetting to place the scheduling order in arrears or not communicating to the MA to place the scheduling order in arrears. On average, the psychiatrists had 5.7 more notes than scheduled appointments in September. I am assuming that scheduled appointments all had a note, and that all notes signified a face-to-face contact – both of which could be false assumptions ([redacted]'s looking into this for me, but I don't have the results back yet).

Dr. [redacted] appears to have only seen 2 patients in September (based on scheduling orders), because her MA checks all cell-front appointments in and out for her. Because of this, the MA got credit for all of those appointments (n = 36), not Dr. [redacted].

Overall thoughts:

1. Psychiatrists' ability to see patients is significantly impeded by the priority hierarchy of Medical appointments > Groups > Psychiatry appointments.
2. The patient refusal rate is very high on most yards, and the psychiatrists appear to not have much (if any) help locating the patient, so the psychiatrists spend a lot of time just trying to find their patients.
3. Custody transporting many patients at once and making them wait for 1-2 hours while the psychiatrist quickly tries to see each of them, and then transporting them all back at the same time, likely leads to a much higher appointment refusal rate.
4. SAC has a lot of PC 2602s (currently 216), which significantly impacts SAC psychiatrists' time. This is not accounted for when looking at productivity data.
5. Custody is a very significant barrier to patient care on several yards.
6. Psychiatrists are unable to pull patients from groups on several yards. Many of the psychiatrists expressed that psychiatry appointments are often brief (10-15 minutes), and groups are often long (90-120 minutes), so the patient would still be able to participate in most of the group and receive credit for attending the group, even if they were pulled partway through for a psychiatry appointment. Not allowing psychiatrists to pull patients from groups often results in the psychiatry appointment not happening, due to barriers with custody, high patient refusal rates, and difficulty tracking patients down.

Recommendations:

1. Speak with the warden regarding the above custody issues.
2. Speak with relevant parties at HQ regarding the appointment priority hierarchy, and the need for psychiatry appointments to take precedence over groups (just like medical appointments do).
3. Educate psychiatrists and MAs on the importance of making sure there is a scheduling order placed for every appointment. This could be directed just at the psychiatrists who had the biggest difference between number of notes and number of appointments (Dr. [redacted] at 21, Dr. [redacted] at 13, Dr. [redacted] at 15, and Dr. [redacted] at 12), or at all psychiatrists. Likewise the MAs could be spoken to as a group, or the MA supervisor could be spoken with and asked to make sure the MAs all place scheduling orders appropriately.

4. Educate Dr. [redacted] and MA [redacted] that the psychiatrist must be the one to check patients in and out on the ambulatory organizer, or the MA will get credit for the appointment.
5. From the September data (which could potentially paint a misleading picture, given that it's just one month), it appears these psychiatrists should be instructed to see more patients:
    a. Dr. [redacted] (2.4 patients per day). Of note, he works on A5 Ad Seg where custody apparently will not pull anyone from their cell for psychiatry appointments.
    b. Dr. [redacted] (3.1 patients per day). Of note, he also works on A5 Ad Seg where custody apparently will not pull anyone from their cell for psychiatry appointments.
    c. Dr. [redacted] (3.5 patients per day). Of note, she works in PSU B, where custody transports many patients to her at once, and they have to wait 1-2 hours before custody will transport them back, so 90+% refuse. She also is acting [redacted] one day per week.
    d. Dr. [redacted] (3.5 patients per day). Works on A7.

I hope this helps. Let me know if you need any more details.

[redacted]

[redacted]
Senior Psychiatrist, Specialist
Elk Grove - Headquarters
California Department of Corrections and Rehabilitation
[redacted]

Dr [redacted]

What LOC are you assigned to? Was in EOP, just moved to PSU

If anything except MHCB, which yard? A6. Lots of problems in A6. Now PSU A2.

What barriers affect your ability to see patients?

Custody issues? A6 custody very rude, often refuses to pull patients for appointments (it's yard time, they're all taking showers, they're not in their cells yet, we have a shortage of staff and cant). If you schedule 6 patients, 1-2 will be brought, but others won't. When you try to see them cell-front, it takes lots of time because there are 3 blocks, and custody will often refuse to even open the block. Two psychiatrists have actually left working at SAC because of working in A6.

In MHCBU, all 3-4 COs will put on their sunglasses and sleep. If you ask for patients to be pulled they'll say "oh, he won't come out".

