CALIFORNIA HEALTH CARE FACILITY

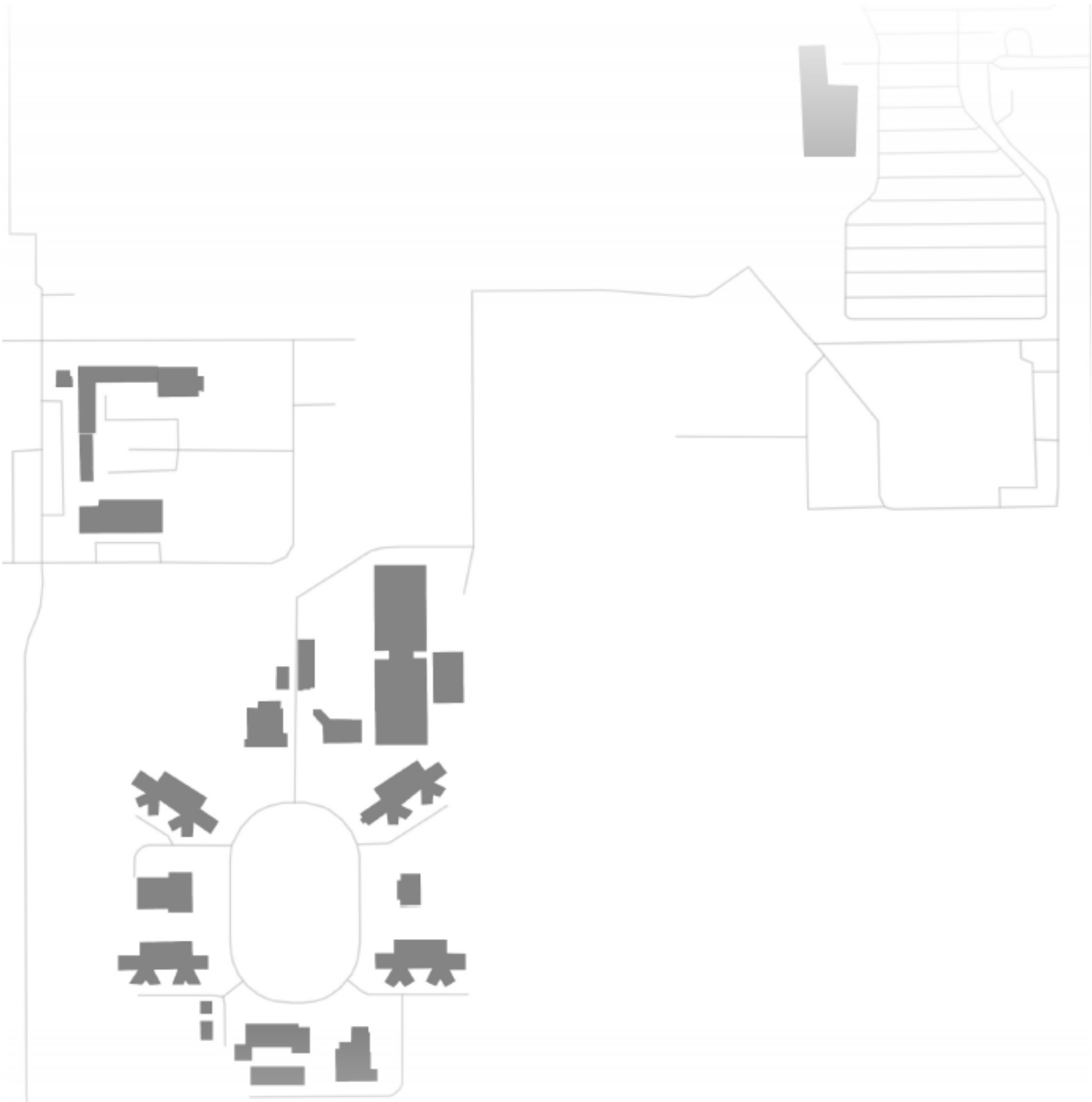
Review Period: Nov 2025 – Apr 2026

Onsite: June 15 – 19, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



CALIFORNIA HEALTH CARE FACILITY

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Background

In 1990, a class of incarcerated individuals with serious mental disorders filed a federal lawsuit alleging that mental health care in California state prisons was constitutionally inadequate. Coleman v. Wilson, No. 2:90-cv-0520 (E.D. Cal.), now known as Coleman v. Newsom. The case remains active.

Following a trial, the U.S. District Court for the Eastern District of California issued findings in September 1995 identifying systemic deficiencies in the delivery of mental health care across the prison system. The court concluded that these deficiencies, including inadequate screening and access to care, insufficient staffing and training, deficient medication management practices, incomplete medical records, and shortcomings in suicide prevention, constituted deliberate indifference in violation of the cruel and unusual punishment clause of the Eighth Amendment to the Constitution. The court further found that disciplinary and housing practices failed to adequately account for the mental health needs of incarcerated individuals. 912 F.Supp. 1282.

To remedy these violations, the court approved a comprehensive plan for mental health care delivery, now set forth in the Mental Health Services Delivery System (MHSDS) Program Guide (Program Guide), and appointed a Special Master to monitor compliance.

Over the ensuing decades, CDCR undertook efforts toward compliance with the court's remedial orders. However, in 2025, the court determined that critical components of the ordered remedy had not been durably implemented. Effective September 1, 2025, the court appointed a Receiver with authority over implementation of the outstanding remedial requirements. Among the Receiver's core responsibilities is the establishment and implementation of an effective quality assurance and improvement system.

To that end, a comprehensive quality measurement framework has been developed over the course of several years with input from the parties, the Special Master, and the court. This comprises over 250 provisional Key Performance Indicators (KPIs) designed to assess each institution's compliance with the court-ordered remedy. Approximately 150 of these indicators are automated, drawing data from electronic health records and other operational databases on a continuous basis. The remaining approximately 100 indicators require onsite data collection utilizing the Continuous Quality Improvement Tool (CQIT), including direct observation of treatment delivery, assessment of treatment environments, and interviews with clinical and custody staff and patients.

As the court has explained, CQIT is central to the transition toward self-monitoring and the durable implementation of constitutionally adequate mental health care: "[T]he key indicators in CQIT signify the material provisions of the Program Guide and the Compendium that must be durably implemented in order to satisfy the Eighth Amendment." August 25, 2021, Order, ECF No. 7283 at 4 (internal quotations omitted).

During 2026, the Receiver is field-testing CQIT and all other remediated indicators in what is being termed a "CQIT+ audit" at approximately two dozen institutions. The purpose of this testing phase is to determine whether the indicators function as intended and yield the information necessary to reliably assess compliance. Following this evaluation, the Receiver is charged with recommending a final set of indicators to the court.

Goals

The Receiver's overarching goals in implementing CQIT+ are to assess compliance with Program Guide requirements and build CDCR's capacity to monitor and sustain the quality of its own mental health care delivery. The latter is a prerequisite for durable reform and, ultimately, for the resolution of this case.

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and effective practices across the system. Where an institution demonstrates strength in a particular area, those practices will be documented and shared so that other facilities can learn from and adopt them.

Approach to Assessing Compliance

The Receiver's site visits integrate the CQIT tool with additional quality assurance activities, including reviews related to level-of-care placement and suicide prevention. The Receiver designed this integrated approach to provide a comprehensive picture of each facility's performance which "will allow her to implement targeted remedial measures soon after identifying noncompliance." ECF 8842 at 3. Moreover, this approach provides facility leadership with specific, actionable information in a single report while reducing the overall burden that multiple separate audit processes have imposed in the past.

Audits are conducted by the Receiver's Compliance Team (RCT), which is composed of independent subject-matter experts, regional clinical experts, and staff from the Office of the Receiver. This blended team reports to the Receiver's Senior Advisor for auditing and compliance. This approach enables the Receiver to exercise independent review of institutions while "assessing transfer of the knowledge and skill sets required to conduct internal auditing and maintain durability." ECF 8842 at 4.

During onsite visits, the RCT takes a collaborative, multi-method approach to assessing compliance and identifying strengths and areas for improvement. In addition to collecting data for the CQIT indicators, the team cross-references automated data that has been collected over time against direct onsite observations. The RCT also examines staff workflows to verify that the operational processes generating automated data are functioning as intended. To gain a fuller picture of institutional performance, the team conducts interviews with both clinical staff and patients. Throughout the visit, the RCT members work diligently to understand why an institution may not be in compliance on a specific issue. This enhances the report findings and recommendations and will enable the Receiver to address broad themes and issues that require her attention.

Prior to arriving at each facility, an onsite audit schedule is created to ensure all areas are audited. The RCT reviews information about previously identified compliance concerns so the team can assess the status of those issues onsite. If critical issues are observed during the audit, the team addresses them in real time. Each day, the RCT convenes a team huddle to discuss emerging themes, identify areas where additional information is needed, and resolve any differences in assessment. At the conclusion of the visit, every RCT member who is on site drafts a summary of their overall observations for use in report drafting.

Using all this information, the process of drafting the audit report uses a report framework developed under the Senior Advisor's leadership. The RCT team leads confer frequently with other team members to ensure the accuracy of all information included in the report. Reports reflect the team's combined expertise and are intended to help institutional leadership prioritize issues and improve performance. Draft reports are reviewed and approved by several members of the Receiver's team, including the Senior Advisor and the Deputy Receivers. The Receiver reviews and approves final reports for issuance.

This report is organized into thematic sections, each presenting both the automated KPI data and the audit team's onsite findings for that domain. In some sections, readers will observe that the automated data reflects high compliance while the onsite findings identify significant concerns, and the recommendations that follow may appear to conflict with the data table. Where the data and onsite observations diverge, the report presents both transparently so that the nature and extent of the gap is visible.

Institutional leadership is responsible for developing a corrective action plan to address the high-priority recommendations identified in the executive summary of each report within 30 days of its issuance. The facility is also responsible for acting on the remaining recommendations, and the RCT will assess the steps taken to address them on the following CQIT visit. Leadership is then responsible for implementing those plans and certifying their completion. Throughout this process, the Senior Advisor and other members of the RCT are actively involved in reviewing plans and tracking implementation. Moreover, the Senior Advisor is developing a process to confirm that recommendations have been implemented in a way that achieves compliance and that institutions maintain compliance in those areas. All of these actions are designed to ensure that these reviews drive measurable changes, rather than producing a document that goes unread.

Methodology

Data Foundation

A central prerequisite to implementing CQIT has been the completion of a court-ordered data remediation process. Beginning in 2019, the court directed a comprehensive review of CDCR's data collection and reporting practices to ensure the reliability and accuracy of the compliance data used in this case. The court subsequently ordered CDCR to undertake data remediation and validation of its mental health data management system, noting "CQIT cannot be implemented until the data on which it depends can be validated and verified." August 25, 2021, Order, ECF No. 7283 at 6.

The data remediation process has involved systematic validation of the electronic data sources that feed the automated indicators, including verification that the clinical and operational data recorded, and that accurate calculation rules are applied, consistent with Program Guide requirements. A majority of this work was conducted under the supervision of the Special Master and with input from all parties in the case.

As a result, each indicator used in this report draw on data infrastructure that has been subject to this multi-year remediation and validation process. The Receiver's 2026 field-testing phase includes ongoing assessment of whether the validated data sources are producing reliable results at the institutional level.

Data Collection

Compliance data is collected through two primary methods. Automated indicators (approximately 150 of the over 250 total KPIs) draw data from electronic health records, operational databases, and other systems used in day-to-day operations. This data is collected continuously throughout the year and is available for review prior to and during onsite audits. Onsite CQIT indicators (approximately 100 KPIs) require data collection at the institution by the RCT through direct observation of treatment delivery, assessment of treatment environments, review of clinical documentation, and interviews with staff and patients.

During onsite audits, the RCT cross-references automated data against direct observations to assess consistency and identify discrepancies. The team also examines the operational workflows that generate automated data to verify that the underlying business processes are functioning as intended and producing accurate results.

Interpreting This Report

Each KPI in this report is presented with a percentage reflecting the proportion of cases, events, or observations that met the applicable standard. The following conventions are used throughout this report:

- A dagger symbol (†) indicates a small sample size (N < 20). Results based on small samples should be interpreted with caution, as they may not reliably represent overall institutional performance.
- The notation "i" designates an inverse indicator, where a lower percentage reflects better performance. To incorporate inverse indicators into aggregate compliance scores, the individual KPI percentage is subtracted from 100 (e.g., 100 – 2% = 98% compliance).
- Indicators that do not have a specified compliance threshold are excluded from the calculation of aggregate compliance scores.
- Blank boxes in the summary tables are the result of those indicators not being applicable to the institution or program being audited, or data unavailability.

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During early audits, several indicators were identified as producing unreliable results due to technical issues. These

indicators have been excluded from this report while we work to resolve the issues and can be found in Appendix E.

Compliance Color Coding

The compliance thresholds and associated color coding used in this report reflect thresholds that were established prior to the court-ordered data remediation process and prior to the Receiver's appointment. Their use in the 2026 reports does not constitute an endorsement of these thresholds by the Receiver as the final standard for assessing compliance. Like the CQIT indicators themselves, the Receiver will be evaluating them during the 2026 field-testing phase. The Receiver will include proposed compliance thresholds when she submits recommended final indicators to the court. The thresholds in this report are defined as follows:

Color	Compliance Percentage Range
Green	≥ 89.5%
Yellow	≥ 74.5% and < 89.5%
Red	< 74.5%
Blue	No compliance threshold

Recommendations

The recommendations in this report are directed at the institution. As a result, they address deficiencies that institutional leadership has the authority and operational capacity to resolve. These include clinical supervision practices, scheduling workflows, documentation quality, staff training, internal communication protocols, and custodial procedures such as welfare check compliance and procurement. The Receiver expects institutional leadership to take action to respond to these recommendations.

Certain deficiencies are driven by structural conditions that exceed the institution's capacity to remedy independently. These include statewide shortages of designated RHU EOP beds, insufficient physical infrastructure for group treatment, and systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. Where the report identifies a structural barrier, the Receiver will take the lead in developing and implementing a resolution, whether through infrastructure investment, population management, policy revision, or coordination with CDCR and DSH leadership. Institutional leadership is not expected to solve problems it does not control, but it is expected to maximize compliance within existing constraints and to document and escalate structural barriers through the channels the Receiver's office establishes.

Where a recommendation touches both domains, for example, maximizing the use of existing treatment space (institutional) while also requesting capital investment for additional space (systemwide), the report identifies the institutional component as a near-term action item and the structural component as an issue the Receiver will address.

Executive Summary

California Health Care Facility (CHCF) is a large, multi-mission institution primarily designated for individuals who are incarcerated and require acute or chronic medical and mental health services. The facility also includes a Mainline (ML) Level II yard. CHCF delivers the full spectrum of mental health care, including Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), Acute Psychiatric Inpatient Program (APP), and Intermediate Care Facility (ICF).

Facility	Program	Mental Health Level of Care Served
A yard	MHCB, Prison Work Crew (PWC)	MHCB, GP, CCCMS
B yard	Psychiatric Inpatient Program (PIP)	Acute, ICF
C yard	Outpatient Housing Unit (OHU)	GP, CCCMS, EOP
D yard	Correctional Treatment Center (CTC), Assisted Living Outpatient Housing Unit (ALOHU), Alternative Housing (ATH)	GP, CCCMS, EOP, ICF, Acute, MHCB
E yard	ML, Restricted Housing Unit (RHU)	GP, CCCMS, EOP

Strong performance in several core areas of clinical operations was identified. Access to care indicators demonstrated high timeliness in emergent, urgent, and routine referrals, as well as strong compliance with RHU EOP daily contacts and timely transfers to higher levels of care. Psychiatry showed strengths in diagnostic monitoring performance, exceeding statewide averages for multiple measures. Suicide prevention efforts were bolstered by highly collaborative RHU huddles, strong SPRFIT functioning, near universal completion of required training, and consistent safety planning practices in reviewed cases. Additional strengths were observed in comprehensive IDTTs within MHCB and RHU, and adequate justification for MHCB referral rescissions. Overall, patients report satisfaction with the mental health services provided, and staff morale remains high, notwithstanding the complexity of missions at CHCF.

