

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

# REPORT ON THE TREATMENT OF COLEMAN PATIENTS IN DSH PROGRAMS



SUPPLEMENTAL REPORT TO THE LEGISLATURE

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# Department of State Hospitals

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## Supplemental Report to the Legislature (SRL) – Treatment of *Coleman* Patients

Pursuant to the Fiscal Year 2015-16 Budget, the Department of State Hospitals (DSH) submits this Supplemental Report to the Legislature on the Treatment of *Coleman* Patients in DSH Programs. This report details the steps taken to provide *Coleman* patients with treatment consistent with constitutional mandates. In addition, this report includes an update on the Administration's discussions regarding returning the responsibility for the care and treatment of *Coleman* patients to the California Department of Corrections and Rehabilitation.

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### EXECUTIVE SUMMARY

The Fiscal Year (FY) 2015-16 Budget requires DSH to submit a Supplemental Report to the Legislature (SRL) regarding the treatment of *Coleman* patients in its facilities.

DSH provides quality mental health evaluation and treatment for its patients in a safe and responsible manner, seeking innovation and excellence in its operations, across a continuum of care settings. In 1988, DSH began operating the first psychiatric program within the California Department of Corrections and Rehabilitation (CDCR) to provide inpatient mental health care to adult male correctional inmates. Today, DSH provides care for approximately 3,800 *Coleman* patients annually within approximately 1,200 beds located at Salinas Valley State Prison (SVSP) at Soledad, California Medical Facility (CMF) at Vacaville, California Health Care Facility (CHCF) at Stockton, as well as at DSH-Atascadero and DSH-Coalinga. DSH also provides care for two female *Coleman* patients at DSH-Patton.

In 2013, the Eastern District court of California directed the court appointed Special Master in *Coleman v. Brown* to monitor and report issues related to inmate inpatient care within DSH programs. This case originated in 1995, when the court found that CDCR's mental health care system was not constitutionally adequate. In 2006, the Director of DSH was added as a defendant since DSH, as CDCR's contractor, provided inpatient mental health care to the plaintiffs. In 2013, the Court directed the Special Master to monitor and report issues related to inpatient care at each of the DSH programs that treat *Coleman* patients.

The Special Master team began its monitoring of the DSH programs in 2013 and has performed a series of related site visits, the last visit occurring in June 2015. Following the first round of visits, the Special Master issued a written report of its findings and recommendations to the court on May 2014. The Special Master Team then completed another round of visits in 2015 and the report of the Special Master's recommendations from these visits is still pending. Subsequent to its monitoring tours, the Special Master provided recommendations and findings to DSH and the court to further improve the services DSH provides to CDCR inmates.

DSH has taken a number of comprehensive, effective, and innovative actions to address many of the Special Master's recommendations and findings. This has been done by bringing professional and high-quality mental health care more quickly to inmates in need, and in a greater number and type of institutional settings than before. These efforts include:

- Implementing standardized processes across the programs, where appropriate;
- Implementing a new treatment tracking and reporting system to more accurately and consistently measure treatment factors;
- Enhancing group treatment options;
- Strengthening and documenting sustainable patient care processes;
- Improving recruitment and retention of psychiatric and other clinical staff by way of modernizing outreach and enhancing the professional work environment;
- Fully resolving earlier inventory and supply problems;
- Implementing additional performance improvement and quality assurance measures, which included developing an internal Clinical Oversight Team and establishing a psychiatric program Group Treatment Development Workgroup;

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- Reducing the use of mechanical restraints through updated policies, procedures, and training, and piloting a new program to better redirect patients in crisis;
- Modernizing care with technology, by implementing Electronic Health Records in partnership with California Correctional Health Care Services (CCHCS) and employing an electronic staff scheduling and workforce management solution;
- Managing capacity issues with newly opened units, adoption of flex beds, and converting isolation rooms; and
- Improving care management and coordination with CDCR by way of a streamlined referral, admission, movement, and discharge process, as well as a new housing review policy to ensure a more rapid movement of patients to lower levels of custodial care when clinically appropriate.