A2 custody is better. They will pull patients out when requested.

Are you allowed to pull patients from groups in order to see them? A2 – custody will not because Dr. [redacted] said they cannot pull people from groups, even if patient is on his schedule at that time.

Is office space an issue? Not in A2

In MHCBU, there's an office for the psychologist, but none for the psychiatrist. They have to sit in the hallway, prisoners can listen to their conversations, anyone can see his notes, it's really noisy.

About what percentage of your patients refuse to come? A6 66%. PSU most come. A8 (OHU) patients have disabilities so you have to go to them. MHCBU almost everyone refuses/won't be pulled. Do you see them cell-front? Yes.

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? Psychiatrist. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? Dr. [redacted] does. MAs come and go too much.

After the appointment? If so, do you place the scheduling order or does your MA?

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. Lots of PC 2602 hearings and paperwork. Lots of IDTTs. Suggestion: get psychologist to help with PC 2602 paperwork. There is one, but she takes 4 days to do one 2602 paperwork packet.

[redacted]

What LOC are you assigned to? Ad Seg EOP

If anything except MHCB, which yard? A5

What barriers affect your ability to see patients?

Custody issues? Custody won't bring any patients for psychiatrists on A5. The patients are on his ambulatory organizer, have scheduled appointments, but custody won't bring them. They only bring patients for psychologist 1:1 appointments, so he tries to see his patients with the PC when possible, find them in a group, or go cell-front. Sometimes custody doesn't know where a patient is, so he has to run around trying to find his patients.

Are you allowed to pull patients from groups in order to see them? It's frowned on, he has been able to, but other psychiatrists have been told they can't by Dr. [redacted]

Is office space an issue? No

About what percentage of your patients refuse to come? Do you see them cell-front?

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA proposes order, and he co-signs. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Emails MA. If so, do you place the scheduling order or does your MA? MA.

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. No.

Dr. [redacted]

What LOC are you assigned to? EOP PSU

If anything except MHCB, which yard? PSU B

What barriers affect your ability to see patients?

Custody issues? No.

Are you allowed to pull patients from groups in order to see them? Currently yes, but the previous psychology supervisor wouldn't allow it (she was moved to PSU A).

Is office space an issue? No

About what percentage of your patients refuse to come? 90+%, because they don't want to be stuck in the treatment center for 2 hours (custody transports them in groups). So she stopped scheduling them and just pulls them out of groups. Do you see them cell-front? About 50% of the time has to do cell-front, because patient also refuses group.

How do you schedule appointments?

Ahead of time? Do you place the scheduling order or does your MA? Do you check the patients in and out or does your MA? Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Yes. If so, do you place the scheduling order or does your MA? MA puts in scheduling order, and places appointment on ambulatory organizer and checks in/out. Psychiatrist doesn't even have to co-sign. The MA checks the Current Due Dates report for the PSU psychiatrists and makes sure everyone stays in compliance. Dr. [redacted] was only psychiatrist on PSU B for 2 years (they were 50% staffed), but a new psychiatrist started in PSU B in October so they are now 100% staffed and should meet their psychiatry compliance numbers for the first time.

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. Administrative duties all day on Fridays (acting [redacted].

Dr. [redacted]

What LOC are you assigned to? CTC

If anything except MHCB, which yard?

What barriers affect your ability to see patients? "There aren't really any barriers in the CTC."

Custody issues? No. Has a good relationship with custody and anytime he wants to see someone custody will pull them out for him.

Are you allowed to pull patients from groups in order to see them? N/A (no groups)

Is office space an issue? No

About what percentage of your patients refuse to come? Do you see them cell-front?

How do you schedule appointments? After the appointment.

Ahead of time? Do you place the scheduling order or does your MA? Do you check the patients in and out or does your MA? Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Yes. If so, do you place the scheduling order or does your MA? Psychiatrist places the scheduling order, and then MA schedules them (places them on ambulatory organizer and checks them in and out).

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc.

Lots of PC 2602s. Lots of trainings – Columbia scale, SRE, etc. Trainings definitely get in the way of seeing patients.

In outpatient, custody has always been a problem. Lots of patients refuse, and custody doesn't make them go, so they just won't show up and the psychiatrist has to run all over the institution finding patients. Occasionally (he guesses it's a small minority) patients want to go, but custody won't bring them.

Dr. [redacted]

What LOC are you assigned to? CTC

If anything except MHCB, which yard?