Despite these strengths, significant deficiencies exist across multiple domains. Access to care performance was hindered by inadequate primary clinician and psychiatry contacts, chronic shortfalls in required treatment hours in ML EOP and PIP, inconsistent use of interpreters, and barriers to maintaining confidentiality during treatment sessions. Psychiatry exhibited substantial gaps in timely contacts, medication nonadherence responses, and required diagnostic monitoring for mood stabilizers. Suicide prevention deficiencies included inconsistent SRE mentoring, incomplete risk documentation in SRMP treatment plans, improper use of holding cell forms, and inconsistent clinician evaluations for patients on suicide precautions in the PIP. Patient care concerns included variable IDTT quality in PIP and EOP settings, resulting in insufficient safety assessments during IDTT, inconsistent collaboration, and unmet staffing benchmarks for IDTT participation.

Across domains, several themes emerged: workflow and procedural reliability are more impactful barriers than staffing. There are several areas with adequate staffing but persistent gaps associated with processes, documentation accuracy, and scheduling systems. Communication breakdowns among clinicians, schedulers, custody staff, and interdisciplinary teams—contributed to gaps in out-of-cell access, treatment planning, timely completion of required contacts, and appropriate use of forms and documentation. Collectively, these themes indicate the need for more reliable operational processes, strengthened quality assurance structures, and greater consistency in implementing established clinical and procedural expectations.

Priority Recommendations

1. **Ensure Timely Clinical Contacts and Enhance Structured Treatment Hours:** During the review period, primary clinician contacts were completed in accordance with required standards 64% of the time. Psychiatry contacts demonstrated a lower rate of 38%. Timely Psychiatry responses to medication non-adherence notifications averaged 11% for critical medications and 43% for non-critical medications over six months. Structured treatment opportunities in both PIP and non-PIP settings consistently fell below the minimum requirements throughout the review period. Although the PIP provided both core and supplemental treatment, the required minimum hours of treatment were not regularly offered to patients. On average, 1% of patients were offered at least 20 hours of programming, including a minimum of 10 hours of core treatment hours. The ML EOP program similarly did not consistently deliver the required number of treatment hours; only 54% of mainline EOP patients were offered the minimum 10 hours of treatment. Current psychiatrist staffing vacancy rates are at 0%, so staffing shortages do not appear to be driving the gaps in timely psychiatry contacts. Vacancies among psychologists for the inpatient units and specialized areas are at 21%, with the vacancies concentrated in the PIP, which has about 75% of its beds currently full. The vacancy rate for primary clinicians is 32%.

   Establish clear procedural guidelines and regular audits for clinical contacts to address gaps in primary clinician and psychiatry contacts. To ensure consistent and efficient psychiatric care, conduct a review of timely psychiatry contacts, including timely and accurate closure of appointments to ensure data accuracy. Identify factors contributing to delays in responding to medication non-adherence notifications. Ensure that patients in PIP and ML EOP are offered the required treatment hours by expanding group offerings, including clinician-led groups and adjusting scheduling practices as needed.

2. **Maintain Confidentiality of Treatment Space:** Two observed group sessions were conducted with the door open, resulting in a lack of confidentiality for participants. Onsite observation also revealed that an RHU GP screening was conducted without adequate confidentiality; the door remained open. Also, custody officers should not be present during mental health groups or confidential treatment unless serving as certified translators or attending based on a specific security need. When present in treatment, custody officers have a duty to protect patient information.

   Implement a facility-wide standard requiring closed doors for all treatment sessions including but not limited to groups and screenings. Limit custody presence in group treatment and screenings to officers present for approved purposes, such as certified translators.

3. **Strengthen Suicide Prevention Documentation Quality and Communication Strategies in High-Risk Areas:** Suicide prevention documentation was below benchmarks throughout the review period. Chart reviews of patients who experienced emergent and urgent referrals during the review period revealed instances where potential self-harm or intentional overdose was indicated but not explicitly documented as the reason for referral; the required suicide risk assessment (SRE) was completed in 73% of these cases. Of the reviewed master treatment plans for patients enrolled in the suicide risk management program (SRMP), 60% had comprehensive risk documentation addressing the reason for the patient's placement in the SRMP. Clinical follow-ups had a completion rate of 67% over the audit period. In the PIP, 50% of the patients on suicide watch or suicide precaution did not have the required clinical contacts, resulting in orders for observation status being entered without corresponding assessments. Additionally, several patients were discharged from suicide observation without receiving an evaluation from a clinician. For patients placed in temporary holding cells, CHCF was using a non-CDCR authorized "Holding Cell Log" form, which lacked a section for documenting the reason for placement. There was limited access to out-

of-cell activities in MHCB due to a communication breakdown; only 31% of patients housed in MHCB during the onsite audit were offered the required minimum of out-of-cell activities.

Require clinical staff to develop comprehensive risk documentation for every patient, ensuring that interventions and goals directly address the reasons for SRMP placement. Conduct supervisory reviews of SRMP-related treatment plans. Ensure SREs are completed consistently for all applicable referrals. Implement a protocol in which no patient may be discharged from suicide watch or have orders entered without a documented clinician evaluation. Implement the use of the authorized CDCR holding cell log form to facilitate accurate recordkeeping. Improve communication between the IDTT and the housing unit staff, to relay all approved out-of-cell activities; update orders for privileges to include both yard and dayroom, thereby expanding out-of-cell opportunities for MHCB patients.

4. **Implement a Structured IDTT Quality Improvement Initiative:** Only 29% of observed IDTTs demonstrated an interactive process. Instances of misinformation regarding level of care, least restrictive housing, and referrals to the Department of State Hospitals being provided to patients in the PIP's acute and intermediate levels may have adversely affected patient care. There was limited discussion regarding safety planning and self-harm assessments were not conducted when patients reported self-harm during IDTT.

   Implement targeted training for IDTT members and program supervisors in PIP, ML EOP, and CCCMS to promote integrated, collaborative treatment planning and improve communication. Establish routine leadership reviews of IDTT meetings to ensure accurate information is shared with patients and that self-harm assessments are conducted thoroughly when concerns arise. Standardize the process of offering or providing patients with copies of their treatment plans during or immediately after IDTT meetings to increase transparency and patient engagement.

Institution's Operational Perspective

CHCF has implemented a number of improvements to support patients and staff and increase compliance with Program Guide requirements during the review period.

Staffing and Onboarding

Staffing levels at CHCF have shown significant improvement throughout 2025, and into the first quarter of 2026. The facility is nearing full capacity across many direct care provider classifications. Outside the PIP, psychiatrists, psychologists, social workers, and recreation therapists are fully staffed, while primary clinician positions are currently filled at 73%.

With enhanced staffing, outpatient programs have successfully eliminated all modifications to the Program Guide, allowing for comprehensive implementation of treatment timelines and compliance standards. The first quarter of 2026 demonstrated substantial progress in metrics related to Mental Health Primary Clinician (MHPC) Contacts and IDTT Timelines, while the timeliness of referrals remained above benchmark.

Given the influx of new staff, including a considerable number of unlicensed personnel, CHCF has extended its onboarding process to cover much of the probationary period. Newly hired staff participate in multiple training courses and unlicensed staff are provided clinical supervision. Additionally, all employees with less than six months of service attend a monthly meeting with leadership, offering opportunities for support, collaboration, and connection with other recent hires.

Quality Management

In January 2026, mental health support personnel were assigned to work collaboratively with supervisors to conduct audits aimed at enhancing program management. This joint effort has led to increased compliance rates, and both clinical staff and supervisors have gained a more comprehensive understanding of data tracking processes, including the identification of triggers and the requirements for fulfillment necessary to accurately document activities across multiple reports.

Clinical Services and Programming

Mental Health has instituted continuous coverage for emergent response efforts. This enables timely intervention during crises, supporting patient stability and delivering ongoing support throughout critical situations. This provides continuous coverage for emergent response needs and supports timely intervention during crises.

The RHU EOP program has maintained certification throughout the past year, following its opening in April 2025. CHCF continues to meet the requirements for the monthly RHU EOP hub certification.

In May 2026, CHCF received clarification regarding weekend huddle requirements for inpatient units, resulting in the identification of a gap in compliance with the Custody and Mental Health Partnership Plan (CMHPP). Remedial measures have been implemented, and the required weekend huddles began in June 2026.

Access to Care

This section examines whether patients initiate and sustain meaningful contact with mental health services across custody settings, levels of care, and transition points. Effective access has several dimensions: contact must be timely, communication confidential and clinically effective, scheduling and transfer processes reliable, treatment appropriate to need, and the physical environment adequate to the encounter. The subsections below assess each in turn: Confidential and Effective Communication; Timely Access; Timely Transfers; Appointments; Treatment Offered; and Treatment Environment (formally Facility and Environment of Care), measuring whether patients receive care of the frequency, timeliness, and clinical adequacy the Program Guide requires, in spaces that protect confidentiality, safety, and dignity.

Confidential and Effective Communication

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Effective Communication Achieved	95%	95%	96%	95%	95%	96%	95%
Group treatment in a confidential setting	67%	69%	69%	72%	65%	64%	68%
IDTTs in a confidential setting	98%	99%	99%	97%	97%	96%	98%

Timely Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Daily PC Interactions – RHU EOP High Refusers	99%	100%	100%	99%	99%	100%	99%	
IRU Reviews Completed Timely	33%†	100%†			100%†	100%†	71%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	25%†	38%†	20%†	33%†	33%†	0%†	27%	
RC MH Screens						50%†	50%†	
RHU GP Screens				100%†	100%†	100%†	100%†	
RHU Pre-Screen	85%	82%	56%†	67%†	87%	76%	78%	
Timely IDTTs (v2.0)	78%	82%	78%	87%	87%	88%	83%	
Timely MH Referrals (v2.0)	91%	89%	91%	94%	92%	93%	92%	
Timely MHMD Contacts (v2.0)	31%	36%	37%	39%	40%	46%	38%	
Timely PC Contacts (v2.0)	49%	62%	64%	69%	67%	74%	64%	
Custody MH Referrals								97%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	16%	3%	0%	0%	5%	3%	4%
Timely Transfer to MHCB (v2.0)	100%†	95%	89%†	100%†	92%	88%†	93%
Timely Transfers to EOP (v2.0)		100%†		100%†	100%†		100%†
Timely Transfers to PIP	83%	100%	94%	97%	100%†	100%	96%
Timely Transfers to RHU CCCMS	100%†		0%†		100%†	33%†	56%†

Appointments

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	6%	7%	20%	15%	12%	18%	12%
Scheduled MH Appointments Completed or Refused	58%	61%	72%	66%	64%	74%	66%

Least Restrictive Housing

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
PIP ICF Patients Housed Outside of their LRH	32%	37%	39%	41%	42%	41%	40%

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	100%
Adequate IDTT Spaces	94%
Adequate Individual Treatment Spaces	89%

Treatment Offered

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Treatment Offered (Core and Supplemental): PIP	0%	1%	0%	1%	2%	1%	1%
Treatment Offered (Core and Supplemental): PIP Evaluation Period	0%	0%	0%	0%	0%	0%	0%

Treatment Offered (Specified Core Subset and Supplemental): PIP	0%	0%	0%	0%	0%	0%	0%
Treatment Offered (Specified Core Subset and Supplemental): PIP Evaluation Period	0%	0%	0%	0%	0%	0%	0%
Treatment Offered (Structured): non-PIP	37%	55%	57%	60%	66%	50%	54%

Space-by-Space Assessment

Space/Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	**IDTT**	28	26	No conference table (N=2)
	Group	4	4	
	Individual	74	67	Space is not safely configured as treatment space, giving patients access to equipment that can be inappropriately used and the patient chair in an area blocking the egress route (N=7)
ML EOP	**IDTT**	5	4	Insufficient seating (N=1)
	Group	9	9	
	Individual	13	11	
RHU EOP	**IDTT**	1	1	
	Group	3	3	
	Individual	5	5	
MHCB	**IDTT**	2	2	
	Individual	5	5	
ACUTE	**IDTT**	5	5	
	Group	15	15	
	Individual	25	23	Space not safely configured as treatment space with the egress route blocked by equipment(N=2)
ICF	**IDTT**	9	9	
	Group	27	27	
	Individual	45	38	Patients sitting outside room can see into treatment compromising confidentiality

				(N=6); could hear easily from room adjacent (N=1)
TOTAL	**IDTT**	50	47	
	Group	58	58	
	Individual	167	148	

✓ **Strengths**

Timely mental health referrals were completed within required timeframes throughout the review period: Emergent, urgent, and routine referrals to primary clinicians and psychiatrists were completed within required timeframes at 89% or higher, with an average compliance rate of 92%.

Treatment provided in the RHU was consistently provided at high rates: Daily PC interactions for RHU EOP high refusers demonstrated an average completion rate of 99% over six months. During the review period, daily contacts with RHU EOP high refusers consistently ranged from 99% to 100%. The average rate of treatment offered was 99%.

Timely transfers to higher levels of care: Patients transferring to MHCB, EOP, and PIP achieved an average timely transfer rate of 93% or higher, based on the six-month average across all transfer types.

Treatment spaces are appropriately allocated throughout the facility: The facility has designated treatment spaces that were observed to be well-ventilated, clean, and appropriate for confidential patient care. During the onsite audit, certain treatment spaces were observed being used as staff offices for non-healthcare personnel; if these areas are required for treatment purposes, they should be reconfigured to be safe for clinical treatment.

RHU GP screens were completed within required timeframes across the review period: GP screens were consistently completed within the required timeframe throughout the review period.

⚠ **Concerns**

Clinical contacts across disciplines were frequently below required performance thresholds: MHPC contacts were completed within required timeframes 64% of the time during the review period. Improvements in staffing have coincided with better timeliness of MHPC contacts, which began trending upward at the end of the review period. Psychiatry contacts were completed in compliance with required timeframes 38% of the time. Further review found that randomly sampled patients housed in the PIP and labeled as not meeting the required contact standard had documented psychiatric encounters, but data entry errors in the resolution of the orders for clinical contact caused these contacts to be excluded from compliance counts. This suggests that actual psychiatry contacts may be higher than the data indicates. Interdisciplinary Team Treatment (IDTT) meetings showed improvement, with compliance rates rising to 87% in March and 88% in April, though the overall average compliance for IDTTs during the review period was 83%. Current psychiatrist staffing vacancy rates are at 0%, so staffing shortages do not appear to be driving the gaps in timely psychiatry contacts. Vacancies among psychologists for the inpatient units and specialized areas are at 21%, with the vacancies concentrated in the PIP. Currently around 310 of the 415 active PIP beds at CHCF are in use, so the impact of these vacancies should be limited, but treatment access issues persist.

RHU pre-screen compliance demonstrated variability throughout the review period: The average rate of timely RHU pre-screen completions was 78%, with monthly completion rates fluctuating from a low of 56% to a high of 87%.

Treatment offered was deficient across programs: Treatment offered in the PIP and EOP did not meet minimum requirements for any month within the review period. In the PIP, the required minimum hours of treatment were not consistently offered to patients. During the review period an average of 1% of patients were offered at least

20 hours of treatment, including at least 10 hours of core treatment. The EOP program also did not provide the required number of treatment hours consistently; 54% of ML EOP patients were offered the minimum10 hours of minimum treatment. Currently, ML EOP patients have limited access to clinician-led group therapy, with the only exception being the START NOW group. This lack of clinician-led groups limits the range of clinician-led treatment options available to these patients. To address this issue, CHCF leadership is implementing a plan to offer more clinician-led group sessions for ML EOP patients.