### THE DEPARTMENT OF STATE HOSPITALS OVERVIEW

#### The Department of State Hospitals

DSH is responsible for the daily care and provision of mental health treatment of its patients. In FY 2014-15, DSH served almost 13,000 patients and on average the inpatient census was approximately 6,800 in a 24-hour-a-day, seven-days-a-week hospital system. There is also a census of approximately 600 in the outpatient conditional release program. DSH oversees five state hospitals and three psychiatric programs located in state prisons, employing approximately 12,000 staff. Additionally, DSH oversees the conditional release programs serving all 58 counties and provides services in jail-based competency treatment programs in participating counties.

DSH's five state hospitals are Atascadero, Coalinga, Metropolitan – Los Angeles, Napa and Patton. The three psychiatric programs are operated through an interagency agreement with CDCR, treating inmates at prisons in Salinas Valley, Stockton, and Vacaville. The jail-based competency treatment programs are located in San Bernardino, Riverside, and Sacramento County Jails.

#### History of the DSH's Involvement in the *Coleman v. Brown* Lawsuit

DSH has operated psychiatric programs within the CDCR system, providing inpatient mental health care to adult male correctional inmates, since 1988. In the class action lawsuit, *Coleman v. Brown* (formerly *Coleman v. Wilson*), plaintiffs (CDCR prisoners) alleged an Eighth Amendment constitutional violation challenging the quality of mental health care that CDCR provided to prisoners. In 1995, the Eastern District Court of California found that CDCR's mental health care system was not constitutionally adequate. While DSH was not initially included as a defendant in this class action, the Director of DSH was added as a defendant in 2006, due to DSH's status as CDCR's contractor providing inpatient mental health care to plaintiffs.

In 2013, the Court directed the Special Master to monitor and report to the court on issues related to inpatient care at each of DSH programs that treat CDCR inmates, in addition to the 45-bed inpatient program at the California Institution for Women (CIW), which is operated by CDCR. Following the Special Master's initial report, the Court ordered further monitoring of DSH and CDCR inpatient programs. Counsel for *Coleman* plaintiffs moved for enforcement of various orders related to treatment of *Coleman* class members in DSH programs. The primary issues of concern presented to the Court were a reported shortage of psychiatrists at the Salinas Valley

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Psychiatric Program (SVPP) and the delivery of patient care items such as clothing, linens, and personal care items.

In 2015, DSH experienced a significant increase in patient referrals by CDCR to its acute inpatient programs, resulting in a waitlist for acute inpatient care. On August 19, 2015, the Court ordered DSH to report on whether regular and consistent use of the full complement of 256 beds at DSH-Atascadero designated for *Coleman* class members was sufficient to permanently eliminate the ongoing waitlist for inpatient mental health care and, if not, why not, and the alternate plans in place for waitlisted class members. In response to that order, on October 30, 2015, DSH filed a report on the use of the DSH-Atascadero beds, its patient movement plan, and current measures to address capacity needs.

### SPECIAL MASTER’S RECOMMENDATIONS

#### Special Master Monitoring Tours

The initial monitoring tour of DSH programs was conducted in August 2013 at SVPP, and the remaining DSH *Coleman* programs were toured during the Fall of 2013 and Spring of 2014. During these tours, many aspects relative to patient care were reviewed, including:

- Recruitment and retention
- Mechanical restraints
- The role and use of medical technical assistants (MTAs)
- Escort practices
- Discharge planning
- Supply ordering
- Patient admissions and movement
- Group treatment
- Use of force
- Emergency response
- Mortality review process
- Utilization review and quality management
- Unusual occurrences and serious incidents
- Patient complaints and satisfaction
- Visitation
- Law library access

On May 30, 2014, the Special Master provided to the *Coleman* court and DSH a written report on the status of inpatient care in the DSH *Coleman* programs. On July 25, 2014, the *Coleman* court adopted the Special Master’s recommendations contained in the report order, which include:

*The Special Master shall review further all six inpatient programs, by means of paper review of the California Institution for Women Psychiatric Inpatient Program and Coalinga State Hospital, and by on-site monitoring of Atascadero State Hospital, California Health Care Facility, Salinas Valley Psychiatric Program, and Vacaville Psychiatric Program.*