What barriers affect your ability to see patients?

Custody issues? No. Has good rapport with custody. Can see from 7:30 – 10:30, and 11 – 1:30.

Are you allowed to pull patients from groups in order to see them? N/A

Is office space an issue? There are only two offices to see patients on the unit, so can sometimes get difficult. But he gets there early (5am).

About what percentage of your patients refuse to come? 20%. Do you see them cell-front? Yes.

How do you schedule appointments?

Ahead of time? Do you place the scheduling order or does your MA? Do you check the patients in and out or does your MA? Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Yes. If so, do you place the scheduling order or does your MA? Psychiatrist places order in arrears and MA places them on ambulatory organizer and checks them in/out.

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. IDTTs, PC 2602 hearings, lots of trainings.

He feels things run smoothly in the CTC.

Dr. [redacted]

What LOC are you assigned to? CTC-2

If anything except MHCB, which yard?

What barriers affect your ability to see patients?

Custody issues? Occasionally, if seeing a difficult inmate is a lot of work for 2 of the COs they'll push back a lot. Others are fine. Overall things run well and she doesn't have issues.

Are you allowed to pull patients from groups in order to see them? N/A

Is office space an issue? No

About what percentage of your patients refuse to come? Do you see them cell-front?

How do you schedule appointments?

Ahead of time? Do you place the scheduling order or does your MA? Do you check the patients in and out or does your MA? Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Yes. If so, do you place the scheduling order or does your MA? Psychiatrist.

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. No, but EC box pops up a lot, and all of the EC notes clutter up the chart and make it hard to review notes. Labs in results review sometimes don't show up (like creatine kinase or other specialty labs), so she checks Quest. Smartphrase for labs doesn't pull in all relevant labs.

Dr. [redacted]

What LOC are you assigned to? EOP

If anything except MHCB, which yard? A3

What barriers affect your ability to see patients?

Custody issues?

Are you allowed to pull patients from groups in order to see them? Yes. No push-back.

Is office space an issue? No, there are lots of offices in the EOP building.

About what percentage of your patients refuse to come? 50%+ don't come. It's unclear whether the patients are refusing or custody doesn't bring them. Do you see them cell-front? Yes

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA, with co-sign. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? Yes.

After the appointment? If so, do you place the scheduling order or does your MA?

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. Fair number of PC 2602s.

Dr. [redacted]

What LOC are you assigned to? EOP

If anything except MHCB, which yard? A7

What barriers affect your ability to see patients?

Custody issues? No, the COs are helpful and nice.

There are 2 yard shifts, so patients won't show up if he schedules them during their yard time. He'll go to cell-side, but usually can't find them (in yard, working, group, etc), so has to run around yard. MA could schedule around yard time.

Are you allowed to pull patients from groups in order to see them? Yes, and custody are helpful with this.

Is office space an issue? No

About what percentage of your patients refuse to come? 75%+. Do you see them cell-front? Yes, see above.

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA, and psychiatry co-signs. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? MA does, they put in scheduling orders based on Current Due Dates.

After the appointment? If so, do you place the scheduling order or does your MA?

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. Lots of turnover on his yard. Lots of PC 2602s, has to devote one full day to PC 2602s/hearings most weeks.

He feels things run well on A7, except yard time.

Dr. [redacted]

What LOC are you assigned to? MHCBU

If anything except MHCB, which yard? I do fill in on other blocks at times.

What barriers affect your ability to see patients?

Custody issues? Not in MHCBU B1 but it was terrible in PSU 1 and 2

Are you allowed to pull patients from groups in order to see them? Sometimes, not always.

Is office space an issue? Yes everywhere. The interview booths are hard to hear the IP in and usually have partially open wire mesh that the IP can gas you if he so chooses. The booths rarely have any air circulation.

About what percentage of your patients refuse to come? Do you see them cell-front? In MHCBU B1 about 50%. In the PSU A 1&2 it was higher.

How do you schedule appointments?

Ahead of time? Do you place the scheduling order or does your MA? Do you check the patients in and out or does your MA? Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? In the PSU the IPs were scheduled ahead of time. In the MHCBU the schedule is done by the clinicians.

After the appointment? If so, do you place the scheduling order or does your MA? After seeing the IP I will check them in and check them out in the MHCBU. In the PSU it was a check out procedure

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc.There are a fair number of PC2602s to be done.