Inconsistent use of certified interpreters impacts effective communication: During the RHU EOP group session, an interpreter was provided specifically because auditors were present. While effective communication as recorded by staff averaged 95% throughout the review period, this figure may not accurately reflect patient experience if interpreters are not consistently used when required. Regular and appropriate use of certified interpreters is essential to ensure that effective communication is achieved during all clinical interactions.

Remediable confidentiality concerns: During onsite observation of group treatment, two group sessions were conducted with the door open, resulting in a lack of confidentiality for participants. To ensure patient privacy, all group treatment sessions should be held with the door closed. Groups conducted with the door open should be identified as a confidentiality concern and addressed through established supervisory or quality assurance processes.

Increasing group impact: Running multiple groups simultaneously in adjacent treatment spaces can be disruptive, especially when one group is louder than the other, such as when a process group is held next to a recreation group. Onsite auditors observed a group that was disrupted by a louder group next door. The noise from a more boisterous group next door may distract a process group and impact the therapeutic milieu. Efforts should be made to minimize distractions by considering group location, scheduling, and the noise levels of adjacent activities.

Safety and security measures for groups conducted in dining areas require improvement: Clinical staff are not able to secure the dining room doors during group sessions. Clinicians do not have access to the keys required to lock and unlock the dining areas. Additionally, the locking mechanism on the dining area doors cannot be configured to allow the doors to be readily accessed from outside once closed, creating a potential safety and security risk for staff and patients.

Recommendations

1. Ensure Timely Clinical Contacts and Enhance Structured Treatment Hours: See Priority Recommendations.
2. Maintain Confidentiality of Treatment Space: See Priority Recommendations.
3. Establish a tracking and notification system for RHU pre-screening: This system should proactively remind staff to complete pre-screens before SOMS bed placement and regularly generate compliance reports for management review, to enhance completion rates and prevent omissions.
4. Use interpreters whenever necessary: Provide staff with certified language interpreter contact information and train staff on the importance of routine certified interpreter use when indicated; ensure documentation reflects the use of certified interpreters, when applicable, and whether effective communication was achieved.
5. Review groups occurring in adjacent spaces: Conduct a review of the facility's group scheduling and room assignments for sessions held in adjacent spaces. Identify opportunities to schedule similar types of groups (e.g., process groups with process groups, recreational groups with recreational groups) at the same time and in neighboring rooms to minimize distractions.
6. Evaluate the locking system in dining areas used for treatment: Work with plant operations to modify the locking mechanism in dining areas used for treatment to enhance safety and confidentiality in these

spaces. Locks on the dining room areas should be similar to those on group room doors, allowing the lock to be set to unlock.

Custody and Mental Health Partnership Plan

This section evaluates the mechanisms that integrate custody and mental health functions at the institutional level. The custody mental health partnership plan encompasses executive rounding, daily huddles, supervisory meetings, training completion, and patient advisory structures. These mechanisms are designed to ensure that custody and mental health operations are coordinated, that information flows between disciplines, and that incarcerated persons have structured input into the mental health program.

Indicator	Onsite Audits
CMHPP MH Daily Huddles	89%
CMHPP MH Huddle Documentation of Required Attendees	44%
CMHPP MH Huddle Documentation of Supervisor Attendees	39%
CMHPP Monthly Executive Leadership Joint Rounding	100%†
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	100%†
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	100%
Healthcare Staff with CMHPP Annual Training	93%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	83%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings	46%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%†
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	100%†
Quarterly Partnership Round Table Training Completed as Required	85%
Required Staff Attendance of Quarterly Partnership Round Table Training	90%†

✓ **Strengths**

Consistent achievement of collaboration, leadership and oversight requirements: Executive joint rounding components of CMHPP show full engagement by staff, strong interdisciplinary coordination, and consistent supervisory engagement, oversight, and reliability.

High compliance with staff training requirements: CMHPP training indicators reveal strong compliance, demonstrating a robust commitment to competency development, and alignment of goals across both custody and healthcare disciplines.

⚠ **Concerns**

Documentation of attendance is inconsistent for CMHPP huddles: Review of documentation from a random sample of six weeks during the review period demonstrated that institution-wide, CMHPP huddles were documented as occurring in 89% of required instances, just below the compliance threshold. The primary gaps in huddle occurrence were noted during weekends and holidays in inpatient settings. CHCF Mental Health leadership identified this issue prior to onsite review and has implemented a corrective action: beginning in

June 2026, inpatient huddles will be held seven days per week for both shifts. Two huddle-related indicators reflect particularly low performance: documentation of required attendees stands at 44%, and documentation of supervisor attendees is at 39%. To uphold the intent of the collaboration, custody and mental health staff must be present. The low rates of documented attendance raise concerns about whether required cross-disciplinary participation is occurring and whether attendance is being consistently documented.

Inconsistent supervisory meetings and joint supervisory program tours: ML CCCMS CMHPP weekly supervisor meetings were completed 46% of the time during the review period. Regular supervisory engagement is significantly below threshold, which may affect oversight, staff coordination, and timely issue resolution within the CCCMS program. Completion of ML CCCMS and monthly joint supervisory program tours is 83%, which is below the desired level.

Recommendations

1. Ensure accurate and consistent documentation of huddle attendance: Provide training for staff on the attendance requirements for daily huddles and the importance of accurate attendance documentation, emphasizing the role of cross-disciplinary communication, procedural compliance, and oversight. Establish a process for routine supervisory review of huddle occurrence and documentation of required attendees.
2. Improve frequency of supervisory meetings and program tours: Establish a standardized scheduling and tracking system for supervisory meetings and program tours. Assign clear responsibility for weekly meeting coordination.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).[1] MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks the required diagnostic monitoring for psychiatric medications. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	9%	11%†	16%†	7%†	10%	14%	11%	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	49%	35%	37%	59%	41%	41%	43%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								70%

**13% of the MHSDS participants at CHCF have an active PC2602 court order for medication.*

✓ **Strengths**

Diagnostic monitoring is above statewide average: The overall diagnostic monitoring averaged 85% which is above the current statewide average of 84%). Compliance with EKGs for patients on QT prolonging medications

[1] See Appendix B

ranged from 78% to 90% over the reporting period. Timely monitoring of blood pressure, height and weight was evident across multiple medication classes.

⚠ Concerns

Timely responses to medication non-adherence notifications: Timely response to medication non-adherence notifications averaged 11% for critical medications and 43% for non-critical medications over six months. Psychiatry staffing is at 120% of authorized staffing in non-PIP and 97% filled in PIP, suggesting that the necessary staffing to conduct this follow up is available.

Medication monitoring is low across antipsychotics and mood stabilizers: Completion rate of the Abnormal Involuntary Movement Scale (AIMS) for patients prescribed antipsychotic medications was 63%. Lithium level monitoring averaged 49% and Valproic acid therapeutic level monitoring averaged 42%. Both medications have narrower therapeutic windows and require careful monitoring to reduce the potential for toxicity.

Recommendations

1. Review MAPIP measures to ensure adherence to timelines: Ensure timely AIMS completion and conduct a retrospective review of all patients prescribed mood stabilizers (valproic acid and lithium) during the reporting period to confirm that required laboratory monitoring has been completed or is now scheduled. Identify and address the root cause of the monitoring gap, whether it is an ordering failure, a laboratory completion failure, or a documentation/data entry issue. Implement a prospective tracking system for mood stabilizer lab monitoring (e.g., standing lab order review, automated reminder through EHRS) and demonstrate sustained performance at or above 90% across all mood stabilizer monitoring measures.

Patient Safety

This section examines patient safety indicators including heat-related illness prevention, seclusion and restraint events, and the availability of alternative programming during environmental restrictions. Patient safety metrics measure whether institutional protocols protect patients from physical harm, particularly for clinically vulnerable subpopulations such as those prescribed heat-alert medications.

Indicator	Apr 2026	6-Month Avg	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications			0†
Maximum Number Restraint Incidents	1†	1†	
Restraint Duration Incidents Greater than 4 Hours	0%†	0%†	
Restraint Incidents	1†	1†	

✓ Strengths

No heat-related illness occurred for MHSDS patients during the review period: During the reporting period, there were no incidents of heat-related illness among MHSDS patients at CHCF who were prescribed heat alert medications. The onsite audit verified that all custody officers interviewed could clearly explain their duties during a heat alert. The facility's heat plan is up-to-date, meets statewide requirements, and can be accessed at each post.

Minimal use of restraints in MHCB and ICF: There has not been a clinical restraint initiated in MHCB since February 2023. During the review period there was one clinical restraint incident in the Acute program in April 2026. There were no clinical seclusion/restraint events in ICF.

⚠ Concerns

Discrepancies in clinical restraint documentation: During the review period, there was one incident involving clinical restraint in the PIP Acute-Maximum Security Unit. Discrepancies were observed between the recorded end time in the restraint log, the physician's order for terminating the restraint, and the nursing documentation. Additionally, the CHCF restraint log noted a deficiency because the patient's door was kept closed throughout the duration of the restraint episode. The door being closed during the restraint event was not consistent with the 2/27/2026 local operating procedure (LOP), which states, "the door shall remain open to enhance observation while patient is in restraints."

Recommendations

1. Clarify and streamline restraint procedures: Enhance training provided to nursing to emphasize accurate clinical restraint documentation and improvement in communication between nursing and providers. Continue to engage with Headquarters on refining the LOP to address clinical and safety and security concerns with whether the door should be open or closed during a clinical restraint event.

Quality of Care

This section evaluates the clinical quality of treatment planning and documentation, focusing on interdisciplinary treatment team meetings, higher level of care reviews, and the individualization of clinical documentation. Quality of care indicators measure whether the treatment planning apparatus produces individualized, clinically informed plans through interactive process with required participants present.

Care Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	76%	78%	79%	76%	74%	74%	76%	
IDTT Required Staffing	51%	46%	58%	57%	52%	53%	53%	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available								100%
IDTTs with Observed Interactive Process								29%

Documentation

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								49%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								100%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								95%

IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%

✓ **Strengths**

IDTTs in MHCB and RHU were comprehensive: Overall, the MHCB and RHU IDTTs were comprehensive and interactive. Required criteria were met in all but one observed IDTT in each program. Comprehensiveness of the safety planning discussions varied by clinician. In MHCB, the assigned correctional counselor did was an active participant, providing relevant information in all observed IDTTs. IDTTs observed in the RHU consistently stated their purpose, provided complete case formulations, set measurable treatment goals, and discussed progress for routine cases. All IDTTs discussed higher level of care considerations, RVRs, and RVR-MHAs; relevant behaviors from recent RVRs were included in treatment plans as needed. The CCI actively participated, offering helpful insights and answering questions. The psychiatrist contributed diagnostic and medication information, including side effects. Patients were encouraged to join the discussion through open-ended questions and were engaged in the planning process, and each team member was involved in interactive discussions.

⚠ **Concerns**

IDTT attendance by assigned clinicians did not meet the established benchmark: Monthly compliance thresholds for IDTT staffing were not achieved during the review period, and the six-month average compliance was 53%. Although the majority of IDTTs were attended by a complete team of staff, it was common for the designated clinician, psychiatrist, and/or CCI to be represented by alternates.

IDTT quality and supervisory oversight of the process did not meet expectations in the APP, ICF, EOP, or CCCMS: A more integrated and collaborative approach to treatment team discussions would benefit IDTTs, with particular emphasis on thoroughly assessing the appropriate level of care for patients in the APP and ICF programs. During IDTTs observed in ICF, there were instances where patients were provided with incorrect information regarding expectations for treatment planning, including inpatient length of stay and referrals to least restrictive housing. In addition, teams failed to discuss core elements of treatment planning, including the referral reason, case formulation, level of care, measurable treatment goals, diagnosis, and safety planning. There was limited discussion about safety planning in required cases, and self-harm assessments were insufficient when patients reported self-harm during IDTT meetings in both EOP and ICF.

None of the observed IDTTs in the Acute, ICF, or CCCMS programs demonstrated an interactive process in which all participants, including the patient, participated and provided input regarding the treatment plan and goals. Two of nine observed IDTTs for patients at the EOP level of care were collaborative and appropriately interactive; both of these patients were in the OHU program. During patient interviews, multiple patients across programs expressed uncertainty about their treatment plans and requested documentation; offering/providing patients with copies of their treatment plans during or after IDTT meetings could improve transparency and patient understanding. Furthermore, patients indicated that increased collaboration among providers may further improve their overall experience.

Recommendations

1. Implement a Structured IDTT Quality Improvement Initiative: See Priority Recommendations.

RVRs, Sentinel Events, and Specialized Custody

This section reviews rules violation reports, mental health assessments, use-of-force incidents and training, hearing officer integration of clinical input, and behavioral treatment interventions. Sentinel events indicators measure whether the intersection of custody disciplinary processes and mental health services functions as

designed—with timely assessments, individualized documentation, private settings, and meaningful integration of clinical findings into hearing outcomes.

RVRs

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	26%	30%	24%	30%	28%	32%	29%	
RVR MH Assessments where Documentation Requirements were Met	73%†	68%†	100%†	85%	89%†		83%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%†	100%†	100%	95%†		99%	
Timely RVR MH Assessment Request	47%	56%	57%	61%	47%	49%	53%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	83%	83%	96%	77%	90%	95%	87%	
RVR MHAs where Captain Disagreed with Documenting in an Alternative Manner								73%†
RVRs Issued								579†
RVRs Issued to Non-MHSDS Participants								22%
RVRs Issued to Patients at the Acute Level of Care								9%
RVRs Issued to Patients at the CCCMS Level of Care								25%
RVRs Issued to Patients at the EOP Level of Care								27%
RVRs Issued to Patients at the ICF Level of Care								14%
RVRs Issued to Patients at the MHCB Level of Care								3%
RVRs recommended for mitigation that were mitigated								82%†
RVRs Recommended for Mitigation with Custody Documentation								82%†

**MHSDS participants comprise 64% of the population at CHCF.*

Sentinel Events

Indicator	Onsite Audits
Thermometer Checks completed and accurate	100%†

Use of Force

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	100%
Health Care Staff Required to Attend UOF Training	93%
Use of Force Involving MH Patients	98%

✓ **Strengths**

RVR assessments were conducted thoroughly: Comprehensive RVR-MHAs were performed during the review period. The assessing clinicians provided recommendations grounded in mental health considerations. Clinical documentation requirements for RVR MHAs were met in 83% of reviewed cases; these requirements include documentation of the patient's cognitive and adaptive functioning deficits and clinician collaboration with peers and supervisors.

Use of force training completion: Both custody and health care personnel completed the annual use of force training requirements, with 100% of custody staff and 93% of health care staff completing the training.

⚠ **Concerns**

Clinical recommendations regarding alternative documentation of behavior were not consistently reflected in RVR outcomes: In 11 instances, the clinician assessing the patient recommended that behavior be documented using a method other than an RVR. The reviewing Captain disagreed with the clinician's recommendation in 73% of these situations. Three RVRs were reduced to a counseling chrono by the reviewing Captain consistent with the mental health clinicians' recommendation; in eight cases, the captain concluded that the individual should be held accountable for their actions despite the clinician opining that mental illness strongly influenced the patient's behavior. In one instance, the captain cited an incorrect RVR offense, stating it was for assault on staff when it was for refusing housing.

RVR-MHAs were frequently conducted in non-private settings: During the review period, an average of only 29% of RVR-MHAs were conducted in a private setting. The MHA was conducted in a private setting in two cases. Patients refused the interview altogether in six cases, or 30% of the time. Additionally, the patient refused a private setting in seven cases, or 35% of the time, and in four cases a private setting was not offered due to custody restrictions. The noted restrictions included no escort, and per custody instructions, no private setting.