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*The CDCR and DSH defendants shall, under the guidance of the Special Master and his staff, review and re-evaluate the use of orientation, cuff status, Discretionary Program Status, and the steps/stages processes and any variations thereon at the six inpatient programs, and whether those policies, as designed and implemented, achieve the proper balance between legitimate security needs and access to necessary inpatient mental health care.*

*The CDCR and DSH defendants shall, under the guidance of the Special Master and his staff, review and re-evaluate existing clinical staffing levels in the six inpatient programs and their effect on the delivery of treatment to CDCR patients in those programs, and to the extent indicated, develop a plan to adjust clinical staffing levels where necessary to ensure that adequate and sufficient treatment can be delivered to class members at those programs.*

### **Follow-Up Monitoring (January and June 2015)**

The Special Master conducted monitoring tours at DSH *Coleman* programs in January and June of 2015. The Special Master's report to the *Coleman* court regarding these tours is expected to be issued in the spring of 2016.

### **PERFORMANCE IMPROVEMENT MEASURES TAKEN BY DSH**

As each round of monitoring was completed, the Special Master's team held exit conferences to apprise DSH's Executive Management of its preliminary findings and recommendations. In response, DSH has taken the following actions to consider and implement the Special Master's recommendations and address findings.

#### **Recruitment and Retention**

DSH increased efforts to recruit and retain qualified clinical staff within each of the three psychiatric programs. These efforts include the use of centralized contracted staff, the use of civil service staff working in additional positions, offering alternate work schedules to improve retention in these highly competitive fields, and the formation of a centralized Recruitment Unit with a focus on hard-to-fill classifications.

One of the Recruitment Unit's priorities is to recruit psychiatrists. Specific efforts to recruit and retain psychiatrists include: focused recruitment resources; contracting with various recruitment firms to refer psychiatrists for hire; outreach to residency and fellowship training programs; the establishment of a forensic psychiatry fellowship; continued development of DSH residency training programs with California universities; attendance of psychiatric recruitment events; online and print advertisements in psychiatry journals; outreach to psychiatric organizations nationwide; and an expedited hiring and credentialing process. Through this unit's focused marketing and recruiting efforts, the DSH has hired nine new psychiatrists for the three psychiatric programs and currently has seven active applicants.

#### **Laundry and Supply Ordering**

DSH identified deficiencies in the SVPP laundry and supply process, resulting in difficulty in tracking of inventories and supplies. A multidisciplinary committee was formed to assess the laundry and supply process, identify barriers, and account for supplies versus needs. Based on

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its findings, the committee formulated solutions, developed policies and procedures and, ultimately, implemented a new laundry and supply process which included training, auditing, and monitoring components to ensure consistency and sustainability. Since the last Special Master's monitoring tour, there have been no further supply issues identified. This process has been, and continues to be, successful.

### **Use of Mechanical Restraints**

DSH and CDCR worked collaboratively to review and revise policies and procedures to reduce the use of, and duration of time that patients are placed in mechanical restraints, along with the implementation of tracking, which includes supervisory review and auditing of the collected data. The Departments also modified existing space to serve as additional treatment space for patients requiring mechanical restraints for safety reasons. These policy changes have resulted in a significant reduction in the use of mechanical restraints and improved access to treatment for patients with higher custodial restrictions.

In addition to these efforts, the VPP launched a pilot program within one of its 32-bed acute units to reduce the use of mechanical restraints by restructuring its treatment program to allow patients to attend treatment groups and have access to yard more quickly. The program was designed to ensure that the treatment provided aligns with each patient's risk level and clinical needs, as well as to increase the number of treatment hours provided to acute patients while they require higher custodial restrictions. This led to more out-of-cell programming activities, a reduction in aggressive behavior, and quicker rates of symptom improvement. The effectiveness of this program continues to be monitored through the use of: monthly patient satisfaction surveys, Special Incident Reports, seclusion and restraint usage data, unit length of stay reviews, tracking of length of time on mechanical restraint, length of time of patients' progress in reaching group status, patient group treatment hours, total treatment hours offered by the unit, and group cancellations.