Dr. [redacted]

What LOC are you assigned to? Ad Seg EOP

If anything except MHCB, which yard? A5

What barriers affect your ability to see patients? "I cannot see the patient in a confidential setting on the block."

Custody issues? Was told in a meeting that custody won't pull patients out of their cell to see the psychiatrist, and tried a long time ago to get custody to pull them but was refused, but they are very helpful in pulling patients from group to see him.

Are you allowed to pull patients from groups in order to see them? Yes. Pulling them from groups is the only way he can see patients in a confidential setting.

Is office space an issue? No

About what percentage of your patients refuse to come? Most of them. Do you see them cell-front? Yes. Patients are either in their cell or in a small yard, so they're easy to find.

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA puts in scheduling order and places on ambulatory organizer. He cosigns orders. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? MA.

After the appointment? If so, do you place the scheduling order or does your MA?

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. A few months ago they had a much higher patient load (there were more Ad Seg EOP patients at SAC in general), so patients were housed on other blocks, and there were many more PC 2602s.

Dr. [redacted]

What LOC are you assigned to? PSU A1

If anything except MHCB, which yard?

What barriers affect your ability to see patients? Sees patients via ducats and on tier rounds

Custody issues? Custody will not pull patients from groups. Most COs are fine, will pull patients out when directly requested, but some are difficult.

Are you allowed to pull patients from groups in order to see them? No. Dr. [redacted] forbids it.

Is office space an issue? No

About what percentage of your patients refuse to come? 70% don't show up – about 50% of those inmates say custody didn't go pick them up. Do you see them cell-front? Yes. Sometimes they're on the yard, or in the law library, or out to court, or at a medical appointment, so can be difficult to track them down.

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA proposes order and psychiatrist co-signs. Do you check the patients in and out or does your MA? Psychiatrist. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due?

After the appointment? Only for add-ons. If so, do you place the scheduling order or does your MA? Psychiatrist.

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. Lots of PC 2602s. There is a psychologist who helps out with PC 2602. Has about 2 hours of emails every day, mostly about patients and necessary (collaborating with PCs and PCPs).

Has had 5 MAs since February; 2 were pulled for Medicine.

Someone sends an email 2-3 times per week listing everyone who has to be seen this week.

Dr. [redacted]

What LOC are you assigned to? EOP

If anything except MHCB, which yard? B5

What barriers affect your ability to see patients? It seems to be getting better – for a while the OTs were insisting on scheduling, but now MAs do.

Custody issues? No

Are you allowed to pull patients from groups in order to see them? Yes

Is office space an issue? Not usually. Psychiatry has dedicated space, and only 1-2

About what percentage of your patients refuse to come? 50% don't show up - unclear if patient refused, if patient couldn't hear their name called, or if custody didn't call their name or go pick them up. Thinks it's mostly the patient refusing. Do you see them cell-front? Yes. Usually not hard to find them – they're usually in their cell, but if not are probably in group.

How do you schedule appointments?

Ahead of time? Yes. Do you place the scheduling order or does your MA? MA, with co-sign order. Do you check the patients in and out or does your MA? MA. Explained that psychiatrist has to. Do you or your MA check the Current Due Dates report to ensure people are scheduled before they are due? MA.

MA puts together a file on each new patient, including previous psych notes from eUHR.

After the appointment? If so, do you place the scheduling order or does your MA?

Do you have any other duties that cut into patient care time? E.g. administrative duties, lots of PC 2602s, etc. No. She has assistance with PC 2602s from a team.

Lack of continuity (they're constantly moving people within the institution and to and from other institutions) significantly impacts care. It's hard to have effective treatment when you only get to work with a patient for a little while.

SAC PSU

1. Psychiatrist Locations: (Sac A1, A2) & (Sac B7, B8)
2. Psychiatrist Assigned:
   a. PSU A: Drs. [redacted] & [redacted]
   b. PSU B: Drs. [redacted] (only as needed for emergencies) & [redacted]
3. Scheduling is usually done in advance
4. Schedules are made by the MA's assigned to each individual psychiatrist
5. Custodial barriers: Groups and Prioritizing Psychiatry Appointments

I just spoke with Dr. [redacted] and was able to get more information about SAC PSUs. He said in PSU B they actually do pull patients out of groups for psychiatry appointments, due to the Senior Psychologist Supervisor being okay with this, and telling custody it is fine. On PSU A, however, the Senior Psychologist Supervisor (he believes her name is Dr. [redacted], although I looked in the directory and couldn't find anyone with any variation of that name) has directed custody to never pull patients out of groups for psychiatry appointments, so custody refuses psychiatrists' requests to see patients during groups. Dr. [redacted] believes this is the case for all groups, including RT groups. He said he has discussed the issue with the CMH, Dr. [redacted], and Dr. [redacted] informed him there is a policy that states groups take priority over psychiatry appointments, and you cannot take patients out of groups for any reason, except in a crisis. Do you know if there is such a policy?