Recommendations

1. Establish a standardized protocol for RVR-MHA consideration and privacy: Implement mandatory training and clear guidelines for clinicians and reviewing custody managers to ensure consistent application of documentation requirements and consideration of mental health factors when adjudicating RVRs. Identify causes for RVR-MHAs being conducted in non-private settings and ensure all incarcerated people are offered the opportunity to participate in assessments in a private setting, consistent with applicable security requirements.

Restricted Housing

This section evaluates mental health services, out-of-cell programming, clinical engagement, and environmental conditions in restrictive housing units. Restricted housing indicators measure whether patients placed in the most restrictive custodial settings receive the clinical services, out-of-cell opportunities, and treatment engagement mechanisms the Program Guide requires. The RHU population includes both general population and enhanced outpatient program patients.

Timeliness

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
ICC Review of Max Custody ICF Patients Prior to Admission				100%†	100%†	33%†	60%†	
ICC Review of Max Custody PIP Patients Within 10 Calendar Days of Arrival	69%	60%	68%	52%	58%	71%	63%	
CCII, Captain, and Warden Reviews of RHU EOP Patients with LOS Over 90 Calendar Days						100%		100%
ICCs with Mental Health Clinicians Present and Relevant Information Provided								100%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement								100%

Documentation

Indicator	Onsite Audits
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria	100%
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria	100%
PT Rounds Completed in Restricted Housing Units	100%

Out-of-Cell Activities/Care

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
NDRH Patients Provided Personal Property	100%†
Observed RHU Screening Questionnaire Conducted in Confidential Settings	0%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU EOP Out of Cell Time Offered	100%
RHU Shower Access	100%
Staff Who Report Unclothed Body Searches Conducted in a Private Area	100%†
Weeks where NDRH Patients are Offered Required Phone Calls	100%

✓ **Strengths**

RHU EOP largely maintained compliance with Program Guide requirements: RHU EOP certification met Program Guide requirements for December 2025, January 2026, and February 2026. In November 2025, and March 2026, CHCF's RHU EOP met certification standards with explanation due to mental health referrals not reaching the required threshold and an insufficient discussion of measurable treatment goals for one patient.

Barriers to achieving a timely mental health referral rate of 90% or higher included patient contacts occurring in non-confidential environments and order check-out errors.

PT rounds completed accurately: The PT asked the required questions and exhibited empathy. The PT rounds would be improved and benefit from having a flashlight at all times and using it whenever needed for clear visibility inside the cell. One cell observed during PT rounds was quite dark and the PT would have had better visibility into the cell if using a flashlight; the patient was verbal despite limited visibility.

⚠ Concerns

RHU screening was observed to be conducted without adequate confidentiality: One RHU screening occurred and was observed during the audit, during which the screening was conducted without adequate confidentiality; the door remained open.

ICC review of maximum custody ICF patients was inconsistent: When patients on maximum custody are being referred for inpatient care, the ICC must review whether all of the maximum custody restrictions on the patient can be suspended in the inpatient context. This review should occur before admission to the inpatient setting and again within ten days of arrival. The ICC review occurred for maximum custody patients prior to admission to CHCF's ICF in 100% of cases in February and March but only 33% of cases in April for an average of 60% over the review period. In April, two patients did not have preadmission ICCs at the referring institution, and were then transferred to CHCF's ICF program; sending institutions are responsible for completing the ICC review prior to admission and transfer to CHCF's ICF program.

Similarly, the ICC review of maximum custody PIP patients within 10 calendar days of arrival to the PIP averaged 63% during the review period. Per policy, upon arrival to the endorsed PIP location, an ICC shall occur no later than 10 calendar days for any patient designated MAX custody. This provides another opportunity for the ICC to consider whether all restrictions are necessary and appropriate. For patients at the Acute level of care, in two of the 10 cases identified as not meeting the review requirement, a review by the ICC occurred within 10 calendar days, but the ICC did not code the review "Max Custody Reduction Review" in the system. Instead, other ICC review types were selected.

In addition, CHCF did not consistently conduct the ICC reviews within the required timeframe for patients transferring between the acute and intermediate levels of care at the PIP. Staff do not interpret policy as requiring another ICC in that instance, but the business rule is triggered by the change in placement, including a change between acute and intermediate. Further review of this issue by the headquarters mental health team is required to ensure the policy and indicator programming are aligned and clarify the requirements for the field.

Recommendations

1. Maintain Confidentiality of Treatment Space: See Priority Recommendations.

Suicide Prevention

This section evaluates the institution's suicide prevention infrastructure, including suicide risk evaluations, safety planning, MHCB clinical practices, crisis intervention, welfare checks, temporary holding cell compliance, training delivery, and post-discharge continuity. Suicide prevention indicators measure whether the clinical, custodial, and administrative components of the prevention continuum identify, respond to, monitor, and follow up with patients at risk of self-harm.

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits

Discharges from MHCB with clinician review of d/c summary		0%†	0%†		0%†		0%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days		100%†					100%†	
Emergent and Urgent MH Referrals That Result in SREs	94%	90%	93%	92%	86%	98%	92%	
MHCB clinical stays within timeframes	97%	92%	97%	95%	96%	98%	96%	
MHCB Daily Provider Contacts (v2.0)	72%	70%	80%	90%	95%	90%	83%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	48%	51%	56%	75%	79%	75%	64%	
Safety Plans Signed Timely	66%	73%	61%	57%	62%	61%	64%	
Timely Clinical Follow-Ups (V2.0)	63%	80%	64%	47%†	68%	72%	67%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Staff with CPR Training								100%
Custody Staff with Suicide Prevention Training								100%
Healthcare staff current with suicide prevention training								99%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
Institution SPRFIT Meetings Observed that Satisfy All Audit Criteria								100%†
MHCB and Acute/ICF Out of Cell Activities - Dayroom								100%
MHCB and Acute/ICF Out of Cell Activities – Phone Calls								85%
MHCB and Acute/ICF Out of Cell Activities - Showers								67%
MHCB and Acute/ICF Out of Cell Activities - Yard								94%
MHCB and Acute/ICF Records with Rationale for Partial Issue								60%
MHCB Out of Cell Activities								31%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Observed Initial Health Screenings (PIP)								0%†
Onsite Review of Patient Orders for Issue and Observation								100%†
Patients in Alternative Housing with a Bed								100%†
PIP Out of Cell Activities								100%

Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								73%†
Suicide Resistant Cells								100%†

✓ **Strengths**

Second watch RHU huddle was well attended and collaborative: The meeting was well attended, with active participation from clinicians, psychiatry, nursing staff, psychiatric technicians, and custody personnel. All relevant areas—including new arrivals, high-risk individuals, and SRMP patients—were thoroughly addressed. Overall, the huddle demonstrated a consistent focus on relevant suicide prevention concerns and participation across disciplines.

Suicide prevention-related training completion: Suicide prevention training was completed by 99% of custody, healthcare, and mental health staff. CPR certification was achieved by 100% of both custody and nursing personnel.

Five-day clinical follow-ups and safety planning: Clinical follow-ups were conducted on the first full calendar day following the change to outpatient level of care for all 15 cases reviewed, with each follow-up including the necessary safety plans within the appropriate forms. Safety plans completed in MHCB and PIP were generally deemed adequate. The performance report indicated a compliance rate of 67% for clinical follow-ups over the audit period. That compliance rate was calculated under the business rule that was in place until July 1, 2026, which required contact within 24 hours of discharge or rescission from MHCB level of care instead of contact on the next calendar day. CHCF attributes low compliance to an influx of new staff and changes in the policy for timelines of clinical follow ups.

SPRFIT committee observation: The SPRFIT meeting was observed during the site visit. All requisite members attended, and the meeting was determined to be well attended and organized. The SPRFIT committee demonstrated active participation by the required members.

MHCB issue and observation orders justification: While MHCB and Acute/ICF records with rationale for partial issue averaged 60% across programs, MHCB issue and observation orders were sufficiently justified in 90% of cases reviewed. Only one case in MHCB was identified where the daily issue and observation record was absent.

Justifications for rescinded MHCB referrals were deemed appropriate: Clinical documentation reviews were conducted onsite for 15 patients whose MHCB Level of Care was rescinded. Adequate justification was identified in 93% of these cases. In one instance, the abbreviated SRE was incorrectly utilized, and the clinician selected a consult for suicidal ideation as the reason for the SRE being completed rather than MHCB referral recission, which would have more accurately described the reason for the SRE.

Emergency Response Equipment: Cut-down kits and inventory sheets were reviewed across multiple housing units located on all facilities, including RHU and PIP. All kits were found to be complete, properly maintained, and paired with current inventory documentation. Each cut-down kit contained the necessary equipment within a durable bag, and the corresponding inventory forms were kept up to date.

Initial health screenings in R&R: Upon arrival, initial health screenings were conducted in full accordance with established protocols. Suicide prevention posters, displayed in both English and Spanish at eye level, ensured clear visibility for patients. Furthermore, all interviews were held in settings that safeguarded confidentiality.

Suicide resistant cells in RHU: All designated intake cells in RHU EOP met the criteria to be suicide resistant. There were no incarcerated persons on intake status within the first 72 hours of placement during the onsite audit.

⚠ **Concerns**

SPRFIT meeting minutes were deficient in meeting audit criteria: A review of six months of SPRFIT meeting minutes determined that, with the exception of November 2025, all meetings achieved quorums consisting of the required mandatory members or their designees. However, none of the meeting minutes reviewed (November 2025-April 2026) met all of the audit criteria. The minutes consistently lacked documentation regarding the SPRFIT Coordinator's attendance at both the Incarcerated Person Family Council meeting and the Incarcerated Person Advisory Council meeting, as well as records of the discussions that took place during these meetings.

Treatment plans for patients included in the SRMP lacked comprehensive risk documentation: Only 60% of the master treatment plans reviewed contained interventions and goals directly addressing the reason for the patient's placement in the SRMP. The institution maintains an internal log of patients enrolled in the SRMP.

Temporary holding cell (THC) placements exceeding four hours: An examination of THC logs for the four primary yards utilizing THCs during the review period revealed that nine individuals were confined in these cells for danger to self for periods ranging from four hours and six minutes to six hours. CHCF was using a non-CDCR authorized "Holding Cell Log" form, which lacked a section for documenting the reason for placement.

Emergent and urgent referrals not marked for danger to self were inconsistently accompanied by a SRE when clinically indicated: For referrals concerning self-harm or suicidal ideation, approximately 92% of the necessary SREs were completed. In contrast, a review of approximately 50 patient charts for emergent or urgent referrals that were not marked as danger to self revealed 15 cases in which danger to self was present and an SRE was required; of these, only 73% had the SRE completed.

Observation and issue orders, justifications, and contacts not completed consistently in PIP: A review of 20 cases revealed that 50% (10/20) of patients on Suicide Watch or Suicide Precaution were not evaluated daily by a clinician, resulting in provider observation and issue orders being entered without corresponding assessments that would justify the orders and could have resulted in changes to the orders. Furthermore, several patients were discharged from suicide observation without receiving an evaluation from a clinician.

Limited access to out-of-cell activities in MHCB due to communication breakdown: There were notable gaps in out-of-cell opportunities for MHCB patients. Of 13 MHCB patient records reviewed, only 31% were offered the required minimum of out-of-cell activities. According to a review of the ARHR, MHCB patients received limited access to the dayroom. This issue appears to stem from a breakdown in communication between the CCI and housing unit officer, resulting in unclear communication of IDTT-approved activities for each patient. Additionally, many patients are restricted to walk-alone yard, which limits the number of individuals who can use the yard simultaneously. Clinician orders typically indicate approval for “yard,” and custody staff interpret this as excluding dayroom access.

Initial health screening upon admission to the PIP: The observed admission screening in the PIP did not meet audit standards due to inadequate confidentiality measures. The interview was conducted with the door propped open by a couch, while two custody officers were present throughout. Furthermore, the screening was terminated prematurely when the patient chose not to answer additional questions.

Recommendations

1. Strengthen Suicide Prevention Documentation Quality and Communication Strategies in High-Risk Areas: See Priority Recommendations.

Sustainable Process and Utilization Review

This section evaluates MHCB utilization review processes, including clinical stay compliance with established timeframes and the timeliness of transfers to crisis-level care. Sustainable process indicators measure whether MHCB admissions proceed through acute stabilization and discharge planning at the pace the clinical model requires, and whether patients requiring crisis-level care are transferred without avoidable delays. A

comprehensive report containing the detailed findings from the Regional Sustainable Process Review is provided separately and is not attached to this document.

✓ **Strengths**

IDTT observations for sustainable process: All programs reviewed for sustainable process—MHCB, RHU, ML EOP, and Medical EOP—demonstrated collaborative team processes and consistently discussed RVRs for all patients; however, some relevant RVR-MHA recommendations from the assessing clinician were not specifically addressed. Measurable treatment goals were covered in each observed IDTT, and both MHCB and RHU exhibited comprehensive discussions regarding higher levels of care.

⚠ **Concerns**

Sustainable process data review: The quality of higher level of care documentation, supporting decisions not to refer patients to a higher level of care, is reviewed quarterly through the headquarters (HQ) documentation review process. The 2026 second quarter audit encompassed 59 cases, with 27% classified as "good" and 73% rated as "unacceptable." The proportion of cases rated "unacceptable" increased by 3% compared to the previous quarter. Across the programs at CHCF, cases deemed "unacceptable" were most frequently attributed to insufficient narrative content (77%), followed by insufficient interventions (14%) and Inpatient Coordinator (IPC) errors (9%). Among narratives designated as "unacceptable," 82% were considered inadequate due to missing or incomplete mental status examinations within the rationale documentation.

Recommendations

1. Enhance support for drafting the higher level of care section of the treatment plan: Establish a structured feedback mechanism among clinicians, supervisors, and the IPC to address areas identified in the headquarters documentation audit and improve the quality of higher level of care documentation. Progress should be monitored through periodic reviews of documentation and systematic tracking of improvements in documentation standards.

Staffing

This section assesses the fill rates for clinical and supervisory mental health positions, training completion across disciplines, and the relationship between staffing levels and service delivery outcomes. Staffing indicators measure whether the institution maintains the workforce capacity and competency infrastructure required to deliver clinical services at the frequency and quality the Program Guide requires.

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief of Mental Health	1.0	1.0	0%
Chief Psychologist	3.0	3.0	0%
Chief Psychiatrist	2.0	1.3	33 %
Senior Psychiatrist (Supervisor)	3.3*	0.2	95 %
Senior Psychologist (Supervisor)	9.5*	9.3	2%
Supervising Psychiatric Social Worker I	2.2*	3.3	0%
Senior Psychologist (Specialist)	14.3*	10.8	24%
Recreation Therapist	51.3*	51.7	0%
Staff Psychiatrist	48.5*	46.4	4%
Psychologist – Clinical	50.3*	39.7	21%
Clinical Social Worker	29.2*	32.2	0%
Primary Clinician (PC)	33.3*	22.6	32%
PC: Psychologist – Clinical		3.2	
PC: Clinical Social Worker		16.8	
PC: Marriage and Family Therapist		2.6	
PC: Professional Clinical Counselor		0.0	

The figures in this table come from the monthly Mental Health Staffing, Allocated and Filled reports published on the CCHCS public website (https://cchcs.ca.gov/reports/). The institution's allocated and filled positions are pulled from each of the six monthly reports covering the review period. Table figures are six-month averages, and the functional vacancy rate is (Average Allocated − Average Filled) ÷ Average Allocated.

Filled counts include telehealth and registry providers: Staff Psychiatrist combines onsite and tele-psychiatry, MHPC combines onsite and tele-clinicians, supervisory social work combines Supervising Psychiatric Social Worker I and II, and Recreation Therapist includes registry staff. The Primary Clinician discipline breakdown is published as filled positions only, so those rows show no allocation.