### **Patient Admissions and Movement**

DSH's Patient Management Unit (PMU) and CDCR's Health Care Placement Oversight Program (HCPOP) have worked closely to address variable wait times for *Coleman* patients to be admitted into inpatient beds across the DSH continuum of care. These teams support and track effective patient movement into, within, and out of the three psychiatric programs. Additionally, PMU and HCPOP regularly convene clinical case conferences to discuss and manage complex cases.

Further, DSH developed a statewide patient reservation and tracking system (PaRTS) for all DSH admissions. This system is a centralized data repository of patient referrals, legal documents, placement criteria, and scheduling that is currently used in the state hospitals. It is anticipated that the three psychiatric programs will implement this system in the coming year.

### **Group Treatment**

DSH has increased the number of group treatment hours provided and has improved its tracking of treatment provided. The primary barriers to resolving this issue were twofold. First, the psychiatric programs did not have a database in place to accurately track the number of groups scheduled, assigned, and attended by *Coleman* patients. Secondly, treatment space is limited.

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Although DSH was scheduling and conducting groups and individual therapy sessions at each of the psychiatric programs, DSH did not have a consistent tracking system to effectively collect, analyze and report the data to demonstrate its performance. To improve in this area, DSH implemented new treatment tracking and reporting software, which provides the capability to use data to drive performance improvement. The My Activity Plan and Participation (MAPP) module, which is a supplement module to the Psychiatric and Wellness Support System (PaWSS), allows for the creation of patient group treatment schedules and review of group hours. The MAPP module is linked to each patient's treatment plan, which assists DSH treatment teams in placing patients in clinically appropriate groups and in reviewing the group hours that the patient is offered and attends on a weekly and monthly basis. With these scheduling tools now available, each psychiatric program collects and tracks data related to group treatment, leisure groups, individual therapy, and out-of-cell activities offered and attended, thus DSH is better able to demonstrate its provision of treatment.

As a result of these efforts, monthly tracking audits of individual therapy and group treatment at the psychiatric programs now accurately reflect the increased number of treatment hours provided. Additionally, patients are provided more opportunities for activities in out-of-cell leisure and recreational groups.

### **ADDITIONAL EFFORTS TAKEN BY DSH**

In addition to the areas of concern noted by the Special Master and the solutions that DSH has implemented, as described above, DSH has also taken action in the areas of performance improvement and quality assurance, technology solutions, addressing capacity needs, and formal policy development between DSH and CDCR to improve processes related to patient care and movement.

#### **Performance Improvement and Quality Assurance – Clinical Oversight Team**

DSH has developed an internal Clinical Oversight Team as a temporary subgroup of the DSH Clinical Operations Advisory Council to specifically work with the three psychiatric programs. This team is comprised of one clinician from each of the following clinical disciplines: psychiatry, psychology, and rehabilitation therapy, as well as two clinicians from nursing (registered nurse and psychiatric technician). Their role is to assist in the evaluation and implementation of the Special Master recommendations; to coordinate clinical efforts across all three psychiatric programs for efficiency and consistency; and to ensure that statewide clinical efforts are evaluated and implemented within the psychiatric programs where applicable and feasible. The team's specific efforts are as follows:

- Facilitated collaboration between the clinical chiefs of all three psychiatric programs, leading to the development of a comprehensive clinical audit tool, training on the use of the tool for clinician leaders, and training to ensure adherence amongst users of the audit tool, with the goal of improving the quality and consistency of patient treatment plans. This process included, and continues to include, auditing of current treatment plans, developing training protocols where indicated, and entering data from the audit tool into a database that allows for monthly reviews of progress and deficiencies. These evaluations allow for ongoing training to mitigate deficiencies and for providing further recommendations of improvement to the DSH Medical Director and Executive Management.