Interestingly, Dr. [redacted] said the MAs handle all psychiatry scheduling in both PSUs. The MAs propose the scheduling order, and use the Scheduling program to actually schedule the appointment. The psychiatrists have no control over their schedule, unless they want to add a patient on. He said the MAs have been trained to use the Current Due Dates report to make sure the psychiatrists remain in compliance with their appointments, but no one double-checks to ensure that they are doing this. He said they have a supervisor, but the supervisor has been hands off regarding scheduling.

It appears that 1) the MAs may not be closely following Current Due Dates, given the low levels of compliance, and 2) that the psychiatrists may not be properly communicating with the MAs regarding scheduling any add-ons or impromptu appointments they see so they get credit. If [redacted] is able to run that query and it shows the compliance % based on notes is much higher than the compliance based on scheduling orders, that would support #2, but if the compliance % based on notes is about the same as the compliance based on scheduling orders it would support #1 (or a staffing shortage, or that the psychiatrists see too few patients per day – although per Dr. [redacted] their schedules are controlled by the MAs, so they shouldn't be able to see too few patients).

Other info from Dr. [redacted]:

Dr. [redacted] works W, Sa, Su in PSU

Dr. [redacted] works MWF in PSU

Dr. [redacted] works T, W, Th in PSU. Covers other yard on M.

Dr. [redacted] works T, W, Th in PSU. Does admin/supervisory on F.

Tuesdays all PSU IDTTs are done, and psychiatrists are unable to see many/any 1:1 appointments

Wednesdays PC 2602 hearings occur.

PSU B8 has 65 beds, PSU B7 has 64 beds, PSU A1 has 70 beds, PSU A2 has 70 beds

EXHIBIT JJJ

Home > QM > Dashboard > Dashboard

Dashboard Month: September 1 - Present Institution [redacted]

1 of 1 100% Find | Next

HEALTHCARE SERVICES DASHBOARD

[redacted] ([redacted])

September 1 - Present

Dashboard Scorecard | Institution Dashboard | Statewide Comparison | Trended View | Dashboard Glossary

SCHEDULING & ACCESS TO CARE

	6 Mo. Trend	CHCF	Statewide
ACCESS			
Medical Services		85%	88%
Dental Services		-	-
Mental Health Services		95%	90%
APPTS COMPLETED AS SCHEDULED			
Cancelled Due to Custody		0.4%	1.3%
Seen as Scheduled		93%	89%
EFFECTIVE COMMUNICATION			
Effective Communication Provided		98%	96%
Sign Language Interpreter (SLI) Provided		-	-

MEDICATION MANAGEMENT

	6 Mo. Trend	CHCF	Statewide
EHRS INSTITUTIONS - *Med Administration*			
All Medications Received Timely (EHRS)		89%	88%
FORMULARY MANAGEMENT			
Non-Formulary by Psychiatrists		4.3%	3.7%
Non-Formulary by Medical Providers		7.1%	5.3%
Central Fill Prescriptions		66%	60%

CONTINUITY OF CLINICIANS & SERVICES

	6 Mo. Trend	CHCF	Statewide
Primary Care Provider (PCP)		91%	91%
Mental Health Primary Clinician		-	-
Psychiatrist		-	-

STAFFING

	6 Mo. Trend	CHCF	Statewide
Actual Vacancies		-	-
FTE Usage		-	-
Hires Completed Timely Non-PCP (87/108 Days)		-	-
		-	-

POPULATION HEALTH MANAGEMENT

	6 Mo. Trend	CHCF	Statewide
Asthma Care		92%	88%
Therapeutic Anticoagulation		82%	84%
Diabetes Care		90%	88%
End Stage Liver Disease Care		91%	85%
Colon Cancer Screening		83%	79%
Women's Care		-	86%
Diagnostic Monitoring		85%	86%
Utilization Specialty Services		72%	90%
Polypharmacy Medication Review		95%	95%

AVAILABILITY OF HEALTH INFORMATION

	6 Mo. Trend	CHCF	Statewide
All Documents		93%	84%
Specialty Notes		94%	93%
Community Hospital Records		100%	96%
Scanning Accuracy		-	-
EHRS Timely Documentation		95%	94%

COMPLETE CARE MODEL INFRASTRUCTURE

	6 Mo. Trend	CHCF	Statewide
QM Program			
Patient Safety Program		-	-

MAJOR COSTS PER INMATE PER MONTH**

	YTD 17/18	YTD 16/17	Statewide
Total Labor Cost	-	$4,929	-
Total Non Labor Cost	-	$1,561	-

GRIEVANCE PROCESSING

	6 Mo. Trend	CHCF	Statewide
Timely Grievances		-	-

CARE MANAGEMENT

	6 Mo. Trend	CHCF	Statewide
Appropriate Placement High Risk Patients		N/A	79%
High Risk Patient Care Plan			
Timely Completion of Discharge Follow-Ups		100%	95%
30-Day Community Hospital Readmission		-	-
30-Day MHCB or PIP Readmission		-	-
Potentially Avoidable Hospitalizations*		-	-
EOP/MHCB Treatment Plan		-	-
Suicide Watch Discharge Plan		-	-
Quality of Suicide Risk Evaluation Documentation		-	-

RESOURCE MANAGEMENT

	6 Mo. Trend	CHCF	Statewide
Specialty Teleservices		-	-
Availability of Medical Equipment		81%	86%
Health Care Environment		-	-

WORKLOAD PER DAY

	6 Mo. Trend	CHCF	Statewide
Appointments per PCP		2.8	8.2
Appointments per PCRN		2.5	4.9
Encounters per Primary MH Clinician		3.1	4.2
Encounters Per Psychiatrist		2.7	3.2

OTHER TRENDS

	6 Mo. Trend	CHCF	Statewide
Hospital Admissions*		-	-
Emergency Department Visits*		-	-
Specialty Care Referrals*		129	33
Prescriptions Per Inmate		9.1	2.7
Diagnostics Per Inmate		-	-
Grievances Received*		-	-
Prison Population Capacity		-	-

EXHIBIT KKK

MAPIP DASHBOARD - *Trended View*

Statewide

April 2018

Statewide Comparison | Trended View | MAPIP Specifications

DIAGNOSTIC MONITORING	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	12 mo. Trend
Antidepressants: Thyroid Monitoring	99%	99%	100%	100%	99%	100%	99%	99%	99%	100%	100%	100%	
Antidepressants: Venla Blood Pressure	-	-	62%	69%	78%	84%	81%	94%	92%	97%	97%	97%	
Antipsychotics: AIMS	90%	89%	86%	84%	85%	87%	81%	84%	87%	88%	91%	89%	
Antipsychotics: Blood Pressure	-	-	65%	69%	79%	87%	84%	95%	93%	96%	97%	98%	
Antipsychotics: Blood Sugar	96%	96%	61%	59%	57%	58%	53%	57%	51%	72%	77%	78%	
Antipsychotics: CBC with Platelets	94%	93%	71%	70%	69%	70%	65%	67%	61%	65%	68%	69%	
Antipsychotics: CMP	94%	94%	69%	69%	68%	68%	60%	64%	59%	62%	66%	68%	
Antipsychotics: EKG	90%	90%	49%	51%	50%	53%	44%	63%	56%	56%	63%	60%	
Antipsychotics: Height	-	-	62%	64%	75%	84%	78%	90%	87%	92%	95%	96%	
Antipsychotics: Lipid Monitoring	93%	93%	61%	62%	60%	61%	54%	59%	52%	55%	59%	62%	
Antipsychotics: Med Consent	93%	92%	84%	80%	82%	85%	77%	79%	86%	84%	88%	87%	
Antipsychotics: Thyroid Monitoring	99%	99%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	
Antipsychotics: Weight	-	-	62%	64%	74%	83%	78%	90%	87%	92%	95%	95%	
Carbamazapine: Carbamazepine Level	92%	83%	53%	14%	29%	45%	38%	53%	27%	23%	39%	30%	
Carbamazapine: CBC	92%	79%	81%	50%	67%	61%	64%	78%	64%	64%	63%	44%	
Carbamazapine: CMP	92%	88%	75%	45%	68%	56%	61%	79%	62%	58%	67%	41%	
Carbamazapine: Med Consent	92%	88%	91%	90%	69%	93%	60%	76%	67%	79%	85%	75%	
Clozapine: AIMS	94%	87%	85%	82%	76%	89%	78%	83%	83%	92%	90%	89%	
Clozapine: Blood Pressure	-	-	68%	65%	80%	100%	97%	97%	100%	100%	100%	100%	
Clozapine: Blood Sugar	100%	100%	78%	78%	46%	75%	56%	70%	64%	100%	100%	100%	
Clozapine: CBC	98%	98%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	
Clozapine: CMP	100%	100%	81%	86%	60%	88%	48%	70%	64%	76%	72%	80%	
Clozapine: EKG	94%	92%	64%	72%	53%	88%	59%	82%	64%	86%	83%	77%	
Clozapine: Height	-	-	63%	59%	57%	100%	79%	88%	89%	100%	100%	96%	

Please direct questions or feedback to [redacted]

Report run: 6/12/2018 4:13:48 PM

MAPIP DASHBOARD - *Trended View*

Statewide

April 2018

Statewide Comparison | **Trended View** | MAPIP Specifications

DIAGNOSTIC MONITORING	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	12 mo. Trend
Clozapine: Lipid Monitoring	99%	97%	78%	70%	46%	83%	45%	63%	64%	64%	81%	65%	
Clozapine: Med Consent	95%	93%	69%	85%	56%	100%	81%	82%	92%	78%	92%	100%	
Clozapine: Thyroid Monitoring	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Clozapine: Weight	-	-	68%	59%	83%	100%	87%	97%	97%	100%	100%	100%	
Depakote: CBC with Platelets	96%	96%	73%	73%	70%	70%	71%	67%	68%	71%	76%	74%	
Depakote: CMP	96%	97%	70%	72%	69%	68%	63%	64%	62%	67%	74%	72%	
Depakote: Depakote Level	93%	93%	54%	61%	59%	62%	51%	58%	51%	56%	68%	60%	
Depakote: Med Consent	90%	90%	79%	79%	85%	84%	70%	75%	83%	84%	86%	84%	
Lamotrigine: Med Consent	-	-	87%	79%	77%	85%	78%	72%	78%	69%	83%	76%	
Lithium: Creatinine & BUN	99%	98%	78%	71%	80%	72%	70%	79%	67%	76%	77%	79%	
Lithium: EKG	88%	89%	38%	42%	50%	40%	39%	42%	42%	33%	43%	50%	
Lithium: Lithium Level	96%	95%	71%	69%	75%	68%	64%	67%	58%	72%	69%	72%	
Lithium: Med Consent	91%	93%	81%	85%	87%	87%	81%	76%	83%	86%	93%	88%	
Lithium: Thyroid Monitoring	93%	91%	77%	76%	76%	70%	68%	78%	66%	75%	71%	72%	