✓ **Strengths**

Improvement in clinical non-supervisory position fill rates: The staffing of non-supervisory clinical positions, including psychiatrists, psychologists, clinical social workers, primary clinicians, and recreation therapists in both PIP and non-PIP settings, has markedly increased, substantially reducing vacancy gaps. With the exception of psychologists and primary clinicians, all other non-supervisory positions have met or surpassed a 95% fill rate. CHCF has made considerable progress in filling direct-care positions, increasing staffing capacity for direct-care services.

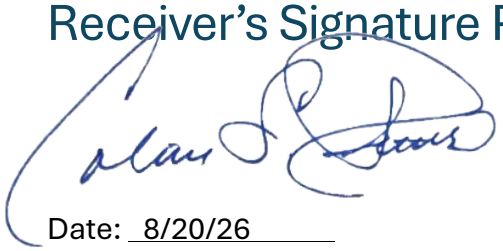
⚠ **Concerns**

Unfilled psychiatrist supervisor and psychologist specialist positions: The fill rate for Senior Psychologist (Specialist) positions is an average of 76% across programs. The Senior Psychiatrist (Supervisor) classification averaged a 5% fill rate during the review period. Vacancies in supervisory and specialist roles across various programs limit available supervisory clinical oversight.

Recommendations

1. Collaborate with CCHCS HR to fill vacant supervisory and specialist positions: Filling vacant positions will provide additional support for supervisory oversight, mentorship, and technical assistance to address identified clinical deficits.

Receiver's Signature Page



Date: 8/20/26

Appendix A: Acronyms and Initialisms

Acronym List	
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CNE	Chief Nurse Executive
COR	California State Prison, Corcoran
CPR	Cardiopulmonary Resuscitation
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	Correctional Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DOT	Direct Observed Therapy
DSH	Department of State Hospitals
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prisons
HPS I	Health Program Specialist I
HQ	Headquarters

ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
ISP	Ironwood State Prison
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Plan
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHPS	Mental Health Program Subcommittee
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MSF	Minimum Support Facility
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
PT	Psychiatric Technician
PVSP	Pleasant Valley State Prison
QIP	Quality Improvement Plan
QIT	Quality Improvement Team
QMSU	Quality Management Support Unit
R&R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento

SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Camp
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCMP	Transitional Case Management Program
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: MAPIP

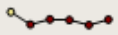
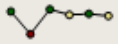
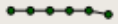
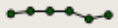
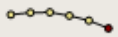
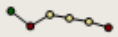
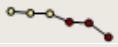
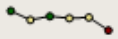
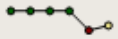
INSTITUTION 6 MONTH TREND

California Health Care Facility (CHCF)

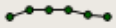
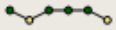
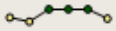
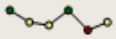
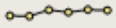
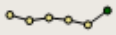
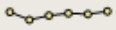
April 2026

Population Health Management	6 Months	Trend	NOV	DEC	JAN	FEB	MAR	APR
Diagnostic Monitoring (All)	**85%**		**86%**	**84%**	**86%**	**85%**	**84%**	**84%**
QT Prolongation EKG 12 Months	84%		78%	83%	88%	79%	86%	90%
Antipsychotics (All)	86%		86%	85%	87%	87%	87%	85%
Lipid Monitoring	77%		75%	76%	77%	81%	79%	72%
Blood Sugar	88%		88%	85%	88%	89%	91%	85%
EKG	80%		67%	-	-	100%	50%	100%
AIMS	63%		55%	71%	61%	58%	66%	66%
Med Consent	90%		86%	85%	95%	93%	89%	91%
CBC with Platelets	88%		87%	88%	93%	90%	85%	83%
CMP	89%		92%	83%	92%	93%	88%	85%
Thyroid Monitoring	82%		86%	75%	82%	85%	82%	82%
Blood Pressure	98%		99%	98%	100%	97%	98%	97%
Height	88%		90%	89%	87%	88%	85%	90%
Weight	95%		99%	91%	97%	94%	95%	95%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	91%		93%	94%	84%	89%	93%	91%
Blood Sugar	86%		100%	100%	33%	83%	100%	88%
Lipid Monitoring	79%		100%	100%	33%	60%	100%	83%
CBC	90%		88%	93%	89%	91%	90%	91%
CMP	82%		100%	100%	50%	67%	100%	88%
EKG	100%		100%	100%	100%	100%	100%	100%
AIMS	77%		100%	100%	67%	67%	100%	50%
Thyroid Monitoring	100%		100%	100%	100%	100%	100%	100%
Med Consent	93%		100%	100%	100%	100%	100%	50%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%

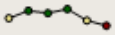
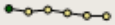
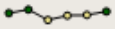
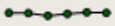
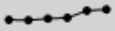
CHCF CQI Report | 2026

Height	100%		100%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Mood Stabilizers (All)	77%		83%	78%	80%	79%	72%	72%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	74%		82%	68%	74%	73%	67%	73%
Med Consent	88%		96%	50%	100%	89%	91%	87%
Blood Pressure	99%		100%	100%	100%	100%	100%	96%
Height	84%		89%	76%	86%	80%	80%	90%
Valproic Acid Level	42%		44%	45%	39%	44%	38%	40%
CBC with Platelets	54%		70%	47%	45%	61%	48%	50%
CMP	53%		69%	55%	58%	47%	43%	38%
Weight	97%		97%	100%	100%	100%	90%	95%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	80%		83%	86%	86%	82%	75%	65%
Lithium Level	49%		43%	69%	40%	63%	53%	27%
Thyroid Monitoring	77%		90%	69%	85%	80%	75%	67%
CMP	67%		83%	80%	79%	64%	62%	36%
CBC	87%		100%	85%	91%	88%	89%	67%
EKG	89%		100%	100%	100%	100%	67%	75%

CHCF CQI Report | 2026

Med Consent	94%		100%	88%	100%	93%	90%	100%
Height	92%		85%	100%	100%	88%	88%	85%
Weight	96%		92%	100%	100%	100%	94%	92%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	90%		95%	84%	90%	100%	89%	86%
CBC	95%		100%	88%	100%	100%	100%	88%
CMP	92%		89%	83%	100%	100%	100%	88%
Med Consent	82%		100%	80%	75%	100%	67%	80%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	92%		100%	100%	-	100%	67%	100%
Antidepressants (All)	87%		85%	84%	89%	86%	86%	91%
EKG (Tricyclics)	100%		-	-	-	100%	100%	100%
Med Consent	85%		82%	81%	88%	85%	88%	87%
Thyroid Monitoring	82%		88%	80%	84%	81%	75%	93%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Medication Management	**6 Months**	**Trend**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**
Medications Received Timely (All)	**94%**		**94%**	**94%**	**94%**	**94%**	**94%**	**93%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	100%		-	-	-	-	-	100%
New Arrival to CDCR (RC) – CTC	85%		-	-	-	-	-	85%
Intra-System (Within Institutions) – GP	77%		83%	79%	62%	77%	79%	73%
Intra-System (Within Institutions) – RHU	84%		87%	79%	83%	86%	85%	88%

CHCF CQI Report | 2026

Intra-System (Within Institutions) – MH Inpatient	88%		88%	89%	91%	88%	87%	84%
Intra-System (Within Institutions) – Specialized Medical	91%		90%	90%	91%	90%	92%	93%
Inter-System (Between Institutions) – GP	87%		84%	90%	87%	90%	85%	87%
Inter-System (Between Institutions) – RHU	83%		86%	97%	94%	100%	82%	74%
Inter-System (Between Institutions) – MH Inpatient	85%		90%	86%	88%	85%	82%	81%
Inter-System (Between Institutions) – Specialized Medical	90%		92%	96%	83%	88%	89%	94%
Return to CDCR – GP	69%		63%	72%	38%	77%	78%	71%
Return to CDCR – RHU	89%		87%	94%	90%	95%	13%	92%
Return to CDCR – MH Inpatient	87%		86%	84%	96%	73%	93%	97%
Return to CDCR – Specialized Medical	92%		93%	93%	93%	89%	93%	87%
Stable Housing	94%		95%	95%	94%	94%	94%	94%
Leaving CDCR	99%		99%	99%	96%	98%	100%	99%
By Provider Type								
Psychiatry	95%		95%	95%	95%	95%	95%	94%
Medications Refused (All)	**4%**		**4%**	**4%**	**4%**	**4%**	**4%**	**4%**
By Provider Type								
Psychiatry - Refused	4%		4%	3%	4%	3%	4%	4%
Non-Formulary by Psychiatrists	**16.9%**		**17.1%**	**16.9%**	**17.0%**	**16.7%**	**16.4%**	**17.2%**

Appendix C: Suicide Prevention Report

Restricted Housing Unit (RHU)

CHCF's Restricted Housing Unit was activated on April 14, 2025.

Second Watch Partnership Huddle: The morning huddle in RHU was observed on June 16, 2026. There was full attendance and participation by all attendees, including clinicians, psychiatry, nursing, PTs, and custody. All areas, including new arrivals, high risk and SRMP incarcerated patients were discussed. The huddle was very comprehensive.

Psychiatric Technician (PT) Rounds: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Intake Cells: A review of the unit revealed that CHCF has five designated intake cells (110 – 114). Each cell is clearly marked "Intake Cell" and was found to be suicide resistant.

RHU Screening (Pre-placement): Please refer to the CQIR for a summary of the findings.

Welfare Check Completion (Guard One): Please refer to the CQIR for a summary of the findings.

Mental Health Crisis Bed (MHCB) Inpatient Units

Suicide-resistant cells: CHCF has two licensed MHCB buildings open (A1A and A1B) consisting of 30 beds in each unit. All MHCB cells are retrofitted in compliance with statewide policy.

Interdisciplinary Treatment Teams (IDTT): Two IDTT meetings were observed in A1A and three were observed in A1B. One of the two A1A meetings was an initial IDTT meeting held for a patient admitted for danger to self or expressing suicidal ideation. The other one was a routine IDTT meeting for a patient admitted for SIDDMI and was referred to ICF. Overall, in each meeting the clinician presented a brief overview of the reason for admission, treatment goals, issue and observation status. Both patients presented in full issue with no mental health observation status ordered. The psychiatrist presented the patient's current medications, side effects of medication, along with each patient's diagnosis. All team members contributed to the discussion. Although one IDTT was an initial meeting, safety planning was discussed.

All three of the A1B IDTT meetings were discharge IDTTs for patients admitted for danger to self or expressing suicidal ideation. Overall, similar to the IDTT meetings in A1A, the clinician presented a brief overview of the patient's mental health history, self-harm history, and reason for admission. The psychiatrist presented the patient's current medications and possible side effects along with each patient's diagnosis. All team members contributed to the discussion. Safety planning was covered in all meetings, but the comprehensiveness of the discussion varied greatly among the presenting clinicians. The CCI who was present for all observed MHCB IDTTs provided invaluable and pertinent information and was a critical member of the IDTT.

Quality of Safety Planning: A review of five safety plans from patients discharged from the MHCB were reviewed. All five reviewed safety plans were deemed adequate. However, in review of the MHCB referrals rescinded, as shown below, only 53% (8 of 15) had adequate safety plans. Plans were viewed as inadequate if the narrative did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk. The quality of safety planning is currently on CHCF's Improvement Priorities List and Project Pipeline and will remain open. CHCF's SPRFIT Coordinator conducts monthly audits of safety plans for each MHCB and CIT clinician.

Suicide Watch and Suicide Precaution: There were 19 patients in A1A, and 13 patients housed in A1B on the initial day (June 15) of the review. Of these 32 patients, 30 patients were not on any suicide observation status, with one patient on Suicide Precaution and one patient on Suicide Watch.

The review of ten MHCB patient charts was reviewed to determine if justification was present for cases of limited issue and enhanced observation status during the review period. The audit revealed that justification

documentation for issue and observation orders was present in all cases of limited issue except for one day for one patient's order.

Observation and Issue Orders: Issue orders on the doors were reviewed for patients in the MHCB units. Patients had up to date orders posted on the door and the property allowed matched the level of observation. Tier walks indicated patients had property and clothing in compliance with statewide policy. Documentation was reviewed for ten patients housed in both of the MHCB units.

Privileges: The Automated Restricted Housing Record (ARHR) system was examined for documentation of out-of-cell activity (OCA) for 10 MHCB patients during seven-day periods of the review period. All had been cleared for out-of-cell activities by providers. The review found that the 10 patients were offered unstructured out-of-cell activity (yard and dayroom) during the time period, ranging from zero to 17 hours per week. The average was 6.3 hours. There was no explanation as to why one patient was not offered any OCA. Only two (2) of the 10 patients were offered a minimum of 10 hours of out-of-cell activity during seven-day periods. All patients averaged more than 2 showers and 2 telephone calls per week.

Of note, the above findings might differ from those appearing in the CQIT report as examined by the DAI's Mental Health Compliance Team (MHCT) due to slight differences in methodology. The RCT's suicide prevention expert tracks clinical justification for out-of-cell activities, 10-hour minimum offering per week of yard/dayroom (and not mental health appointments), and samples of 10 patients who were recently placed on Suicide Precaution and/or Suicide Watch status during an in-patient placement. The MHCT adheres to the CQIT guidebook audit instructions, which reviews those patients currently housed in the inpatient program at the time of the onsite assessment, and records two totals – one which includes MH appointments in the OCAs, and one that does not.

Clinical Discharge Follow-Ups: A review of the Mental Health Performance Report for November 1, 2025, to April 30, 2026, revealed that CHCF was 67% compliant for completion of 5 Day Follow Ups. A sample of 15 patients' 5 Day Follow Up documentation was reviewed. All reviewed follow ups were completed for at least five days in all cases. All series of follow ups included a safety plan each day when required. The institutional SPRFIT Coordinator reviews and audits all clinical discharge follow up deficiencies each month and reports the findings in the SPRFIT meetings. Low compliance has been attributed to changes in policy and an influx of new staff.

As of March 2025, the business rule indicates that day 1 of the clinical follow up must occur within 24 hours of discharge or recission from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant for the entire follow up series, whereas it was previously calculated daily. Currently if one day of the follow up is out of compliance, the entire follow up is now deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are being updated to reflect the intent of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.

MHCB Supervisor Review of Discharging Safety Plans: A review of the Mental Health Performance Report for November 1, 2025, to April 30, 2026, revealed that CHCF was 64% compliant with timely supervisor review of safety plans.

Alternative Housing

Cells to temporarily house individuals identified as suicidal and awaiting MHCB placement were used infrequently at CHCF. Alternative housing is located in D-Yard (CTC) any available cell, C-Yard (OHU) 14 cells, Patient Management Unit (PMU), and any other CHCF housing unit.

For a six-month period of November 1, 2025, through April 30, 2026, 141 patients were placed in alternative housing, with all released within 24 hours. Of this total, 29% (41 of 141) of cases resulted in the MHCB referrals being rescinded and incarcerated persons returned to their housing units. As to those admitted to an MHCB, most (93%) were timely admitted.

Medical chart review of 15 rescinded cases found that all had SREs (although in one case the abbreviated SRE reassessment form was incorrectly completed instead of the non-abbreviated SRE). In 92% (12 of 13) of applicable cases, all daily clinical follow-ups were completed for each of the five required days. The review, however, also found that only 53% (8 of 15) had adequate safety plans. Plans were viewed as inadequate if the narrative did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk.

Finally, examination of Temporary Holding Cell (THC) Logs for the four main yards that utilized THCs during the review period found that nine individuals were confined in the cells for DTS in excess of four hours, averaging 4.10 to 6 hours in the cell. CHCF utilized a non-CDCR authorized "Holding Cell Log" form that did not include a box for "reason for placement." The facility should utilize the authorized CDCR form.