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- Established a psychiatric program Group Treatment Development Workgroup. This workgroup developed standardized treatment terms and definitions of each term that are utilized by all three psychiatric programs. The workgroup also created a centralized space for document-sharing between the three psychiatric programs using MS SharePoint, in which all existing lesson plans and curricula have been uploaded and continued to be uploaded as they are developed. The uploading of this information into a readily accessible web portal has allowed for the ability to view, share, and utilize resources from all three psychiatric programs, which has greatly increased the number of lesson plans and group resources available. Sharing resources also allows for greater consistency in treatment group content and quality among the psychiatric programs.
- Collaborated with each psychiatric program's Standards Compliance Department staff to assist with the continued modification of patient tracking and trending mechanisms, initiated the standardization of data collection and reporting efforts, and assisted with the implementation of additional quality improvement software tools used in the state hospitals, known as Plato Data Analyzer.
- Conducted outreach to various treatment programs to learn best practices, both within California and nationwide, that have been successful in providing inpatient psychiatric treatment in settings similar to the DSH psychiatric programs, such as the CIW and San Quentin State Prison; those identified by the Special Master as the "gold" standard for psychiatric care of inmates, such as the Central New York Psychiatric Center; and those with limited physical space, such as the Mendota Juvenile Treatment Center in Wisconsin.
- Improved nursing practices by collaborating and consulting with the Nurse Administrators at all DSH facilities to eliminate the practice of time-out and to reduce the use of restraints. Training was provided to nursing staff on all aspects of nursing documentation, including various nursing assessments, progress reports, and restraint documentation. Nursing staff was mentored on their role in the treatment planning process and treatment planning documentation.
- Assisted with developing mechanical restraint policies and implementing solutions to better align clinical and operational policies among the three psychiatric programs, which has allowed for improvement of processes and greater continuity of care.

### Technology Solutions

To further enhance treatment and care, DSH is in process of implementing the following technology solutions at its Psychiatric Programs:

#### Electronic Health Record System (EHRS)

An EHRS is to be implemented by CCHCS within CDCR institutions. An EHRS is the integration of multiple modules providing data into a patient's clinical health record. The EHRS contains clinical information, captures data, and documents information about the patients and their care from each practice area.

CCHCS successfully piloted the EHRS at three CDCR prisons in October 2015, including management of the data used for *Coleman* reporting. The three DSH psychiatric programs are slated to implement the EHRS later in 2016. Staff training on the EHRS computer modules is

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underway, including a gap analysis of current critical systems and how they will be maintained or transitioned to the EHRS. DSH executive assessments found sufficient data and reporting functionality and approved utilization of the EHRS for DSH *Coleman* reporting purposes. Upon successful EHRS adoption, the DSH psychiatric programs will produce *Coleman* reports through the EHRS.

### Automated Staff Scheduling and Information Support Tool (ASSIST)

ASSIST is an electronic staff scheduling and workforce management solution that is hosted centrally and deployed statewide. The primary focus of the ASSIST solution is to efficiently manage daily scheduling of the DSH's 24/7 classifications at every DSH facility across all shifts.

Paperless scheduling was achieved at all eight DSH facilities on September 30, 2015. ASSIST has not been fully implemented for Bargaining Unit 6 staff at the SVPP and the VPP. Tentative plans for Bargaining Unit 6 target mid-2016 to complete this deployment. The project team continues to work with each DSH facility, including the three psychiatric programs, to improve system usability as well as identify and implement staffing and scheduling best practices across all DSH facilities.

### **Addressing Capacity Needs**

DSH continues to experience growth within the *Coleman* population. In the spring of 2015, CDCR's population projections illustrated the need for beds in excess of DSH's current levels. Specifically, in the first quarter of FY 2015-16, DSH observed an increase in acute referral rates.

The CDCR referrals to intermediate and acute levels of care at DSH are dynamic and can, in a short period of time, exceed available beds at either the intermediate or acute levels. To accommodate the growing population and respond to fluctuations as they occur, DSH is managing the following capacity expansion efforts:

### 30-Bed Unit Activation at the VPP (August 2015)

The Budget Act of 2015 included \$4.6 million (State General Fund) and 38.2 positions to activate a 30-bed intermediate care unit at the VPP. These resources were requested in order to accommodate CDCR's population forecast for this Fiscal Year (FY) 2015-16 (Mental Health Bed Study – Spring 2016). The approved intermediate care unit was activated in August 2015 and remains full with a census of 30. There is currently no waitlist for Intermediate High Custody patients.

### Designation of "Flex" Beds at the SPP (December 2015)

DSH worked closely with CDCR to designate a 29-bed intermediate care unit as a "flex" unit at the SPP, which was activated on December 14, 2015. This unit was converted to operate and be staffed at the acute level in order to meet the mandated staffing required to quickly adapt to periodic changes in level of care. When this unit operates at the intermediate level, staffing redirections will occur in order to offset overtime and vacancies. Should the need arise, additional units may be converted in this manner. At this time, no fiscal impact is anticipated.

### Use of Isolation Rooms at the SPP (Spring 2016)

DSH is also coordinating with CDCR to increase the number of available acute and intermediate beds at the SPP by modifying medical isolation rooms for regular use which requires slight modifications to the shower area. Final implementation plans are currently being completed and

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it is expected that these rooms will be available for occupancy by the end of FY 2015-16 at a minimal cost to be absorbed by CDCR.

### FORMAL POLICY DEVELOPMENT BETWEEN DSH AND CDCR

In November 2015, DSH and CDCR, in collaboration with the Special Master, negotiated a new Memorandum of Understanding for management of inpatient psychiatric treatment of *Coleman* patients in DSH programs. The MOU incorporates new policies as described below.

#### Streamlined Referral, Admission, Movement, and Discharge Process

The MOU includes a Joint Referral, Admission, and Movement policy and a Joint Discharge policy. Under the new policies, the PMU and the HCPOP will be more involved in patient admissions and discharges, ensuring that any delays or issues at the local level are quickly elevated and resolved. Information regarding admissions and discharges from DSH will be simultaneously shared at the local and headquarters levels to ensure real-time monitoring of compliance with transfer timelines for accepted or discharged patients. As a result, DSH beds will be more efficiently managed and transfer timelines will be reduced.

#### New Housing Review Policy

A new DSH Housing Review Policy has been included in the updated MOU to provide DSH treatment teams with a patient's pre-approved CDCR custody designation, known as the Least Restrictive Housing (LRH) designation, prior to admission to DSH. If a patient is placed into a higher custodial setting within DSH for clinical reasons, the treatment team will identify the clinical concerns preventing the patient from being placed within his LRH setting, and develop a treatment plan to address those concerns. DSH is committed to moving patients to the least restrictive setting as soon as clinical factors permit such movement. Treatment teams will be trained and required to address the patient's progress on transferring to a less restrictive setting as part of the monthly treatment planning meetings. Further, CDCR will continue to conduct custodial reviews for patients housed in DSH to determine whether a patient's LRH designation should be adjusted based on the patient's behavior within DSH, or other custodial factors. If a patient's LRH designation is adjusted, the new LRH designation will be communicated to the treatment team.

The new MOU and associated policies will ensure effective movement into, throughout, and discharge from the DSH-continuum of care for *Coleman* patients. In response to the court's interest in the regular and consistent placement of patients at DSH-Atascadero, DSH and CDCR have implemented interim processes until the new MOU and policies can be fully implemented. These interim processes have helped to facilitate the placement or movement of patients into DSH-Atascadero. As a result, DSH has been able to increase the *Coleman* census at DSH-Atascadero from 150 at the beginning of November 2015 to 249 at the end of March 2016.

### UPDATE ON POTENTIAL PSYCHIATRIC PROGRAM TRANSFER

DSH and CDCR continue to evaluate the feasibility, possible timing, and potential outcomes of returning the responsibility for the *Coleman* patients' inpatient psychiatric treatment to CDCR.

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### CONCLUSION

In response to the recommendations of the Special Master and in collaboration with CDCR, over the past three years, DSH has developed and implemented many performance improvement measures at its psychiatric programs and state hospitals treating *Coleman* patients.

As a result, DSH has continued to improve processes associated with clinical treatment and patient outcomes; improved reporting and documenting of treatment and care efforts through newly implemented technology solutions; and further cemented collaboration between DSH and CDCR across the continuum of mental health care. DSH continues to work closely with the *Coleman* Special Master and CDCR to effectively address current and ongoing concerns as they arise.