MAPIP DASHBOARD - *Trended View*

Statewide

April 2018

Statewide Comparison | Trended View | MAPIP Specifications

MEDICATION MANAGEMENT	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	12 mo. Trend
02A Medication Order Processing - Dental Stock	100%	100%	100%	100%	100%	100%	88%	96%	97%	97%	97%	-	
02B Medication Order Processing - Routine Orders No Dental Stock KOP	83%	100%	72%	100%	96%	100%	100%	93%	92%	96%	92%	-	
02B Medication Order Processing - Routine Orders No Dental Stock NA/DOT	93%	84%	88%	87%	88%	77%	84%	88%	83%	83%	79%	-	
02C Medication Order Processing - Same Day Orders No Dental Stock KOP	100%	100%	99%	99%	99%	100%	100%	99%	98%	99%	98%	-	
02C Medication Order Processing - Same Day Orders No Dental Stock NA/DOT	84%	83%	84%	79%	78%	82%	83%	80%	78%	80%	79%	-	
04 Continuity of Meds Upon Arrival at RCs	62%	59%	54%	38%	42%	55%	51%	50%	51%	54%	60%	-	
05 Continuity of Meds Upon Inter-Institutional Transfer at R&R	80%	82%	82%	81%	81%	81%	81%	82%	82%	83%	84%	-	
06 Continuity of NA/DOT Meds with Intra-Institutional Transfers (Excluding ASU/SHU/PSU)	85%	83%	83%	83%	82%	84%	82%	81%	82%	83%	83%	-	
07 Continuity of Meds: Mental Health Crisis Bed (MHCB) Transfers	86%	82%	81%	78%	84%	82%	79%	82%	81%	81%	84%	-	
08 Continuity of Meds with Intra-Institutional Transfers to ASU/SHU/PSU	85%	86%	85%	86%	87%	84%	84%	85%	87%	88%	88%	-	
09 Continuity of Meds: Discharge/Transfer from a Community Hospital and/or DSH	87%	85%	90%	87%	81%	81%	89%	90%	88%	87%	86%	-	
10 Continuity of Meds Upon Parole/Transfer to Community	-	-	-	-	89%	77%	-	76%	87%	71%	49%	-	
12 Medication Compliance with PC 2602, Involuntary Meds: Court Order	50%	50%	58%	48%	65%	71%	69%	72%	69%	73%	73%	-	
12 Medication Compliance with PC 2602, Involuntary Meds: Med Order	44%	24%	64%	51%	72%	87%	83%	83%	82%	91%	89%	-	
18A Observation of Medication Preparation and Administration: HS	91%	92%	91%	92%	91%	89%	83%	86%	87%	87%	87%	-	
18B Observation of Medication Preparation and Administration: AM PM	72%	83%	83%	82%	81%	78%	76%	75%	73%	73%	72%	-	
20 Medication Admin: Chronic Care Medications Historical Administration (Psychiatrist)	93%	94%	95%	94%	94%	92%	90%	91%	90%	91%	90%	-	
21 Medication Admin: Chronic Care Medications Historical Administration (Medical Provider)	75%	77%	78%	76%	81%	76%	75%	85%	85%	86%	87%	-	
22 Medication Admin: Outpatient Provider New Medication Orders (Psychiatrist)	90%	90%	91%	90%	88%	89%	85%	89%	89%	88%	87%	-	
23 Medication Admin: Outpatient Provider New Medication Orders (Medical Provider)	63%	65%	67%	65%	68%	53%	56%	80%	81%	82%	85%	-	
24 Medication Administration: Prescribed TB Medications	88%	86%	88%	89%	88%	86%	87%	89%	91%	94%	94%	-	
DIAGNOSTIC MONITORING	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**12 mo. Trend**
Antidepressants: EKG (Tricyclics)	100%	80%	9%	19%	39%	31%	36%	0%	18%	36%	33%	30%	
Antidepressants: Med Consent	92%	92%	84%	81%	80%	83%	72%	74%	83%	77%	84%	85%	

Please direct questions or feedback to [redacted]

Report run: 6/12/2018 3:58:17 PM

MAPIP DASHBOARD - *Trended View*

Statewide

April 2018

Statewide Comparison | Trended View | MAPIP Specifications

DIAGNOSTIC MONITORING	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	12 mo. Trend
Clozapine: Lipid Monitoring	99%	97%	78%	70%	46%	83%	45%	63%	64%	64%	81%	65%	
Clozapine: Med Consent	95%	93%	69%	85%	56%	100%	81%	82%	92%	78%	92%	100%	
Clozapine: Thyroid Monitoring	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Clozapine: Weight	-	-	68%	59%	83%	100%	87%	97%	97%	100%	100%	100%	
Depakote: CBC with Platelets	96%	96%	73%	73%	70%	70%	71%	67%	68%	71%	76%	74%	
Depakote: CMP	96%	97%	70%	72%	69%	68%	63%	64%	62%	67%	74%	72%	
Depakote: Depakote Level	93%	93%	54%	61%	59%	62%	51%	58%	51%	56%	68%	60%	
Depakote: Med Consent	90%	90%	79%	79%	85%	84%	70%	75%	83%	84%	86%	84%	
Lamotrigine: Med Consent	-	-	87%	79%	77%	85%	78%	72%	78%	69%	83%	76%	
Lithium: Creatinine & BUN	99%	98%	78%	71%	80%	72%	70%	79%	67%	76%	77%	79%	
Lithium: EKG	88%	89%	38%	42%	50%	40%	39%	42%	42%	33%	43%	50%	
Lithium: Lithium Level	96%	95%	71%	69%	75%	68%	64%	67%	58%	72%	69%	72%	
Lithium: Med Consent	91%	93%	81%	85%	87%	87%	81%	76%	83%	86%	93%	88%	
Lithium: Thyroid Monitoring	93%	91%	77%	76%	76%	70%	68%	78%	66%	75%	71%	72%	