Suicide Risk Management Program (SRMP)

During early audits, data discrepancies were discovered between the Mental Health reports and the EHRS. As a result, the Mental Health report has been temporarily suspended and the issue was escalated to the Mental Health Reporting Unit for resolution.

CHCF maintains an internal SRMP list which as of April 30, 2026, included 29 patients classified as being placed in the program or currently in the program. A review of Master Treatment Plans for five patients enrolled in the SRMP revealed that 60% (3/5) had interventions and goals documented within the SRMP tab of the Master Treatment Plan.

Discharge Custody Checks

The process by which individuals were provided Discharge Custody Checks at 30-minute intervals following release from either an MHCB or alternative housing placement was not reviewed during this assessment because of a CCHCS directive dated June 8, 2026, that stated: "The overall audit and reporting of the MH 7497s (paper and electronic) indicators have been paused to allow for updates to the audit questions associated with the new Web-App based digital process." Discharge custody check compliance is currently an active improvement project at CHCF.

Local SPRFIT Committee

Both the CHCF and CHCF-PIP had a large integrated SPRFIT, with mandatory representation required for both the out-patient and in-patient programs. There was one chairperson and two coordinators for the committee. A review of six months of SPRFIT meeting minutes found that all meetings except one (November 2025) had quorums of all required mandatory members or designees (the minutes incorrectly named the CMH as a psychiatric designee, but the CMH was not a psychiatrist). Minutes included discussion on compliance data, improvement projects, SRMP data, a clinical case summary of a serious suicide attempt, and the status of corrective actions based upon prior Receiver's suicide prevention expert assessments and regional SPRFIT audits. In sum, 4 of 5 significant SPRFIT compliance areas were adequate.

The SPRFIT meeting was observed on June 17, 2026. All required members were present, and the meeting was very comprehensive. The Review Team noted that recently closed CAP items remain on the monitoring schedule for a short duration to ensure sustainability, a practice that exceeds SPRFIT policy requirements.

Although the CHCF's SPRFIT Coordinator and/or designee attended the Patient Advisory Council (PAC) meetings on January 30, March 13 and March 20, 2026 and staff also attended the Patient Family Council (PFC) meetings on March 20, 2026, the SPRFIT meeting minutes did not include any attendance and/or discussion at either the IP Family Council or IP Advisory Council meeting (where attendance for both is required once every 6 months).

Policies: CHCF has a local suicide prevention policy (Suicide Prevention and Response, LOP 19.4.12, revised September 2025) that addresses required Suicide Prevention trainings, Discharge Custody Check

requirements, and documentation of self-harm events, as well as other SPRFIT responsibilities. It also includes procedures for Bad News screening and the SRMP. The Alternative Housing LOP (19.4.11, revised April 2026) was also reviewed and it is consistent with the statewide memorandum. Finally, although CHCF's Crisis Intervention Policy (19.10.4, revised September 2025) was consistent with the statewide memorandum, the policy is not consistent with current practices because the facility has not had a full CIT since June 2023.

Urgent and Emergent Referrals for Danger to Self

During the review period, CHCF was 90% compliant for completion of timely MHPC emergent consult orders and 88% compliant for MHPC Urgent Consults orders.

Examination of approximately 50 charts for emergent/urgent mental health referrals not marked for DTS found 15 cases that required an SRE during the review period, and only 73% (11 of 15) of these cases had the SRE completed.

Suicide Risk Evaluations in MHCB and Outpatient

A review of the Mental Health Performance Report for November 1, 2025, to April 30, 2026 indicated that CHCF had an overall compliance rate of 87% for completion of required SREs.

Clinical justification was reviewed for 15 patients whose MHCB referral was rescinded. Adequate justification was present in 14/15 (93%) of cases. In one case, the clinician selected the referral type as a 'consult for SI' rather than a MHCB rescission and incorrectly completed an abbreviated version of the SRE.

The business rules for the MHCB referral indicator have changed in recent months to accurately reflect current statewide policy, and concerns regarding meeting timelines for after hours referrals have been identified, which are negatively impacting overall compliance. As a result, actions have been taken to revise the policy language to better align with the intent of the indicator. Significant decreases in compliance for SREs following MHCB discharge were also noted due to updated policy changes to the compliance timelines.

Emergency Response in MHCB and Outpatient

Cut Down Kits: Please refer to the CQIR for a summary of the findings.

Suicide Case Review Quality Improvement Plan (QIP) Follow Up: CHCF's last suicide occurred in May 2025.

Training and Mentoring Compliance in MHCB and Outpatient

Compliance with the Annual IST Suicide Prevention Training for 2025 was the following: 99% of custody, medical, and mental health staff. Compliance with training requirements for SRE Mentoring and Understanding & Assessing Presence, Severity & Risk of Suicidality are below the expected compliance rate for suicide prevention trainings, as seen below. Training compliance for CHCF as of April 2026 is as follows:

- Understanding & Assessing Presence, Severity & Risk of Suicidality: 89%
- Safety Planning: 90%
- SRE Mentoring: 68%
- Suicide Risk Management Program: 94%
- CPR Certification
    - Custody: 1028/1030= 100%
    - Nursing: 1584/1584 = 100%

It is noted that SRE mentoring training compliance is currently an active project on the CHCF Improvement Priorities List and Project Pipeline.

Receiving and Release (R&R) Screening for Non-PIP Admissions

Intake screening is completed in the PMU, also referred to as the R&R Unit. Please refer to the CQIR for a summary of the findings.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) was launched at CHCF in March 2019 but subsequently suspended in June 2023 due to overall staffing shortages. Recently, the facility embarked upon a process whereby a crisis clinician is posted in the outpatient program almost 24 hours per day, 7 days per week. It is hoped that full staffing of the CIT can be established by August 2026. The Review Team did not observe any crisis clinician responses during the onsite assessment. As indicated above, the current CIT policy does not match current practices.

Psychiatric Inpatient Program (PIP) Units

Suicide-resistant cells: Patients placed on Suicide Watch or Suicide Precaution remain housed in their assigned cells, however, their items are removed from the cell except for what is indicated in the issue order. Tier walks indicated the cells were clean.

Interdisciplinary Treatment Teams (IDTT):

B1B – APP- Three IDTT meetings were observed. Two were routine and one was a discharge IDTT. All three of the patients were admitted for danger to self. All required members were in attendance and participated. The reasons for admission, current suicidal ideation, treatment goals, and treatment progress were discussed. Safety planning was discussed in one case. None of the patients were on enhanced observation status. In all three cases, the psychiatrist provided very little information and did not discuss diagnosis, medications and potential side effects. In one case, the psychiatrist simply asked, "Do you have any side effects?"

B7A – ICF- Two IDTT meetings were observed and found to be very problematic. Two clinicians presented and members of the treatment team were present and participated. The IDTT discussion did not include the reason for admission, mental health and self-harm history, diagnosis, medications, treatment progress and in one case, the discharge plan and discharge level of care. Neither of the patients were on enhanced observations. Safety planning was not discussed in either case.

Overall, CHCF PIP staff would benefit from awareness of the CQIT IDTT audit criteria to assist in organizing and synthesizing relevant clinical information within the IDTT discussion.

Quality of Safety Planning: The safety plans of five discharged PIP patients admitted for DTS were reviewed. All had safety plans, and content was individualized in three of the five cases (60%). The quality of safety planning is currently on CHCF's PIP Improvement Priorities List and Project Pipeline and will remain open.

PIP Supervisor Review of Discharging Safety Plans: According to the On Demand Performance Report, CHCF PIP compliance of timely safety plans reviewed by a supervisor occurred 41% of the time (90 of 220).

Suicide Watch and Suicide Precaution: During the four-day onsite review, there were three to five patients on Suicide Watch and one to three on Suicide Precaution observation depending on the day, in various housing units (B1A, B1B, B2B, B4A, B5A, B7A) and B7B). The observers for patients on Suicide Watch were engaging in direct, continuous observation of the patient.

Observation and Issue Orders: Auditors reviewed observation and issue orders on the cell doors for patients in various housing units (B1A, B1B, B2B, B4A, B5A, B7A) and B7B) during the onsite visit. All of the patients on enhanced observations had current orders placed on their door, with one exception that is detailed below.

However, contrary to these observations, medical chart review of 20 cases found 55% (11 of 20) of patients on Suicide Watch or Suicide Precaution were not being seen by a clinician on a daily basis, therefore, provider orders were entered without an assessment.

In one very problematic case, the patient was placed in a safety smock for SIB (head banging) on June 14, 2026, without placement on either Suicide Watch or Suicide Precaution. Therefore, the patient was not observed by staff (other than presumably on regular nursing rounds). According to the medical chart, custody staff initiated a use of force (including OC spray) to stop the patient's SIB. The following morning (June 15) at approximately 10:20am, the Review Team observed the patient clothed in the smock without any suicide observation provider orders or observation from nursing staff. Upon inquiry, a nurse produced a provider order that indicated discontinuation of the safety smock and provision of full clothing at 10:01am. The medical chart indicated, and nursing staff confirmed, that the patient had not yet been seen by a provider that morning. A brief psychiatric progress note was entered into the chart later that morning by another provider after notification from the morning huddle.

In addition, medical chart review of three other patients during the review period found they were discharged from suicide observation without being seen by a clinician or no indication of assessment, including one patient who was not seen by clinicians for 5 of 19 days on Suicide Precaution.

Privileges: The Non-Clinical Activity Tracking (NCAT) Report was examined for documentation of out-of-cell activity (OCA) for 10 PIP patients during seven-day periods of the review period. All had been cleared for out-of-cell activities by providers. The review found that all 10 patients were offered well over the 10-hour minimum per week, with many patients offered well over 40 hours per week. The offering of unstructured out-of-cell activity (yard and dayroom) at CHCF-PIP greatly exceeds policy requirements. In addition, all patients averaged 3 showers and 9 telephone calls per week (with one patient offered 17 calls during a 7-day period).

PIP SPRFIT Committee

Both the CHCF and CHCF-PIP had a large integrated SPRFIT, with mandatory representation required for both the out-patient and in-patient programs. There was one chairperson and two coordinators for the committee. See findings above.

Suicide Risk Evaluations in PIP

A review of On Demand Performance Report indicated 90% overall compliance for completion of required SREs from November 1, 2025, through April 30, 2026, for CHCF-PIP. During the audit period, SREs upon arrival to the PIP for patients referred for DTS were completed in 89% of cases. SREs completed prior to PIP discharge IDTT meetings occurred 92% of the time.

Emergency Response in PIP

Cut-down Kits: Please refer to the CQIR for a summary of the findings.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews: CHCF-PIP's last suicide occurred in April 2024.

Training and Mentoring Compliance in PIP

Review of the Court Mandated Trainings for April 2026, as well as information obtained from CHCF PIP, indicated the following compliance rates:

- Understanding & Assessing the Presence, Risk & Severity of Suicidality: 73%
- Safety Planning: 87%
- SRE Mentoring: 46%
- Annual IST Suicide Prevention Training (reviewed on institutional side due to combined compliance)
    - Custody: 99%

- Nursing: 99%
- Mental Health: 99%

CPR Training

- Custody: 100%
- Nursing: 100%

It is noted that SRE mentoring training compliance is currently an active project on CHCF PIP's Improvement Priorities List and Project Pipeline.

Receiving and Release (R&R) Screening for PIP Admissions

During the previous assessment, the Acute/ICF Nursing Admission Assessment form was completed on new PIP admissions in the PMU, also referred to as the R&R Unit. Current practices are that the process is now conducted on the new patient's PIP housing unit. Although a summary of the nursing reviewer's findings is contained within the CQIR, the current findings were problematic and are also summarized here.

On June 18, 2026, the nursing reviewers observed the new PIP admission of a non-maximum security patient into one of the APP units (B2B). During the screening process, two escort officers remained in the room and the door was left open, thus eliminating any privacy or confidentiality. A supervising RN subsequently informed the review team that "It has been the practice since she started working in the unit." In addition, the nurse was observed to be documenting the Acute/ICF Nursing Admission Assessment by hand rather than entering the patient's responses directly into the form's Interactive View in EHRS.

Assignment of Corrective Action Plan and Recommendations

As a result of this review, no additional CAPs have been generated for either the CHCF or CHCF-PIP, however nine new recommendations have been generated. Focus should remain on the previously assigned and open CAPs listed on CHCF's Improvement Priorities List and Project Pipeline, as well as the newly identified recommendations listed below.

Please ensure all previously assigned and open SPRFIT CAPs are updated on the Improvement Priorities List and Project Pipeline. All SPRFIT CAPs and recommendations should be listed as an Issue and monthly audit data indicated in the Comment section each month on the Improvement Priorities List and Project Pipeline. The project pipeline is to be uploaded to the SharePoint site monthly.

Conclusion

In addition to the previously assigned and currently open CAPs, the following recommendations were generated:

1) Ensure that PIP patients are provided with both privacy and confidentiality during the initial nursing assessment, with door closed and custody personnel stationed outside the room.
2) Ensure that all PIP patients on Suicide Watch or Suicide Precaution are consistently assessed by a clinician on a daily basis, and no patient should be discharged from suicide observation status without being assessed by a clinician.
3) Ensure that the PIP supervisory reviews of discharge safety plans are occurring timely.
4) Ensure that the maximum length of stay for patients held in THCs for DTS pending clinical assessment does not exceed four hours. In addition, the facility currently utilizes a non-CDCR authorized "Holding Cell Log" form that does not include a box for "reason for placement,". The institution should implement the use of the approved CDCR "holding cell log" form.
5) Increase compliance with SREs required for urgent/emergent mental health referrals not marked as DTS.

6) The Crisis Intervention Team Policy (19.10.4, revised September 2025) should be revised to incorporate current practices, either a full CIT and/or crisis clinician, responses within the outpatient program almost 24 hours per day, 7 days per week, etc.
7) Ensure that safety plans completed for patients discharged from MHCB and PIP units are summarized with patients during their discharge IDTT meetings.
8) Similar to requirements for PIP patients, ensure that MHCB patients are offered a minimum of 10 hours of out-of-cell activities per week.
9) Ensure that compliance for SRE Mentoring and the biennial training (Understanding and Assessing the Presence, Risk and Severity of Suicidality) for PIP and non-PIP staff remains at or above 90%.

Appendix D: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation
(CALIFORNIA HEATH CARE FACILITY)

SITE VISIT DATES

June 15 – 19, 2026
CQIT+

PARTICIPANTS

Regional Mental Health Administrator
Stephanie Neumann, PsyD

Sustainable Process Leads

Senior Psychologist, Specialist (SME) ..... Caitlin Chinn, PhD

Senior Psychologist, Specialist (SME) ..... Shalila Douglas, PhD

Senior Psychologist, Specialist ..... Emily Moresco, PsyD

Program Staff On-Site

Supervising Psychiatric Social Worker ..... Maeve Gormly, LCSW

Senior Psychologist, Specialist ..... Brittany Sawyer, PsyD

Senior Psychologist, Specialist ..... Shanesha Sorensen, PhD

Associate Health Program Advisor ..... Daniel Stebbins

AREAS REVIEWED

Program Area Reviewed:	Sustainable process data review – Prior review – 24% – Current review – 27%

On this CQIT+ site visit, all MHCB, EOP, and RHU areas were toured.

The terms "good" and "unacceptable" are utilized in the headquarters (HQ) documentation review to determine the quality of the documentation on the higher level of care (HLOC) considerations documentation. "Good" means that HLOC documentation adequately supports the decision to not refer the patient to a higher level of care even though one or more of the considerations is positive, and that the documentation adequately summarizes the specific treatment modifications that are documented in the treatment plan to improve the patient's ability to function. "Unacceptable" means one or more of the HLOC considerations were positive, but the explanation for not referring the patient to a higher level of care is deficient, and the HLOC documentation does not adequately summarize the modifications documented in the treatment plan to improve the patient's ability to function.

CHCF identified 29% "good" cases, and the HQ review identified 27% "good" cases in this quarter's HQ HLOC documentation audit. Five cases had discrepant reviews: two were for cases deemed to be "unacceptable" by CHCF, but "good" by HQ; and three were for cases identified as "good" by CHCF, but "unacceptable" by HQ. Regional review concurred with HQ's findings in four of the five cases, and with

CHCF in one case with outcome of "unacceptable" for documentation signed one day late. While not official policy, completion of documentation on the same day is the best clinical practice absent a formal policy.

HQ reviewed 59 cases: 27% (16 cases) were identified as "good" and 73% (43 cases) were identified as "unacceptable."

ML EOP comprised 85% of the documentation, with 13% out of the MHCB, and 2% from RHU EOP. In ML EOP (50 cases total), 26% of the cases were considered "good" and 74% were considered "unacceptable." In MHCB (eight cases total), 25% of the cases were "good" and 75% "unacceptable." In RHU, the one case was "good" (100%).

Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient narrative (77%); insufficient interventions (14%); and IPC error (9%). Of the narratives deemed to be "unacceptable," 82% (27 cases of 33 with an insufficient narrative) were insufficient due to missing or a lacking a complete MSE in the rationale documentation.

Reasons why the cases were considered "unacceptable" were further categorized by program. In EOP (37 "unacceptable" cases), the following were the reasons for "unacceptable" documentation: insufficient narrative (81%); insufficient interventions (16%); and IPC error (3%). In MHCB (six "unacceptable" cases), the following were the reasons: insufficient narrative (50%); and IPC error (50%). In RHU, there were no "unacceptable" cases.

Current results show a 3% improvement in the HQ documentation quality from the previous review. MHCB documentation improved by 25% to 25% "good" documentation in this audit. RHU improved by 69% to reach 100% (with only one case audited). Within-program rates for the individual EOP yards included: C-Yard Medical EOP was 12% (decline of 38%); D-Yard Medical EOP was 18% (improvement of 18%); and E-Yard ML EOP was 53% (improvement of 23%). No programs individually met the 85% threshold of "good" documentation. CHCF will be required to complete this audit for Q3 2026 due to the institution not reaching the 85% benchmark.

A summary of this information was provided to the IPCs, chiefs, and specialist supervisor during the site visit and before the report's completion. The IPCs are now focusing on the completeness of Mental Status Examination (MSE) in the HLOC document during the pre-review process. One comment by the HQ reviewer noted that documentation now has a seven-day timeframe for clinicians to complete their work for it to be completed "timely." This information has not been distributed to staff statewide in writing and the RMHA continued to provide direction that best clinical practice is to complete documentation by end of shift. IPCs reported an increase in time spent consulting with telemental health clinicians as they are not on grounds regularly to engage with the patients in-person or to observe the state of their cells. With the increased time dedicated to reviewing HLOC documentation, the compliance rate improved by 3% from the previous audit. Leadership is drafting a memorandum that will outline changes in steps to be taken when documentation is identified as "unacceptable" in both the pre-review process and signed documentation following the IDTT in an attempt to improve HLOC document quality.

The Q1 2026 follow-up action plan was: 1. Provide all clinical staff (including staff whose documentation was not reviewed in the audit, contractors, part-time clinicians, and TeleMental Health clinicians assigned to CHCF) with an overview of HQ's audit results, along with ways that documentation could improve. Provide 844s.
The institutional response was: 1. Program supervisors will meet with their teams to review the HQ audit results with discussion on improvement for increased documentation success. Updated templates for

staff use, based on VSP's recommended templates for documentation. IPC supervisor and outpatient Chief continue to meet to discuss regularly to review HLOC submission for pre-review.
Follow-up required: YES _X_ NO____ | If YES: Follow-up date: September 21, 2026
Follow-Up Action Plan: 1. Provide all clinical staff (including staff whose documentation was not reviewed in the audit, contractors, part-time clinicians, and TeleMental Health clinicians assigned to CHCF) with an overview of HQ's audit results, along with ways that documentation could improve. Provide 844s.

Program Area Reviewed:	Mental Health Program Subcommittee Minutes

January 2026

Meeting minutes were posted to SharePoint timely. A quorum appeared to have been met; however, the question of whether a quorum was met was left blank on the attendance face sheet. Two of the IPCs in attendance presented HLOC information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative. There were five Acute referrals and six ICF referrals, for a total of 11 referrals. All referrals were submitted timely. Nine patients transferred timely and the two pending referrals remained within designated timelines. HLOC quality of documentation was 68%. It was noted that IPCs facilitated a HLOC training on December in which clinicians were provided feedback regarding utilizing incorrect Sustainable Process Reports (SPRs), signing treatment plans after the date of IDTT, and requests were sent to supervisors to return patients to IDTT who had significant errors in HLOC documentation. Ten patients were discharged from PIP/DSH to CHCF in December. Compliance rates were provided for all five required components. Clinician-to-clinician contacts were at 91%, discharge documentation reviews were at 91%; 24-hour evaluations were at 100%, and 5-Day follow-ups were at 100%. One SRE was documented as being completed as only one patient discharged to outpatient from DSH.

February 2026

Meeting minutes were not posted to SharePoint timely. A quorum was met and the question, "quorum met this meeting" was answered "yes." One of the IPCs was in attendance who presented HLOC information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative. There were five Acute referrals and four ICF referrals, for a total of nine referrals. All referrals were submitted timely. Eight patients transferred timely and the one pending referral remained within designated timelines. HLOC quality of documentation was 58%. It was noted that IPCs provided training to the new hires, provided in-person HLOC support to staff, and attended yard staff meetings. Four patients were discharged from PIP/DSH to CHCF in January. Compliance rates were provided for all five required components. Clinician-to-clinician contacts and discharge documentation reviews were at 100%. Five-day follow-ups and 24-hour evaluations were at 80% as one patient was seen but the forms were not signed within the 24-hour timeframe. It was noted that no SREs were completed because there were no discharges from DSH.

March 2026

Meeting minutes were not posted to SharePoint timely. A quorum was met and two IPCs were in attendance who presented HLOC information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative. There were five Acute referrals and four ICF referrals, for a total of nine referrals. All referrals were submitted timely. Seven patients transferred timely and the two pending referrals remained within designated timelines. HLOC quality of documentation was 60%. IPCs continue to facilitate HLOC training and provide feedback on HLOC documents submitted for pre-review. Three patients were discharged from PIP/DSH to CHCF in February. Compliance rates were provided for all five required components. Clinician-to-clinician contacts and discharge documentation reviews were at 100%. Twenty-four evaluations were at 67% due to documentation being entered after

24 hours of the patients' arrival at the facility. Five-day follow-ups were at 33%. One SRE was documented as being completed as only one patient discharged to outpatient from DSH.

This information was provided, along with all reviewed documentation, to the IPCs, CPs, CMH, IPC supervisor, and program supervisors before the site visit and the report's completion.

The Q1 2026 follow-up action plan was: 1. Discharge documentation review compliance rates will be reported on when discussing PIP/DSH discharge requirements.

The institutional response was: 1. IPCs to review minutes using CQIT/desk reference minutes review checklist for completion. Added a column in our internal tracker for discharge documentation review compliance rates.

Follow-up required: YES _X_ NO___	If YES: Follow-up date: September 21, 2026

Follow-Up Action Plan: 1. Leadership will ensure that MHPS minutes are posted to SharePoint timely.

Program Area Reviewed:	Referral and Non-Referral Reports

Referral Reports

The On Demand Acute-ICF Referrals report was run for the review period of January through March 2026.

January 2026

Nine referrals were initiated: five to Acute and four to ICF.

Of the five Acute referrals, none were rescinded. Master Treatment Plans (MTPs) were signed timely (within four hours) in all entries. The Due Process Signed column was complete for all entries and no Vitek hearings were held. All five consults were submitted timely to IRU.

Of the four ICF referrals, none were rescinded. Two additional entries were generated on the report; one for a patient already at PIP and one for a patient who was originally referred while at a different institution. The Due Process Signed column was complete. One Vitek hearing was held. All four consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 7%.

February 2026

Nine referrals were initiated: five to Acute and four to ICF.

Of the five Acute referrals, none were rescinded. MTPs were signed timely in all entries. The Due Process Signed column was missing data in one entry; the chrono was found in the EHRS and CHCF's internal tracking log identified the missing entry and documented attempts to identify why the data did not populate. One Vitek hearing was held. All five consults were submitted timely to IRU.

Of the four ICF referrals, one was rescinded. MTPs were signed timely in three entries and not timely in one entry. The Due Process Signed column was complete. No Vitek hearings were held. All four consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 7%.

March 2026
Seven referrals were initiated: five to Acute and two to ICF.

Of the five Acute referrals, one was rescinded. MTPs were signed timely in four entries and not timely in one entry. The Due Process Signed column was complete. No Vitek hearings were held. All five consults were submitted timely to IRU.

Of the two ICF referrals, none were rescinded. MTPs were signed timely in one entry and not timely in the other entry. The Due Process Signed column was complete. No Vitek hearings were held. Both consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 4%.

The quarterly referral rate was 6%, a 5% decrease from the previous quarter.

This information was provided, along with all reviewed documentation, to the IPCs, chiefs, specialist supervisor, and program supervisors before the site visit and the report's completion. CHCF has improved in tracking and reporting accurate data – Part V data was consistent with the On Demand data for all three months.

Non-Referral Reports
The On Demand Acute-ICF Referrals report was run for the review period of January through March 2026.

January 2026
There were 129 entries on the report, with 16 entries for patients already referred to Acute/ICF. Sixty (53%) non-referral entries for patients not already referred to Acute/ICF were reviewed. There were 82 (64%) entries with single considerations, 47 (36%) with multiple considerations, 32 (25%) with subjective considerations, 111 (86%) objective considerations, and the most common consideration was #7 (57%).

Data errors identified in the reviewed entries included: inaccurate MHI at IDTT (five entries); consideration was endorsed when it was not flagged on the SPR (three entries); consideration was not endorsed when it was flagged on the SPR (two entries). The data error rate was 17%.

February 2026
There were 137 entries on the report, with 14 entries for patients already referred to Acute/ICF. Sixty-two (50%) non-referral entries for patients not already referred to Acute/ICF were reviewed. There were 103 (75%) entries with single considerations, 34 (25%) with multiple considerations, 14 (10%) with subjective considerations, 123 (90%) objective considerations, and the most common consideration was #7 (61%).

Data errors in the reviewed entries included: inaccurate MHI at IDTT (three entries); no SPR was provided to confirm considerations (three entries); consideration was not endorsed when it was flagged (two entries); and consideration was endorsed when it was not flagged (one entry). The data error rate was 15%.

March 2026
There were 193 entries on the report, with seven entries for patients already referred to Acute/ICF. Eighty-two (44%) non-referral entries for patients not already referred to Acute/ICF were reviewed. There were 149 (77%) entries with single considerations, 44 (23%) with multiple considerations, eight (4%) with

subjective considerations, 186 (96%) with objective considerations, and the most common consideration was #7 (75%).

Data errors identified in the reviewed entries included: consideration endorsed when it was not flagged on the SPR (four entries); consideration was not endorsed when it was flagged on the SPR (two entries); and inaccurate MHI at IDTT (two entries). The data error rate was 10%.

The quarterly data error rate was 13%, a 2% increase from the previous quarter.

This information was provided, along with all reviewed documentation, to the IPCs, chiefs, specialist supervisor, and program supervisors before the site visit and the report's completion.

The Q1 2026 follow-up action plan was: N/A.

The institutional response was: N/A.

Follow-up required: YES ___ NO_X__	If YES: Follow-up date: N/A

Follow-Up Action Plan: N/A

Program Area Reviewed:	Documentation Review – Higher Level of Care Tab

Quality

Eight cases were randomly selected from the March 2026 monthly HLOC audit and reviewed for quality of the rationale and intervention sections within the HLOC section of the MTP. Seven out of the eight cases were found to have unacceptable documentation. In two cases, the rationale and intervention sections were unacceptable because the patient's current clinical presentation was unclear as well as what was driving the endorsed consideration, and it could not be determined if the interventions provided were tailored to the patient's specific needs. In four additional cases, the rationale and interventions were also unacceptable for the following reasons: the information was copied and pasted from the previous MTP without providing sufficient updates (two cases); the endorsed consideration was not flagged on the corresponding SPR and the discrepancy was not addressed; and, the patient's clinical presentation was unclear and the interventions were copied and pasted from the previous MTP. In the seventh and final case, the interventions were unacceptable because no clinical interventions were provided.

Regional review of outcomes was discrepant in one case. CHCF found an intervention section acceptable, but Regional found no clinical interventions.

Consistency

The same eight cases were reviewed for consistency of the endorsed considerations in the HLOC documentation from the MTP, with documentation in the EHRS and corresponding SPR. Seven cases were found to be consistent. In the case that was found to be not consistent, the endorsed consideration was not flagged on the corresponding SPR, and the discrepancy was not discussed in the documentation.

Additional areas of improvement identified with the overall quality of MTP documentation included: the behaviors, symptoms and/or endorsed consideration discussed in the HLOC section of the MTP were not addressed in the patient's problem/symptoms in the treatment plan grid (seven cases); aspects of the treatment plan grid were left blank (four cases); the problems/symptoms listed in the patient's treatment plan grid were not consistent with the described presentation of the patient in the HLOC section of the MTP (three cases); the treatment plan grid had not been updated for over a year; the patient's diagnosis

noted in the HLOC section of the MTP was not consistent with the diagnosis assigned in EHRS (two cases); the patient's clinical presentation described in the HLOC section of the MTP was not captured in the patient's diagnosis; and, the patient is assigned conflicting diagnosis in EHRS.

This information was provided, along with all reviewed documentation, to the IPCs, chiefs, specialist supervisor, and program supervisors before the site visit and the report's completion. One case was reviewed in more depth and the IPCs and Regional collectively identified how the documentation could have been improved.

The Q1 2026 follow-up action plan was: 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

The institutional response was: 1. Program supervisors will meet individually with identified staff to review results from the quality and consistency section of the audit.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: September 21, 2026

Follow-Up Action Plan: 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

Program Area Reviewed:	Attended IDTT in MHCB, RHU, ML EOP, and Medical EOP

MHCB

Five MHCB IDTTs were observed. One IDTT was an initial, four were routine and three patients were discharged. The program supervisor initiated the introductions and the purpose for each of the observed IDTTs. All required members were in attendance and had access to the patient records. None of the patients were on enhanced observation status and all patients were issued full issue. Appropriateness of issue and observation status were discussed in all cases. The clinicians provided historical and brief clinical summaries in four of five cases including adequate case formulation. Measurable treatment goals were identified and discussed in all cases. Diagnosis, medication and side effects were discussed by the MHMD in all cases. The CCI was engaged and contributed significantly. RVRs were discussed in all cases. Nursing staff provided information regarding known and current medical issues and medication compliance. Safety plans were discussed in all relevant cases; however, comprehensiveness of safety plan differed by clinician. The summary of the safety planning discussion during the IDTTs did not always match the documentation within the safety plans. Higher level of care considerations and appropriateness of level of care were also discussed for each patient. Overall, the team was interactive, and all members participated in the discussion. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB. Outcomes did not appear to be predetermined.

RHU

Five IDTTs were observed with four patients in attendance. There were three initials and two routines, with all patients retained at the EOP. The first IDTT started timely. MHMD and MHPC initial evaluations were completed for both initial IDTTs. All required members were present and included the assigned MHPC, assigned MHMD, CCI, program supervisor, and PT.

The purpose of the IDTT was clearly stated across IDTTs. Case formulations were considered adequate for all IDTTs. All IDTTs provided measurable treatment goals, and progress towards goals were discussed for routine IDTTs. For one patient with resistance to treatment, individual treatment goals were discussed but not the associated interventions. Higher level of care considerations were adequately discussed in all IDTTs. RVRs and RVR MHAs were consistently discussed. Behaviors in recent RVRs were incorporated into the treatment plan when necessary.

The CCI was engaged, provided helpful information, and was open to questions from patients and staff. The MHMD was engaged, providing relevant information related to diagnosis, medications to address the diagnosis, and side effects. Patients were invited to participate in the discussion with open-ended questions and provided an opportunity to meaningfully engage in the treatment planning process. Each team member was engaged in interactive treatment planning discussion. Effective communication was ensured for all required patients. Clinical staff and CCI had computer access, allowing them to utilize SOMS/ERMS and EHRS during the IDTT process. For two IDTTs, there was excessive detail that may have hindered some discussion among team members and led to a predetermined IDTT. For the three other IDTTs, the outcome of the IDTT meeting did not appear predetermined.

ML EOP

Five IDTTs were observed with three patients in attendance and two presented in absentia due to the patient refusal. Two were initials and three were routine with level of care sustained for all. The first IDTT started timely but some IDTTs were 30 minutes long and impeded upon other appointment times. All required members were present and included the assigned MHPC (tele-MHPC for three IDTTs), assigned MHMD, MA, CCI, program supervisor, and RN. An additional MHPC and RN were present in two IDTTs that did not participate. Initial assessments were completed by the MHPC and MHMD prior to all initial IDTTs.

The purpose of the IDTT was stated in four IDTTs. Case formulations were considered inadequate across IDTTs. All IDTTs included at least one measurable treatment goal. Two of three routine IDTTs did not provide clear updates on progress. Discussion of higher level of care considerations were considered inadequate for four IDTTs. Two of the four required IDTTs did not provide interventions for treatment resistance. RVRs were consistently discussed in all IDTTs, but one did not discuss the RVR MHA when it was required and it was unclear if the behaviors/issues from the RVR were addressed in the treatment plan. Work and education assignments were discussed in all IDTTs along with any potential reasonable accommodations that may be required.

The CCI was engaged and provided relevant information to the case. The MHMD discussed current medications to address the diagnosis and possible side effects. An RN provided information about recent labs, appointments, and information about Nursing Led Treatment Groups (NLTGs). The supervisor occasionally asked clarifying questions in each IDTT. Not all members of the treatment team participated in two IDTTs. Interaction among the team was interactive but discussion of interventions was lacking in the treatment plan. All patients were provided opportunities to provide meaningful input. Clinical staff and the CCI had computer access, allowing them to utilize SOMS/ERMS and EHRS during the IDTT process. Effective communication was not met for two of the three required patients. None of the IDTTs appeared predetermined. However, the team continued to struggle with some of the most salient points of the treatment plan including robust higher level of care discussions, interventions, and case formulations.

Medical EOP

Four routine IDTTs were observed. The first IDTT started timely. Required members in attendance included the MHPC, the MHMD, and CCI. Also, in attendance were nursing staff, RT, and program supervisor. Three different MHPCs and two different MHMDs were observed. Three patients were present during four of the IDTTs and one was held in absentia due to patient refusal.

In all applicable IDTTs, the program supervisor explained the purpose of the meeting. The patient's mental health status did not appear to impact their understanding in any of the three applicable IDTTs. When the patient was present, they were invited to participate and asked open-ended questions in all IDTTs. The team members also gave the patient the opportunity to provide meaningful input. All team members

participated in all IDTTs. The teams were interactive with one another and with the patient, when present, in all IDTTs.
In two IDTTs, a succinct case formulation was presented. In two IDTTs, the case formulation did not include precipitating factors that led to current symptoms. In all IDTTs, the MHMD and CCI provided relevant information.

In three of the four IDTTs, measurable treatment goals were discussed. However, in two of those IDTTs, the measurable goals did not appear specific to the patient's current presentation. In two IDTTs, the MHPC reviewed progress on current goals. However, the review of progress in one IDTT was non-specific and difficult to determine the patient's status. In three IDTTs, the team members and patients, when present, engaged in a robust discussion of HLOC considerations and appropriateness of level of care. In one IDTT, subjective HLOC considerations were not reviewed in the IDTT.

Relevant RVR history was reviewed in all IDTTs. When applicable, the team did not discuss the results of the MHA since the last IDTT and did not discuss if the behavior that led to the RVR should be accounted for in the treatment plan. All patients were unassigned from work/education assignments at the time of the IDTTs. In all IDTTs, the outcomes did not appear predetermined as discussions appeared influenced by other team members' and patient's input. Overall, the IDTTs appeared patient-focused while also reviewing CQI criteria to provide a more comprehensive treatment plan.

The Q1 2026 follow-up action plan was: *MHCB*: 1. Program supervisor will ensure CQIT criteria are met in each IDTT, including: discussion of patient's mental health diagnosis, including differential diagnoses; ensuring the patient understands their treatment goals and safety plan; and a case conceptualization explaining factors related to how the patient ended up at their current level of care. Provide 844s. *RHU*: 1. Program supervisor will ensure that all CQI criteria is covered during IDTT and prompt for missing criteria, specifically subjective HLOC considerations. Provide 844s. 2. Chief MHMD will provide training to the MHMD to ensure that they will provide side effect information for all prescribed medications in all cases. Provide 844s. *ML EOP*: 1. Program supervisor will ensure IDTT CQI criteria are discussed to include: reviewing treatment goal progress when applicable; ensuring all higher level of care considerations are reviewed and the resulting level of care decision; discussion of interventions and goals when treatment resistance is identified; and discussion of clinical accommodations if the patient is unassigned from a program assignment. Provide 844s.

The institutional response was: *MHCB*: 1. Program Supervisor will meet with all MHCB staff to review CQIT criteria specifically reviewing: discussions of patient's diagnosis including differential diagnoses, ensuring patient understanding of treatment team discussion regarding goals and safety plans, and case conceptualizations that include explanations of the factors that lead to patients current LOC. *RHU*: 1. Supervisor and IPC to meet with treatment teams to review CQI criteria specially prompting for review of the subjective measures. 2. RHU Supervisor met with MHMDs to review discussions of side effects for all cases in IDTT. *ML EOP*: 1. Program supervisor/Chief will meet with ML EOP staff to review CQI criteria which will include a focus on discussing reviewing all HLOC considerations, level of care decisions, interventions and goals to be used with treatment resistant patients, and clinical accommodations for unassigned patients.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: September 21, 2026

Follow-Up Action Plan:
MHCB: 1. Program supervisor will ensure that adequate case formulations are presented for all patients. Provide 844.
RHU: 1. Program supervisor will ensure treatment interventions for treatment resistant patients are discussed. 2. Program supervisor will assist the IDTT lead in facilitating a succinct IDTT to ensure

opportunities for spontaneous input from other team members and allow for further treatment planning development. Provide 844s for both.

ML EOP: 1. Program supervisor will ensure the following CQIT audit criteria are discussed: case formulations that include relevant clinical history and explanation of specific symptoms; RVR MHAs; and integration of any relevant treatment considerations, progress towards treatment goals, interventions to address treatment resistance, robust discussion of higher level of care considerations. Provide 844s. 2. Program supervisor will ensure all staff team members engage in interactive treatment planning discussion. Provide 844s for both.

Medical EOP: 1. Program supervisor will provide training on CQIT criteria for IDTT, including composing individualized measurable goals, reviewing patient-specific progress on current goals, and including a succinct case formulation via worksheets, mock IDTTs, for example. Provide 844s for both.

Program Area Reviewed:	Housing Unit Review

MHCB

A1A

The unit was overall calm with no significant clutter observed in the unit or in any of the cells. One patient was observed in the yard. Custody staff were cordial and helpful, reporting no patients of concern.

A1B

Similar to A1A, the unit was also calm and clean with no significant clutter or piles of food trays as had been observed during previous site visits. Custody reported that the patients are "running their program" and reported no concerns. One patient was released from their cell to conduct a phone call during the observation.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

RHU

Custody staff were engaging and helpful, the unit was clean, and patients were quiet. Multiple patients were observed being escorted to various activities. Custody reported no patients of concern. Several cells were observed with their back windows partially covered but the cells and the patients inside were still visible. Patients in their cells were engaging in various activities including utilizing their tablets. Cells were generally clean with some appearing well lived in. One patient complimented the mental health program. Empty cells were observed clean and ready for potential intake.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

ML EOP

All units were observed to be clean and calm. Custody staff were cordial and helpful across all units as well. Multiple patients in D and E pod reported that the quality of the water was poor. When consulted about this issue, custody staff reported that patients had previously been provided with bottled water but recently had been directed to utilize tap, but that the water is continually tested. Custody further reported that the water will go through chlorination treatments, and the patients are provided with bottled water during these times but are expected to return to tap water following the treatment.

D Pod

Custody staff reported that dayroom was not running because of staffing shortages. Custody identified one patient of concern. One patient reported that their clinician is "fantastic," and groups are very

helpful. Multiple patients reported frustration with lack of dayroom due to short staffing but shared that priority ducats are being honored for the most part. One patient reported disappointment in the increased number of telemental health staff reporting feeling disconnected from their clinician, due to seeing their clinician on a screen.

E Pod
Custody staff reported no patients of concern and cells were observed to be generally clean. One patient also reported that he was unhappy with his clinician.

F Pod
Custody staff identified multiple patients of concern. No significant issues were identified by the patients.

One patient was maintained on the Regional Spreadsheet who was identified during the previous quarter. Three new patients were identified for further review. Following chart reviews, three patients were recommended to be referred to IDTT and one patient had recommendations for the treatment team to consider at the patient's next IDTT.

The Q1 2026 follow-up action plan was: 1. Refer to the Regional Reporting Spreadsheet.

The institutional response was: 1. Completed 4/21.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: September 21, 2026

Follow-Up Action Plan: 1. Refer to the Regional Reporting Spreadsheet.

ACTION PLAN

1. Sustainable Process Data Review – Provide all clinical staff (including staff whose documentation was not reviewed in the audit, contractors, part-time clinicians, and TeleMental Health clinicians assigned to CHCF) with an overview of HQ's audit results, along with ways that documentation could improve. Provide 844s.

2. MHPS – Leadership will ensure that MHPS minutes are posted to SharePoint timely.

3. Referral and Non-Referral Reports – N/A.

4. Documentation Review – Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

5. IDTTs –
    a. ***MHCB***: Program supervisor will ensure that adequate case formulations are presented for all patients. Provide 844.
    b. ***RHU***: Program supervisor will ensure treatment interventions for treatment resistant patients are discussed. Program supervisor will assist the IDTT lead in facilitating a succinct IDTT to ensure opportunities for spontaneous input from other team members and allow for further treatment planning development. Provide 844s for both.
    c. ***ML EOP***: Program supervisor will ensure the following CQIT audit criteria are discussed: case formulations that include relevant clinical history and explanation of specific symptoms; RVR MHAs; and integration of any relevant treatment considerations, progress towards treatment goals, interventions to address treatment resistance, robust discussion of higher level of care considerations. Provide 844s. Program supervisor will

ensure all staff team members engage in interactive treatment planning discussion. Provide 844s for both.

d. ***Medical EOP:*** Program supervisor will provide training on CQIT criteria for IDTT, including composing individualized measurable goals, reviewing patient-specific progress on current goals, and including a succinct case formulation via worksheets, mock IDTTs, for example. Provide 844s.

6. Housing Unit Review – Refer to the Regional Reporting Spreadsheet.

SITE VISIT SUMMARY

Region II continues to appreciate the hospitality from and collaboration with CHCF's mental health, custodial, and executive leadership teams.

The terms "good" and "unacceptable" are utilized in the headquarters (HQ) documentation review to determine the quality of the documentation on the higher level of care (HLOC) considerations documentation. "Good" means that HLOC documentation adequately supports the decision to not refer the patient to a higher level of care even though one or more of the considerations is positive, and that the documentation adequately summarizes the specific treatment modifications that are documented in the treatment plan to improve the patient's ability to function. "Unacceptable" means one or more of the HLOC considerations were positive, but the explanation for not referring the patient to a higher level of care is deficient, and the HLOC documentation does not adequately summarize the modifications documented in the treatment plan to improve the patient's ability to function.

HQ reviewed 59 cases: 27% (16 cases) were identified as "good" and 73% (43 cases) were identified as "unacceptable." ML EOP comprised 85% of the documentation, with 13% out of the MHCB, and 2% from RHU EOP. In ML EOP (50 cases total), 26% of the cases were considered "good" and 74% were considered "unacceptable." In MHCB (eight cases total), 25% of the cases were "good" and 75% "unacceptable." In RHU, the one case was "good" (100%). Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient narrative (77%); insufficient interventions (14%); and IPC error (9%). Of the narratives deemed to be "unacceptable," 82% (27 cases of 33 with an insufficient narrative) were insufficient due to missing or a lacking a complete MSE in the rationale documentation.

Current results show a 3% improvement in the HQ documentation quality from the previous review. MHCB documentation improved by 25% to 25% "good" documentation in this audit. RHU improved by 69% to reach 100% (with only one case audited). Within-program rates for the individual EOP yards included: C-Yard Medical EOP was 12% (decline of 38%); D-Yard Medical EOP was 18% (improvement of 18%); and E-Yard ML EOP was 53% (improvement of 23%). No programs individually met the 85% threshold of "good" documentation. CHCF will be required to complete this audit for Q3 2026 due to the institution not reaching the 85% benchmark.

Regional teams are tasked with observing IDTTs utilizing statewide quality standards determined and agreed upon by several stakeholders, which include plaintiff's attorneys, HQ leadership and staff, and external subject matter experts, which have been vetted and mandated via court processes. This has resulted in the adoption of the Continuous Quality Improvement (CQI) audit criteria for multiple MH program areas, including IDTTs. These standards strive to exceed a constitutional threshold of quality care. All programs observed (MHCB, RHU, ML EOP, and Medical EOP) had interactive team processes and discussed RVRs for all patients (but not all applicable RVR Mental Health Assessments (MHAs) in ML EOP and Medical EOP). Measurable treatment goals were discussed for all patients in MHCB, RHU, and ML EOP. MHCB and RHU were observed to have robust higher level of care discussions for all patients.

Adequate case formulations for all patients were observed in RHU. IDTT outcomes did not appear to be predetermined for all patients in MHCB, ML EOP and Medical EOP.

While two programs were observed to have robust higher level of care discussions, programs continue to not meet the compliance thresholds set for HLOC documentation quality. Despite this, Regional did not observe clinical encounters or review documentation for patients who appeared to be in need of a higher level of care who were not referred.

As CQIT+ audits are being implemented across the State, future site visits are pending further direction from the Receiver's office.

QUALITY IMPROVEMENT FOLLOW-UP
Please refer to the Sustainable Process CAP Spreadsheet.

Appendix E: Excluded Indicators

- AC5.2: Monthly Review of EOP Modified Treatment
- AC26.2: Documentation of Clinical Barriers to Patients LRH Placement are Documented in the MTP
- AC26.3: Documentation of Correctional Counselor Review of LRH during IDTT with an Appropriate Response
- QC5.3: MHSDS Patients Released from CDCR with Completed Pre-Release Forms
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- RH24: High Refusers due to Custody Reasons with Documented Plan of Action
- RH25: High Refusers for Whom a 128B was Completed
- RH26: High Refusing EOP Patients in Restricted Housing for Whom a Meeting Between MH and Custody was Conducted
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide
- SC6: The Use and Documentation of Mechanical Restraints Among Non-MAX Custody Patients in MHCB Units
- SP6: Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training
- SP12.1: Custody Follow Ups, Page 1
- SP12.2: Custody Follow Ups, Page 2
- SP23: Quality of Selected SRE Documentation
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk