10th Sacramento County Remedial Plan Status Report

January 7, 2025

Table of Contents

Introduction 4

Summary of Activities During the Reporting Period Impacting Compliance........................5

Leadership and Strategic Planning 5

Staffing 7

Policy and Process Improvements 8

Facility Renovation Efforts..9

Engagement with Class Counsel and Subject Matter Experts....................................10

Criminal Justice System Impacts 11

Jail Population Reduction Plans 15

Plans for Upcoming Reporting Period 17

Remedial Plan Compliance 18

Current Compliance Level and Progress 19

II. General Provisions 21

III. Americans with Disabilities Act (ADA) 24

IV. Mental Health 55

V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities 84

VI. Medical Care 95

VII. Suicide Prevention 153

VIII. Segregation/Restricted Housing...182

IX. Quality Assurance Systems for Health Care Treatment......................................203

Attachments..211

1. Abbreviations and References 211
2. ACH and ACMH Policy and Procedure Developments and Revisions 214
3. SSO Policy and Procedure Developments and Revisions 216
4. ACH and ACMH Audits and Studies 217
5. Adjustments to 9th County Status Report Compliance Ratings 219
6. Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation 220
7. Mental Health Remedial Plan Expert Rating Reconciliation 221
8. Disciplinary Measures and Use of Force Remedial Plan Expert Rating Reconciliation 223

9. SSO Disciplinary Process and MH Referral Flow Chart 225
10. Medical Care Remedial Plan Expert Rating Reconciliation 227
11. Suicide Prevention Remedial Plan Expert Rating Reconciliation 230
12. Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation .. 233
13. Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation 237

Introduction

Background

The Mays Consent Decree was approved by the federal court on January 13, 2020.

- Every 180 days, Sacramento County is required to issue a Remedial Plan Status Report, which is sent to Mays Class Counsel, the court-appointed experts and filed with the court.
- Each expert completes Remedial Plan Monitoring Reports using document requests, chart reviews, and site visits to provide compliance determinations as well as feedback and recommendations to support County progress toward compliance with the Mays Consent Decree Remedial Plan.

This report covers the period of July 2024 – December 2024. This is the tenth County Remedial Plan Status Report. This report covers Sacramento County's overall progress toward meeting Consent Decree requirements, including current compliance status, data or evidence to support current status, and plans in place to address areas not yet in full compliance. Attachment 1, Abbreviations and References, identifies abbreviations and terminology used throughout the report.

Jail Facilities and Operations

Sacramento County has two jails – the Main Jail (MJ) located in downtown Sacramento and the Rio Cosumnes Correctional Center (RCCC) located in Elk Grove.

The Sacramento Sheriff's Office (SSO) has overall responsibility and management for the jail facilities. Adult Correctional Health (ACH) within Department of Health Services (DHS), Primary Health Division provides the health care services (physical health and behavioral health) through County staff and County contracted staff – working in partnership with SSO. The Department of General Services (DGS) assists with facility construction, remodeling, and maintenance.

The jail population has higher average rates of health care needs as compared to the community, including chronic health conditions, serious mental illness (SMI), and substance use disorders (SUD). In comparison to the prior reporting period of January to June 2024, the Average Daily Population (ADP) of the jail system for the period of July – December 2024 indicates an increase of 1.2% ADP. However, the ADP of the jail system has continually declined since August 2024. The December 2024 ADP (3,074) reflects the lowest ADP recorded in 2024. The ADP of the jail system remains well below the BSCC rated capacity.

	MJ	RCCC
Year Opened	1989	1960
Location	651 I Street, Sacramento	12500 Bruceville Road, Elk Grove
Rated Capacity	2,380	1,625
Jan- June 2024 ADP	1,827 (76.8% Capacity)	1,313 (80.8% Capacity)
July - Dec 2024 ADP	1,737 (73.0% Capacity)	1,440 (88.6% Capacity)
Change	-90 (4.9% Decrease)	+127 (9.7% Increase)

Summary of Activities During the Reporting Period Impacting Compliance

The following highlights represent a summary of activities undertaken by the County since the 9th County Status Report published in July 2024.

Leadership and Strategic Planning

Throughout the present reporting period, there have been significant shifts in County leadership roles and strategic coordination efforts across the various service lines serving Sacramento County correctional facilities.

Jail Conditions Improvement Action Planning Meetings and Policy Group
In June 2024, the Deputy County Executive for the County's Public Safety and Justice Agency (PSJA) re-configured regular meetings with representatives from SSO, ACH, and DGS to support greater communication and coordination related to construction projects occurring in County jail facilities. By August 2024, this effort evolved into Jail Conditions Improvement Action Planning (JCIAP) meetings. Discussions in these meetings are guided by priorities determined by a Policy Group, consisting of the PSJA Deputy County Executive, Social Services Agency Deputy County Executive, Administrative Services Agency Deputy County Executive, Undersheriff, and County Counsel.

JCIAP meetings are facilitated by the PSJA and supported by operational leads from each service line, with the Chief of Corrections representing the Sheriff's Office and Deputy Directors representing DGS and ACH. JCIAP meetings are designed to:

- Maintain situational awareness of progress toward completion of construction projects in County correctional facilities, including the projects prioritized by the Policy Group; and
- Promote effective cross-departmental communication, coordination, and issue resolution to improve compliance with County legal obligations, including Americans with Disabilities Act (ADA) and Mays Consent Decree.

JCIAP meetings have used two week (14 day) operational periods to identify tasks, report out on progress, and address identified challenges. It is anticipated that JCIAP meetings may shift to monthly operational periods in 2025 as regular and ongoing collaboration across service lines have increased. The Policy Group will continue to provide direction and drive priority shifts as needed.

SSO Compliance Coordinator and Integration of Jail Facilities
In October 2024, the Board of Supervisors approved the addition of 1.0 FTE Sheriff Records Officer III (SRO III) position for SSO, referred to as the Compliance Coordinator. The non-sworn Compliance Coordinator for the Mays Consent Decree will facilitate and coordinate SSO compliance planning, implementation, and proof of practice efforts. This is a high-level position to provide sustained ownership and stable leadership to coordinate

expectations, engage in long-range planning, report on progress and setbacks, and facilitate the application of department orders and policies.

To stay in compliance with the Mays Consent Decree, the Compliance Coordinator will provide management and oversight of the Correctional Services Compliance Unit, Intensive Outpatient Program Unit, and Classification Unit. The Compliance Coordinator will ensure both the correctional facilities, Main Jail (MJ) and Rio Cosumnes Correctional Center (RCCC) comply with applicable provisions of the Remedial Plans, review reports and requests from County Counsel, Class Counsel, and Subject Matter Experts, and coordinate required audits, American with Disabilities Act (ADA) transitional upgrades, Title 15 and 24, Prison Rape Elimination Act (PREA), suicide prevention protocols, classification reviews, and mental health compliance. The Compliance Coordinator will serve as the direct liaison between the MJ and RCCC Command Staff to facilitate the unilateral application of department orders and policies.

The Compliance Coordinator position has been filled by Michael Kotara. Kotara has numerous accolades and receives high praise and appreciation from the County and Superior Court for his professionalism, knowledge, thoroughness, and teamwork. Kotara is experienced with the SSO's jail management system (ATIMS) and its transition, is knowledgeable about facility maintenance and modernization efforts, and excels in systemically gathering information, sorting through complex issues, using consensus when appropriate, and promoting clear communications.

Other Leadership Transitions and Additions

During this reporting period, there were leadership changes in other service lines. In ACH, a second Nursing Director has been added to oversee all nursing operations at RCCC. For more effective management of the workload and number of nursing staff at both jails, each facility will now have its own Nursing Director. ACH hopes to fill the position by the beginning of the next reporting period. Three Supervising Registered Nurse positions have also been added, two specifically for Nurse Intake during NOC shift and one to oversee grievances and other administrative processes. All are in the process of recruitment and hiring.

The full-time Assistant Medical Director position has been converted into two part-time positions. Dr. Yeoshina Pillay has accepted one of the positions and began during this reporting period and the other is in the process of recruitment and hiring.

Additionally, the departure of the Quality Improvement Director during this reporting period provided an opportunity for the Quality Improvement Coordinator, Ivan Mendoza-Manzo, to expand their experience, knowledge, and responsibilities until the position is filled. While serving as the Interim Quality Improvement Director, he was officially offered the position after a competitive interviewing process in late December 2024.

In July 2024, the County welcomed a new Director of General Services, Joshua Green. The position had been vacant since October 2023, with the Deputy County Executive for Administrative Services serving as Interim Director. Green has many years of experience leading and supporting highly effective teams in large public agencies in executive-level roles. Since joining the County, Green has demonstrated an ability to provide a clear and forward-thinking vision for DGS and has aided in facilitating cross-departmental coordination and communication.

The assigned Deputy County Counsel maintains a pivotal role in coordinating engagement and communication with Class Counsel, Subject Matter Experts, and the Court, and advising and supporting County partners in interpreting and responding to Consent Decree requirements, as well as documentation and other requests from various entities. In January 2025, this role will be assigned to a full-time employee, Monica Robinson.

Robinson has been with the County for many years, having previously served in the District Attorney's Office before joining County Counsel. Outgoing Deputy County Counsel Sarah Britton and Robinson have been working closely together over several months to ensure a smooth transition of responsibilities.

Staffing

County began to add staff and/or contract augmentations prior to the finalization of the Consent Decree (January 2020). Vacancy rates increase as positions are allocated; therefore, monitoring the total Full-Time Equivalents (FTEs) by position allocated in addition to vacancy rates is important to identify and monitor progress.

Since the prior reporting period:

- ACH Medical and Administrative FTEs have increased with the addition of three Registered Nurses, three Supervising Registered Nurses and a Health Program Manager (2nd Nursing Director). This was partially due to the reallocation of eight Licensed Vocational Nursing positions that had been difficult to fill.
- Contracted Mental Health and Administrative staff have decreased by 13 (9.5%). This was due to freezing vacant positions to meet general fund targets at the start of the 2024-25 fiscal year by 13.0 vacant FTE. The contract is expected to be restored and expanded at mid-year.
- SSO Correctional FTEs have increased by 5 (1%).

Recruitment and hiring remains a priority for all service lines. A notable staffing addition during this reporting period is the Supervising Nurse Educator, a position that has been filled with an RN with 27 years of nursing experience, and over 24 years in correctional nursing. He began his new role within ACH in December 2024 and will oversee onboarding and training new nursing staff, ensuring compliance with mandatory staff training requirements, and training all staff on new policies and procedures and any changes to existing policies and procedures.

Additionally, in FY 24/25, SSO was allocated an additional four (4) Deputy Sheriff positions responsible for escorting inmates to and from medical appointments, escorting medical staff during medication administration, and facilitating other medical or psychiatric appointments, to comply with Mays Consent Decree requirements, which have expanded since last fiscal year. SSO allocated one of these positions to the APU to make its day and swing shifts fully staffed.

Policy and Process Improvements

Many policies related to Remedial Plan provisions are revised and/or developed in consultation with Class Counsel and designated court-appointed Subject Matter Experts.

Adult Correctional Health Policies and Process Improvements
New or updated policies may include significant changes for ACH, including new workflows, development of new forms, electronic health record (EHR) templates, new Quality Improvement (QI) audits and/or reports, etc. Some policies have a phased-in implementation due to the need for sufficient staffing, equipment, or other needs. ACH has completed new policies and/or policy revisions to address Remedial Plan provisions in all major areas.

As of December 2024, 51 ACH Medical or Medical/Mental Health joint policies and 26 Mental Health policies have been approved by Class Counsel and/or Subject Matter Experts. This reflects an increase of seven policies finalized since publication of the 9th County Status Report in July 2024. However, ACH did not count seven policies in the 9th County Status Report because those seven approved policies were under revision. 10 of the 51 policies have been revised and submitted to Class Counsel or Subject Matter Expert for review during this reporting period. An additional three revised policies are undergoing the ACH internal review process. This includes the Grievance, HSR, and Peer Review polices. Attachment 2, ACH and ACMH Policy and Procedure Developments and Revisions, identifies the status of ACH Policies, Guidelines, and Procedures developed in response to the Remedial Plans and identifies all ACH and ACMH policies developed or revised during the reporting period (July 1, 2024 – December 31, 2024).

Notable policy and procedure updates during the reporting period include:

- **ACH Policy Consultant:** During this reporting period, ACH contracted with a policy consultant, Jonnie Lambert, per the recommendation of the Subject Matter Experts to help better align ACH policies with consent decree requirements. Lambert is currently reviewing key ACH policies and will assist with the development and/or revision of Standardized Nursing Procedures. The following policies are currently with her for review:
    - Nurse Intake
    - Health Service Requests
    - Nurse Sick Call
    - Emergency Medical Response
    - Man-Down Drill

    - Healthcare Grievance Process
    - Medical Observation Cell
- **Medical Observation Cell:** As referenced above, based on recommendations from the Court-Appointed Monitors of the Medical Remedial Plan (also known as Subject Matter Experts or SMEs) and necessary process changes, ACH began a new process in November 2024 called "Intake Medical Observation Cell" which was previously known as "Sobering Cell." This new process affects patients that are fit for incarceration, are intoxicated, and require a protective environment for their safety, or the safety of others. A nurse assigned to the intake team will complete a welfare check on each patient housed in the Medical Observation Cell, every 30 minutes. The intake rounding nurse will also complete an assessment every two hours while the patient is housed in Medical Observation Cell. This assessment will ensure that there is a face-to-face encounter between the medical staff and the patient to monitor patient safety during this potentially high-risk time. These changes address a major area of need in the intake/booking process and adds another layer of patient safety to ACH processes.
- **Court Medication Administration:** Effective November 2024, there is a new court medications process at the Main Jail. Through close collaboration between custody, pharmacy and nursing staff, a new method was developed for daily court notification, medication preparation and administration prior to patients leaving for court in the morning. This new process assists staff and patients in the timely administration of medications during the court process. Combined with the pre-established court medication process used at RCCC, this creates improvements across the jail system.
- **Critical Needs Assessment Program (CNAP):** In October 2024, ACMH implemented the Critical Needs Assessment Program (CNAP). CNAP provides intensive services to patients who have reported suicidal ideation and/or engaged in chronic self-injurious behaviors but do not meet criteria for inpatient treatment on the Acute Psychiatric Unit (APU) for danger to self-pursuant to W&I Code 5150. The goal of the program is patient stabilization and return to assigned housing/program or a higher level of care if clinically indicated. The CNAP has designated mental health staff who collaborate with the 3W deputies to provide services to patients participating in the program. Service components include group activities focused on risk reduction, safety planning and coping skills, and 1:1 visits, treatment planning and crisis intervention.

Sheriff's Office Policies and Process Improvements
Attachment 3, SSO Policy and Procedure Developments and Revisions, identifies all SSO policies developed or revised during the reporting period (July 1, 2024 – December 31, 2024).

Facility Renovation Efforts

Facility issues at the Sacramento County jail continue to be an area of focus.

During this reporting period, the MJ-1ST Floor Medical Intake Privacy Project, including signaling/notification, was completed. This project added four confidential rooms in the booking area where nursing intake will be completed. Class Counsel and the Court-Appointed Monitors for Medical Care and Mental Health were able to observe the new nurse intake rooms and provided positive feedback. These rooms now meet the requirements for patient confidentiality, increasing compliance in many areas. Additionally, during this period, enclosures for confidential contacts were installed on floors 3-8 throughout the jail. Privacy curtains for these enclosures will be installed during the upcoming reporting period. Privacy enclosures are used daily by both ACH and ACMH staff and have greatly increased the County's ability to provide confidential treatment services.

Facility renovation projects in process that have been prioritized by the Policy Group include:

- The Intake and Health Services Facility underwent a peer review during this reporting period. The outcome of that peer review is expected in the next reporting period and will assist the county in determining next steps on renovations and/or additions to support compliance with the Consent Decree.
- A project to expand the Acute Psychiatric Unit (APU) by modifying an existing pod in the Main Jail 3rd Floor. The County expects twenty-four (24) of these beds will be LPS certified, and an additional seven (7) will serve as "step down" beds for patients transitioning to a lower level of care. Staffing space will be built within the pod to accommodate the level of care. Other pod elements will be retrofit to provide safety and security for the function of this unit. The County's investment in this project's construction is roughly estimated to exceed $4 million.
- A project to expand the Intensive Outpatient Psychiatric (IOP) program, converting 34 beds to the IOP program: 24 male beds at RCCC and 10 female beds at Main Jail.
- A project to create a dayroom area in the Ramona wing at RCCC to meet Consent Decree out-of-cell time compliance. This will require removing walls to accommodate a day room area.
- A project for Main Jail Recreation Yard Improvement to divide recreation yard areas for increased out-of-cell time compliance.

Engagement with Class Counsel and Subject Matter Experts

During the July 1 – December 31, 2024 monitoring period, the County engaged with Class Counsel and the Court-appointed Subject Matter Experts on several occasions. In addition to both regular and issue-specific meetings, these included:

- Site visits and assessments with the Subject Matter Experts for Remedial Plan IV – Mental Health (Dr. Mary Perrien), Remedial Plan VI – Medical Care (Madeleine L. LaMarre MN, FNP-BC, Angela Goehring RN, MSA, CCHP, and Susi Vassallo MD), and Remedial Plan VIII - Segregation/Restricted Housing (Class Counsel).
- Receipt of the two (2) reports from Subject Matter Experts:

- The “Fifth Monitoring Report of the Medical Consent Decree” by Madeleine L. LaMarre MN, FNP-BC, Angela Goehring RN, MSA, CCHP, and Susi Vassallo MD was submitted July 15, 2024. The report reflects a review of documents and an on-site tour at Sacramento County jail facilities from January 30 – February 3, 2024. Any comments or responses from the County are included in Section VI. Medical Care of this report.
- The “Fifth Monitoring Report of Suicide Prevention Practices” by Lindsay M. Hayes was submitted November 11, 2024. The report reflects a review of requested documents and an on-site assessment from April 23-25, 2024. Any comments or responses from the County are included in Section VII. Suicide Prevention of this report.

- Exchange of letters between County Counsel, Class Counsel, and Subject Matter Experts.

Criminal Justice System Impacts

During this monitoring period, there were several local and statewide initiatives that have the potential to impact the Sacramento County jail population.

Proposition 36

Proposition 36, passed by California voters in November 2024 and effective mid-December 2024, partially reforms laws connected to homelessness, drug addiction, and theft throughout California, while giving judges tools and flexibility to address these concerns. According to the California District Attorneys Association[1], Prop 36:

- provides drug and mental health treatment for people who are addicted to hard drugs;
- adds fentanyl as a prohibited substance to statutes prohibiting the possession of hard drugs while armed with a loaded firearm and trafficking of large quantities of hard drugs;
- gives judges more sentencing options – including state prison – to use their discretion when sentencing drug dealers convicted of trafficking hard drugs in large quantities or who are armed with a firearm while engaging in drug trafficking;
- warns convicted hard drug dealers that they can be charged with murder if they continue to traffic in hard drugs and someone dies as a result;
- reinstates the great bodily injury enhancement (GBI) for hard drug dealers whose trafficking kills or seriously injures someone;
- increases penalties for people who repeatedly engage in theft; and
- adds enhancements for “smash and grab” thefts that result in significant losses and damage, or that are committed by multiple thieves working together.

Statewide organizations such as Californians for Safety and Justice estimate that Prop 36 will add 130,000 more people to California jails each year, with approximately 100,000 of them held in jail before trial and about 30,000 serving less than a one-year sentence post-

[1] https://cpoa.org/wp-content/uploads/2024/11/Proposition-36-2024.pdf

conviction[2]. The Sacramento Superior Court has introduced a working group related to the implementation of Proposition 36. Impacts on the local jail population will be better understood in 2025.

SB 43

On October 10, 2023, the Governor signed Senate Bill (SB) 43, which made substantive changes to the Lanterman-Petris-Short (LPS) Act and a related provision of the Health and Safety Code (HSC). SB 43 amended the LPS Act's definition of "gravely disabled." "Gravely disabled" now means a condition in which a person, as a result of a mental health disorder, impairment by chronic alcoholism, severe substance use disorder, or a co-occurring mental health disorder and severe substance use disorder, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. The policy changes made by SB 43 became effective January 1, 2024; however, counties had the ability to delay implementation until January 1, 2026. Sacramento County delayed implementation to January 1, 2025. At this time, it is unclear the extent to which SB 43 will have an impact on Sacramento County's jail population.

Care Court

On December 1, 2024, Sacramento County officially launched its Community Assistance, Recovery, and Empowerment (CARE) Act Program (known as CARE Court) to connect individuals struggling with schizophrenia spectrum or other psychotic disorders with voluntary, community-based treatment through a civil court process. The voluntary program is available to individuals aged 18 and older who are diagnosed with a schizophrenia spectrum or other psychotic disorder, currently experiencing behaviors and symptoms associated with severe mental illness (SMI), unable to stabilize through existing voluntary treatment, and unlikely to survive safely in the community without supervision.

Objectives of Care Court are to:

- Promote recovery and optimize community functioning by providing support at the appropriate level of care.
- Advance and increase timely linkages to services through collaboration and coordination with various community partners - including Medi-Cal, CalFresh, and Social Security Income.
- Elevate and improve client-driven recovery-oriented culturally responsive, trauma-informed approaches to address mental illness and any co-occurring substance use disorders.
- Further client self-determination in the least restrictive setting with transitions to a lower level of service intensity as appropriate.
- Reduce emergency room visits, psychiatric hospitalizations, admissions to long-term facilities, arrests, incarcerations, and homelessness

---

[2] https://apnews.com/us-news/prisons-gavin-newsom-california-don-barnes-crime-120a4716d3d61a609c64ea7ce6c7762f and https://safeandjust.org/cost-tool/.

The CARE process begins with an individual, family members, behavioral health professionals, directors of organizations or hospitals involved in their care filing a petition, which is reviewed by a Sacramento County Superior Court judge to determine eligibility. If criteria are met, the court may order Sacramento County's Behavioral Health Services Division to investigate and develop a CARE agreement or plan tailored to the participant's needs. Through this process, participants can receive support through the program for up to 24 months, ensuring continuity of care and ongoing access to essential services.
The CARE Act embodies Sacramento County's commitment to a compassionate, recovery-focused approach for addressing mental health challenges. By empowering individuals with the resources and support they need, the program fosters connections within the community, prioritizing dignity and respect throughout the recovery process.

Encampment Enforcement
The Supreme Court decision to overturn the Ninth Circuit of Appeals ruling on *City of Grants Pass v. Johnson* restricting authority to enforce laws regulating encampments and the subsequent Executive Order N-1-24[3] (July 25, 2024) from Governor Newsom generated concern about increased enforcement potentially leading to more people with significant behavioral health and housing needs being booked into jail and/or booked and quickly released without accessing services.

In response to the Supreme Court decision, the Sacramento County Board of Supervisors amended Chapter 9.120 to Title 9 of the Sacramento County Code related to camping including vehicles, trailers, campers and recreational vehicles that, among other issues, undermine the cleanliness and usability of parks, water supplies, and other public resources. It also prohibits camping within 1,000 feet of a shelter providing services to people experiencing homelessness.

While the ordinance amendment includes more specifics about unlawful camping, the code also addresses the County's intention to protect lives and infrastructure and advances the County's efforts to increase the supply of emergency shelters through the code's enforcement (Chapter 9.120.10).

Sacramento County spends more than $220 million annually on programs, services and solutions to homelessness. The Board of Supervisors recently approved a construction bid for the Watt Avenue Service Center and Safe Stay Center, which will host 225 beds in Safe Stay cabins, 50 people in Safe Parking, 75 people for emergency/weather respite beds as well as Behavioral Health services with case management, storage, job training and more. The Board also approved funding for Joshua House, a facility that provides end-of-life comfort care for people experiencing homelessness and terminal illnesses. The County is also moving forward with an affordable housing project to shelter and house people exiting homelessness directly off the American River Parkway.

[3] https://www.gov.ca.gov/wp-content/uploads/2024/07/2024-Encampments-EO-7-24.pdf

Enforcement of County code as it pertains to illegal encampments provide an opportunity for law enforcement to interact with the unhoused population. During these interactions, law enforcement officers may observe criminal conduct and may also find outstanding warrants. These circumstances could contribute to individuals being given citations and/or booked into jail facilities.

To reduce the potential impact on the jail population, behavioral health, housing, and law enforcement partners must work together toward:

- Adequate build out of resources needed to address the behavioral health and sheltering needs of individuals law enforcement interact with in the field;
- Quick access to services through protocol development and coordination; and
- Development of resources and informational tools (websites, cheat sheets, etc.) to train and guide officers in the field to navigate these services.

During this reporting period, Sacramento County's Criminal Justice Cabinet (CJC) shared BHS Resources for Law Enforcement Agencies[4] previously developed by the Law Enforcement Coordination for Booking Alternatives Working Group formed in response to the Jail Population Reduction Plans. The CJC presentation highlighted voluntary and involuntary behavioral health services and resources for officers, as well as voluntary shelter service offerings. Law enforcement leaders were asked to designate an operations manager to participate in the development of protocols to increase use of available behavioral health and shelter services and reduce reliance on jail for clearing issues encountered in the field. The Law Enforcement Coordination for Booking Alternatives Working Group will be re-assembled, with new partner agencies added, in the next reporting period to begin this work.

Mental Health Diversion Court Reorganization

In response to changes in law expanding eligibility for Mental Health Diversion (MHD), applications for Felony Mental Health Diversion increased significantly in 2024. To minimize delays in processing applications, the County made substantial improvements to and investments in its behavioral health assessment processes. This effort largely reduced waiting periods for incarcerated individuals seeking assessments and linkages and increased the time for the application to be calendared and heard by the Superior Court. In response to the increased demand, in November 2024, the Sacramento Superior Court dedicated a new courtroom (Department 3) to mental health diversion applications with the goal of increasing capacity. The Court indicates it will monitor the effectiveness of the new courtroom.

---

[4] https://dhs.saccounty.gov/BHS/SiteAssets/Pages/Community-Wellness-Response-Team/BHS%20Resources%20for%20LEA%20-%20Mobile%20PDF.pdf

Jail Population Reduction Plans

The most recent update to the County's Jail Population Reduction Plans was published to the Public Safety and Justice Agency website on September 30, 2024[5] and shared with the Board of Supervisors under Communications Received and Filed on October 22, 2024. The reports focused on data and program information for the period of January 1, 2024 – June 30, 2024, but also included activities that extended into the current reporting period.

Highlights of the report included:

- Continuing to keep the Average Daily Population (ADP) of the jail system below the level indicated in the 2021 Sacramento County Jail Study and far below the jail's rated bed capacity as determined by the Board of State and Community Corrections (BSCC). While ADP and bookings increased since the prior report, there have been reductions in average length of stay for all inmates (pretrial and sentenced). Increases in ADP may be partially attributed to an increase in court commitments, while increases in bookings are attributed to individuals charged with misdemeanors who booked and released within 24 hours.
- Coordination with justice and health system stakeholders to develop performance measurement goals for each of the six strategies in the Revised Jail Population Reduction Plans published in April 2024. Each of the six strategies includes information about the County's level of ownership and responsibility, with all strategies requiring cross-system partnerships for full implementation and effectiveness.
- Discussion with community groups, including the Public Safety and Justice Agency Advisory Committee, to provide input into the creation of draft Dashboards to document progress toward achieving jail population reduction. Staff have also reviewed public-facing dashboards, such as the Salt Lake County's Jail Dashboard, and initiated discussions about the feasibility of developing similar tools.
- Expansions in crisis response and forensic division efforts by the County's Behavioral Health Services, including increases in availability and requests for the Community Wellness Response Team, coordinative efforts to develop a bilateral referral process for crisis response calls, staffing changes to decrease wait times for clients needing assessment for a mental health diversion application, and investments in full-service partnerships available for justice-involved clients.
- Efforts to secure additional funding to increase post-release service connections to behavioral health treatment, housing, and other resources, including submission of a grant application seeking $8,000,000 in Proposition 47 funds. Once awarded in October 2024, these funds will facilitate the development of a Reentry Opportunities and Access to Resources (ROAR) program, expanding supportive resources to individuals exiting Sacramento County jail facilities.

---

[5] https://dce.saccounty.gov/Public-Safety-and-Justice/Documents/Reports_Resources/JPRPStatusReptJanJune2024.pdf

- Steady increases in the number of clients released on pretrial monitoring, while retaining low rates of pretrial participants with new arrests.
- Ongoing improvements in communication and data sharing efforts, including drafting of a Memorandum of Understanding for the Social Health Information Exchange, and efforts to develop automated reports to better integrate and analyze jail data for ongoing use.
- Coordination with criminal justice and social services partners involved in Mental Health Diversion to create efficiencies and expand capacity. The report also included a deep dive of concerns and efforts involving Mental Health Diversion.
- Analysis of the impacts of the Incompetent to Stand Trial (IST) process, based on changes in legislation instituting a growth cap for the number of persons declared IST requiring treatment in a state hospital setting.
- Completion of a Risk Assessment and Screening Tools Team Report, concluding a year-long working group to identify what information is captured when screening and assessments are conducted; determine if and how that information is shared to support criminal case process and/or healthcare, custody status, and service decisions; discuss operational use and validity; identify improvements that could be made to better align partners; and develop opportunities to apply technology and process changes to better inform decisions and streamline workflows. The complete report includes recommendations to:
    - Set guidelines for alignment across partners and decision points and with CalAIM requirements.
    - Standardize training and education for use of tools across the criminal justice continuum.
    - Identify agency contact persons responsible for linking collaborating agencies through information exchange and communication.
    - Develop a focus on process improvement by looking for streamlining opportunities, which could include increasing use of technology to improve accuracy, reducing duplication of work, increasing efficiency and timeliness, and increasing information sharing across systems and agencies working with the same individuals as they encounter and proceed through the jail/criminal justice system.

The next update to the County's Jail Population Reduction Plans will focus on the period of July 1, 2024 to December 31, 2024. The report continues to build on the County's partnership with O'Connell Research and is intended to be published by March 30, 2025. Also during this reporting period, Sacramento County's Criminal Justice Cabinet (CJC) analyzed its annual data trends and updated the Adult Sequential Intercept Model. Both documents are available on Sacramento County's Public Safety and Justice Agency website under Reports and Resources.

Plans for Upcoming Reporting Period

Focus areas for the upcoming period include:

- Full development and rollout of nursing onboarding and training program.
- Full rollout of provider monitoring and oversight for patients in the withdrawal monitoring and MAT induction units.
- Growth and refinement of our utilization management (UM) system. This includes having a single provider conduct UM reviews on every referral that comes through.
- Refinement of the case management and specialty services tracking and reporting system. Many changes are currently underway and a new, compliant reporting structure should be completed by the next reporting period.
- Development of a Chronic Care Team with defined workflows and metrics. ACH has begun meeting regularly with key leadership and partners to identify staff, set goals, define areas of tracking. Dr. Radha Sadacharan, a physician consultant, has chronic disease management expertise for correctional settings and has been working closely with the Medical Director to develop this program.
- Increases to confidential contacts at the Main Jail with the installation of privacy curtains on the plexiglass enclosures that were installed in 2024 and coordination with SSO to identify deputy escorts that can assist clinicians with seeing patients more efficiently.
- Seeking Board of Supervisors approval to expand Intensive Outpatient Program (IOP) services by 24 male beds at RCCC and 10 female beds at the Main Jail.
- Improvement of Mental Health timelines to care by identifying barriers, coordinating custody escorts with SSO, and redirecting clinicians to support the Outpatient Program during periods of high referrals.
- Increased automation and regular distribution of data/QI reports for Court-Appointed Monitors.

Remedial Plan Compliance

The County has identified 320 provisions in the Mays Consent Decree across eight Remedial Plan sections. Many provisions include sub-provisions, with some provisions including up to 16 sub-provisions.

To consistently track and monitoring progress, provisions are identified using the following convention: Remedial Plan (Roman Numerals) + Category (Letter) + Provision (Number)[6]. For example, **IV.G.3 r**efers to **Remedial Plan IV** (Mental Health), **Category G** (Medico-Legal Practices), **Provision 3** ("The County shall review all County and JPS policies and procedures for PREA compliance, and revise them as necessary to address all mental health-related requirements").

Sub-provisions will not be rated. For example, there will be a single rating given for Provision V.A.3. There will not be individual ratings for sub-provisions V.A.3.a, V.A.3.b.i, V.A.3.b.ii, V.A.3.b.iii, and V.A.3.c. All applicable sub-provisions should be considered and evaluated when assigning a compliance rating for a provision. If some sub-provisions are in Substantial Compliance while others are in Partial Compliance or Non-Compliance, a rating of Partial Compliance will be assigned.

Compliance Rating Definitions

Compliance ratings are to be assigned using the definitions below:

- Substantial Compliance: Indicates compliance with most or all components of the relevant provision of the Remedial Plan for both the quantitative (e.g., 90% performance measure) and qualitative (e.g., consistent with the larger purpose of the Decree) measures.

- Partial Compliance: Indicates compliance achieved on some of the components of the relevant provisions of the Remedial Plan, but significant work remains. A minimum requirement is that for each provision, relevant policies and procedures must be compliant with Remedial Plan requirements, contain adequate operational detail for staff to implement the policy, staff are trained, and the County has begun implementation of the policy.

- Non-Compliance: Indicates that most or all the components of the relevant provision of the Remedial Plan have not yet been addressed and/or have not yet been met.

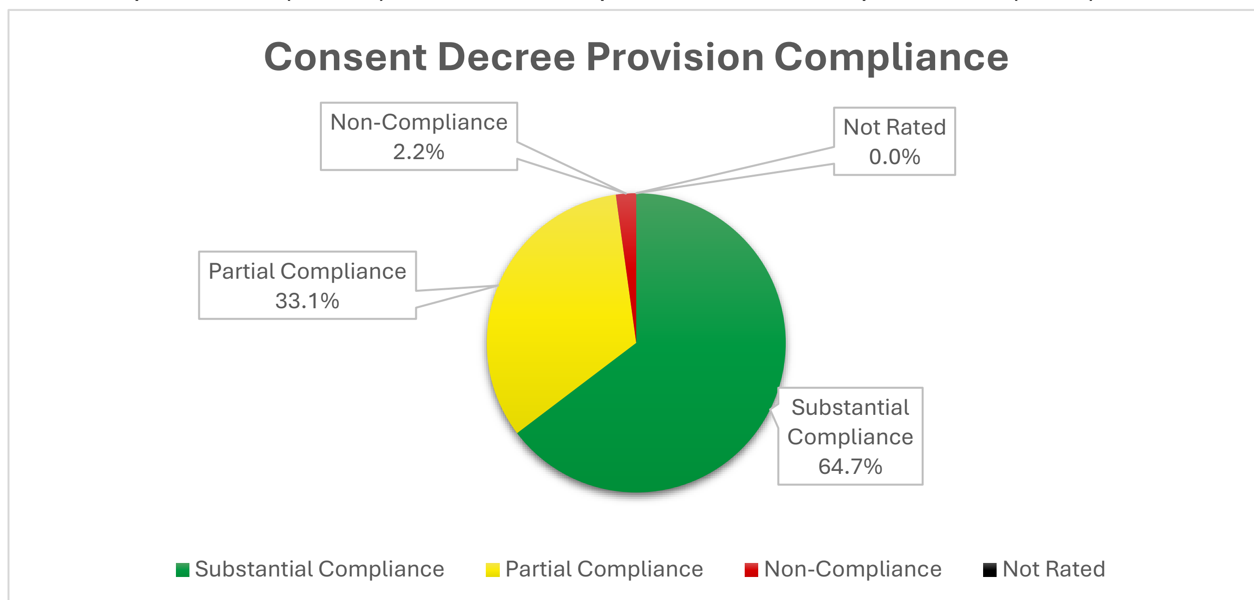
[6] There are three exceptions to this convention. The provisions in Remedial Plan II: General Provisions (II.A, II.B, and II.C) are not given a Category designation. As a result, II.B.1 and II.B.2 are considered sub-provisions of Provision II.B.

Comparison to Prior Status Reports and Expert Monitoring Reports
Prior to the 10th County Status Report, ACH and SSO completed separate compliance ratings. Some provisions were rated exclusively by ACH, some exclusively by SSO, and others received ratings from both ACH and SSO. Additionally, two provisions (IV.E.1 and III.K.3) received multiple ratings as sub-provisions were assigned separate ratings. In an effort to provide a single County rating for each Remedial Plan provision, the 53 provisions with conflicting ratings in the 9th County Status Report were reviewed. Where conflicting ratings were present, the rating was reduced to Partial Compliance[7]. The adjusted rating is included in this report. Attachment 5, Adjustments to 9th County Status Report Compliance Ratings, identifies the provisions with conflicts and the impacts on their original compliance ratings.

Furthermore, each Court appointed monitor has a different approach to identifying and rating provisions. In some cases, Class Counsel and Subject Matter Experts have assigned individual compliance ratings to items the County has identified as sub-provisions. To ensure the County can fairly compare its self-assessed ratings to the ratings assigned by the monitors, the County will resolve any conflicts among sub-provision ratings when determining the monitor's rating. When sub-provision compliance ratings conflict, the monitor's compliance rating for a particular provision will be assigned a rating of Partial Compliance. The number of provisions in the tracking tables included in this document and future County Status Reports may not align with the number of provisions rated in Class Counsel and Subject Matter Expert reports.

Current Compliance Level and Progress

The County is in Substantial Compliance with 207 provisions (64.7%), Partial Compliance with 106 provisions (33.1%), and Non-Compliance with seven provisions (2.2%).

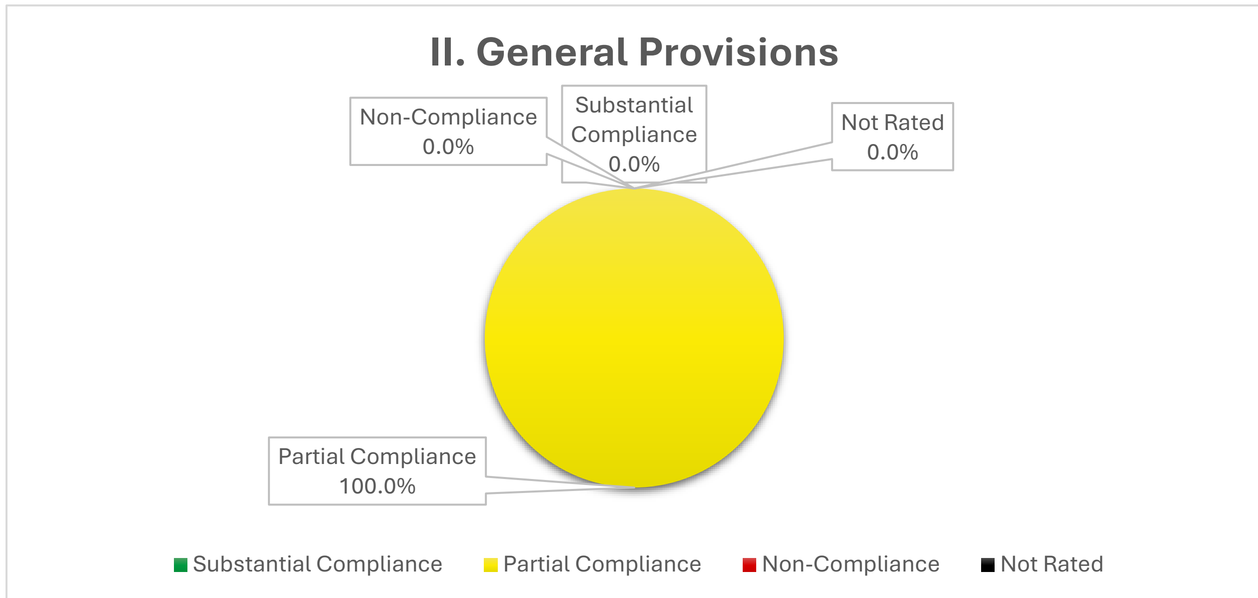


[7] There is one exception; upon closer review, VI.G.2 was reduced to Non-Compliance.

A table comparing the County's ratings in the 9th Status Report (June 2024) and the current report are below.

Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	158 (49.4%)	207 (64.7%)
Partial Compliance	147 (46.3%)	106 (33.1%)
Non-Compliance	11 (3.4%)	7 (2.2%)
Not Rated	3 (0.9%)	0 (0%)
Total Provisions	**320**	**320**

II. General Provisions



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	0 (0%)	0 (0%)
Partial Compliance	3 (100%)	3 (100%)
Non-Compliance	0 (0%)	0 (0%)
Not Rated	0 (0%)	0 (0%)
Total Provisions	**3**	**3**

II.A - Partial Compliance

"The County shall maintain sufficient medical, mental health, and custody staff to meet the requirements of this Remedial Plan."

The County began to add staff and/or contract augmentations prior to the finalization of the Consent Decree (January 2020). Vacancy rates increase as positions are allocated; therefore, monitoring the total Full-Time Equivalents (FTEs) by position allocated in addition to vacancy rates is important to identify and monitor progress.

The County has increased staffing substantially since pre-Consent Decree levels as outlined below:

- County ACH Medical staff and Administrative FTEs has increased from 112.5 pre-Consent Decree to a total of 252.5 permanent allocated FTEs in the current FY.
- County ACH Mental Health & Administrative staff has increased from 50.3 (FY 17/18) pre-Consent Decree to a total of 136.7 allocated positions in the current FY.
- SSO custody FTEs have increased from 650 pre-Consent Decree to a total of 809 permanent allocated FTEs in the current FY.

The total vacancy rate for:

- ACH Medical and Administrative staff is currently at 8.7% as of 11/27/24.
- ACH Mental Health staff is currently at 5.3% as of 12/23/24.
- SSO custody staff is currently at 9% as of 01/6/25.

II.B - Partial Compliance

"The parties agree that the custodial and health care staff must be increased to meet minimal constitutional and statutory standards. Presently, there are insufficient deputies to supervise out-of-cell activities for people in the general population and administrative segregation, and to provide security for health-related tasks. The parties agree that reduction in jail population is a cost-effective means to achieve constitutional and statutory standards.

1. *The County intends to hire additional custodial and health care staff. The parties agree that population reduction of the jails will facilitate compliance with this Remedial Plan. All population reduction measures should be designed to promote public safety through evidence-based programs.*
2. *If through the monitoring process it is determined that the County is not fulfilling the provisions of this Remedial Plan due to staffing deficiencies, the parties will meet and confer regarding what steps to take to reduce the population of the jail, including available resources to facilitate population reduction."*

The County continues to increase its custodial and health care staff to meet the provisions of the Consent Decree. In addition, Jail Population Reduction Plans have been developed per the 2022 Memorandum of Agreement; however, parties to the Consent Decree have limited ability to independently reduce the jail population as many booking justifications and nearly all release decisions are controlled by the Court. The Court is not a party to the Consent Decree. Despite extensive County efforts to expand pretrial service offerings, including supervision services by the Probation Department, support services through Community-Based Organizations, and mental health assessments and community linkages for Mental Health Diversion, the time to process cases and grant access to these programs is controlled by the Court. A recent voter initiative, Prop 36, which repealed parts of Proposition 47 by amending the state constitution to increase penalties and allow felony charges for certain crimes, passed in November 2024 and is expected to contribute to increases in the jail population.

II.C - Partial Compliance

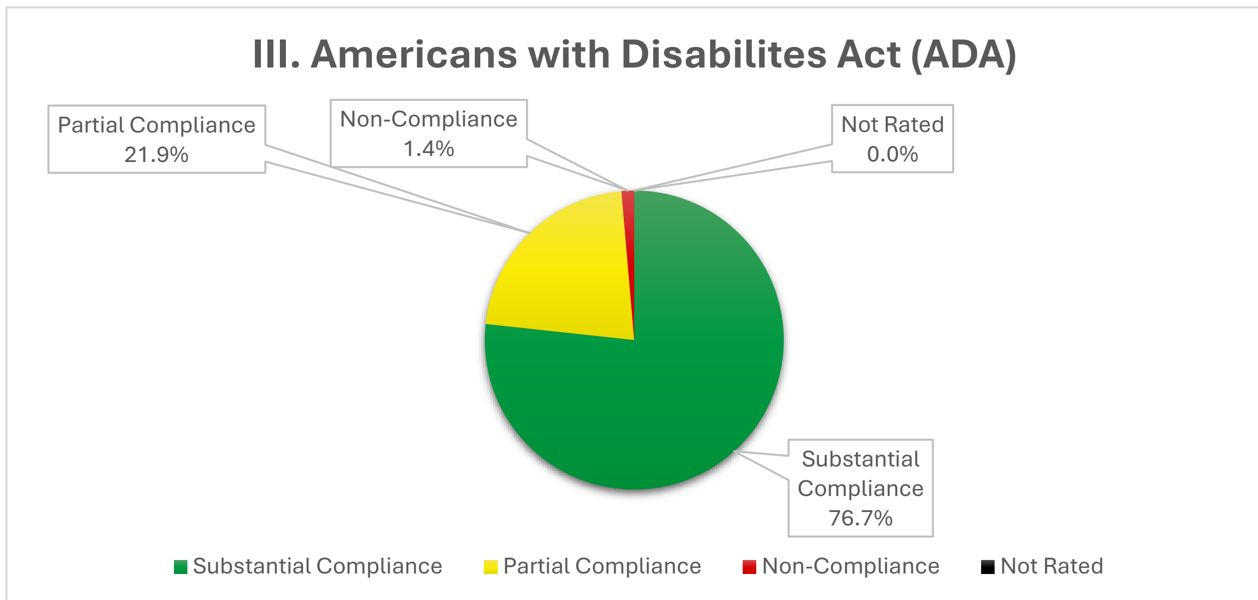
"The parties agree to meet and confer regarding the gathering and posting of data related to the Jail population. The parties agree that the categories of information to be gathered and publicly posted on a quarterly basis are the following:

a) *the number of people with mental illness booked into jail;*
b) *their average length of stay;*

c) the percentage of people connected to treatment;
d) their recidivism rates;
e) the total number of people in jail with a mental health need;
f) the number of people who were receiving mental health services at the time of booking; and
g) the number of sentenced and unsentenced inmates in custody.
h) For sentenced people in the jail, the nature of the commitment convictions, length of sentence(s), and level of mental health care (e.g., Acute, IOP, OPP).
i) For unsentenced people in the jail, the nature of the charges, length of pre-trial detention, and level of mental health care (e.g., Acute, IOP, OPP)."

Portions of this information are completed and posted quarterly via the Mental Health Jail Population Report that is uploaded to SSO's Transparency website. To ensure that all portions of this provision are captured quarterly, data sharing and coordination between ACH and SSO will be required. The current report does not capture booking counts (II.C.a), recidivism or return to custody rates (II.C.d), the nature of charges (III.C.h), and the level of mental health care (III.C.h and III.C.i). The County's Public Safety and Justice Agency is reviewing these requirements and considering a possible dashboard to monitor changes in the jail population.

III. Americans with Disabilities Act (ADA)



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	25 (34.2%)	55 (76.7%)
Partial Compliance	44 (60.3%)	16 (21.9%)
Non-Compliance	3 (4.1%)	1 (1.4%)
Not Rated	1 (1.4%)	0 (0%)
Total Provisions	**73**	**73**

Attachment 6, Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

A. Policies and Procedures

III.A.1 - Substantial Compliance

"It is the County's policy to provide access to its programs and services to prisoners with disabilities, with or without reasonable accommodation, consistent with legitimate penological interests. No prisoner with a disability, as defined in 42 U.S.C. § 12102 shall, because of that disability, be excluded from participation in or denied the benefits of services, programs, or activities or be subjected to discrimination. The County's policy is to provide reasonable accommodations or modifications where necessary, consistent with 28 C.F.R. §§ 35.150 & 35.152, and other applicable federal and state disability law."

See Attachment 2 for ACH Policies, and Attachment 3 for SSO Policies. In addition, the following forms have been updated related to this provision.

- Grievance Form and Appeal Form (revised this reporting period following feedback from the medical SMEs)
- Disabilities Screening Template (EHR) – Final
- Effective Communication Template (EHR; revision 08/31/21) – Final
- Alta Regional Center Referral Form (10/2021) – Final
- Mental Health Adaptive Support Survey (05/2022) – Final
- Mental Health Adaptive Support Program Screener (05/2022) – Final
- Refusal Form (06/2022) – Final
- Health Services Request form (02/2023) – Final

The Sheriff's Office has engaged in several steps, some through policy revision, others through practice to ensure all inmates receive equal access regardless of disability. Notably, the Compliance Unit, through tracking mechanisms and personal visits, ensures equal access and effective communication on an individual basis for all inmates with disabilities. Practices involving lower bunks and lower tiers have been modified to ensure the maximum number of beds are available for those needing accommodations. Patients identified with mobility issues are escorted in or with the proper DME to ensure they are not denied equal access to facilities, programs and services.

III.A.2 - Substantial Compliance ↑

"The County shall, in consultation with Plaintiffs' counsel, revise its Operations Order to establish standard and consistent procedures for the Jail to ensure compliance with the ADA and the remedial provisions outlined herein."

In collaboration with Class Counsel, the Sheriff's Office is continually revising and promulgating Policies and Procedures to ensure compliance with the ADA and remedial provisions. Multiple policies and procedures were finalized during this reporting period. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.A.3 - Substantial Compliance ↑

"The County shall, within 12 months from court approval of the Settlement and in consultation with Plaintiffs' counsel, revise policies, procedures, and inmate orientation materials (e.g. Inmate Handbook), in accordance with the revised Operations Order and the remedial provisions outlined herein. A list of policies which the County will revise consistent with the provisions outlined herein, as appropriate and in consultation with Plaintiffs' counsel, is attached as Exhibit A-1."

See Attachment 2 for ACH Policies and Attachment 3 for SSO Policies and Procedures. Multiple policies and procedures have been finalized during this reporting period in conjunction with Class Counsel. The inmate handbook was revised in 2023 and is currently

being revised incorporating any additional changes. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.A.4 - Substantial Compliance

"All staff will receive training appropriate to their position on policies and procedures related to compliance with the Americans with Disabilities Act (ADA) and related disability laws."

All ACH staff have received training on policies and procedures related to compliance with ADA and this training continues to be part of ACH onboarding of new staff. All staff assigned to corrections (sworn staff and records officers) are assigned Consent Decree training since September of 2021. As new hires begin their employment, they are assigned the training and must attest to the completion of the training. ADA/Medical accommodations have been added to Jail Operations, which is in-service training required for all new hires.

B. ADA Tracking System

III.B.1 - Substantial Compliance

"The County shall develop and implement a comprehensive system (an "ADA Tracking System") to identify and track screened prisoners with disabilities as well as accommodation and Effective Communication needs."

The County has developed and implemented an ADA Tracking System in SSO's jail management system (ATIMS) to identify and track screened patients with disabilities as well as accommodation and Effective Communication needs. ATIMS can communicate with Adult Correctional Health (ACH) Electronic Health Record (EHR) system. This allows data to be shared between the systems and alert Sheriff users of the incarcerated person's ADA and Effective Communication needs. These alerts are prominent in the system and can be customized depending on the requests and needs of stakeholders.

III.B.2 - Substantial Compliance

"The ADA Tracking System shall identify:

- *a) All types of disabilities, including but not limited to psychiatric, intellectual, developmental, learning, sensory, mobility, or other physical disabilities, and special health care needs;*
- *b) Prisoners with disabilities that may pose a barrier to communication, including but not limited to learning, intellectual, or developmental disabilities, and hearing, speech, or vision impairments;*
- *c) Accommodation needs, including as to housing, classification, Effective Communication, adaptive supports, and assistive devices;*
- *d) Prisoners who require specific health care appliances, assistive devices, and/or durable medical equipment (HCA/AD/DME);*

e) *Prisoners who are class members in Armstrong v. Newsom (N.D. Cal. No. 94-cv-02307), with their applicable disability classification(s) and accommodation need(s)."*

The ADA Tracking System in ATIMS identifies all areas outlined as required in the Remedial Plan, including disability type/special health care needs, communication needs, accommodation needs, healthcare assistive devices, and/or durable medical equipment needed (HCA/AD/DME) and class members in *Armstrong v. Newsom* (N.D. Cal. No. 94-cv-02307), with their applicable disability classification(s) and accommodation need(s). ACH developed and implemented a DME note for staff to use when delivering and/or collecting DME from a patient. This allows staff to easily determine if and when DME was actually given to a patient, which enhances DME tracking abilities.

All inmates are screened and accommodations identified are displayed and tracked on ATIMS. ATIMS displays the information enumerated in this section to Sheriff employees. The information is entered by either the Sheriff's Compliance Unit (ATIMS person alert flags) or can be entered by ACH through their EHR program (medical alert flags). The ATIMS medical alert flags below are used to identify the disabilities that may pose a barrier to communication enumerated in this section:

- Developmentally disabled
- Effective communication – other
- Hearing impairment description
- Intellectual disability
- Learning disability
- Speech impairment description
- Vision impairment description

III.B.3 - Substantial Compliance

"The ADA Tracking System's prisoner disability information will be readily accessible to custody, medical, mental health, and other staff at the Jail who need such information to ensure appropriate accommodations and adequate program access for prisoners with disabilities."

The ADA Tracking System in ACH's EHR and SSO's ATIMS is readily accessible to SSO Custody, ACH Medical, ACH Mental Health, and other staff at the Jail who need such information to provide appropriate accommodations and adequate program access for patients with disabilities. ACH developed and refined EHR templates for screening and documenting disabilities and accommodations. These forms permit ongoing changes if the accommodation status needs to be modified.

A Medical Assistant (MA) has been assigned to review the EHR and verify accommodations have been provided and notify Nursing and/or a Provider to assess patient if not. Interfaces

between EHR and Sheriff's Office (SSO) jail management system (ATIMS) system are designed to support communication in this area.

Providers have been instructed to schedule provider follow-ups with patients prior to their DME prescription expiring (ex. Crutches for three weeks). If it is determined that the patient continues to need the device/equipment, the order will be extended. SSO does not take away equipment from the patient even if it shows expired in their system. They will coordinate with medical staff to determine if the accommodation is still needed. If not, medical staff will collect the equipment.

C. ADA Coordinator

III.C.1 - Substantial Compliance

"The County shall have a dedicated ADA Coordinator at each facility."

Each facility has a dedicated Compliance Commander who serves in this role.

III.C.2 - Substantial Compliance

"The ADA Coordinator position shall be dedicated to coordinating efforts to comply with and carry out ADA-related requirements and policies, shall have sufficient command authority to carry out such duties, and shall work with the executive management team regarding ADA-related compliance, training, and program needs."

Each facility has a dedicated Compliance Commander who serves in this role.

III.C.3 - Partial Compliance

"The County shall clearly enumerate, in consultation with Plaintiffs' counsel, the job duties and training requirements for the ADA Coordinator position and for ADA Deputies assigned to support the ADA Coordinator position."

Job duties have been established by SSO for both the Deputy and Sergeant positions assigned to support the ADA Coordinator. This remains in Partial Compliance until training requirements are finalized.

III.C.4 - Substantial Compliance

"The County shall ensure that ADA Coordinators and ADA Deputies possess requisite training to implement and ensure compliance with the Jail's disability program and services, including operating of the ADA Tracking System."

ADA Coordinators and ADA Deputies receive on-the-job training to ensure that they possess and maintain the requisite knowledge to implement and ensure compliance with the Jail's disability program and services, including proper operation of the ADA Tracking

System. This is supplemented by formal training presented by a nationally recognized ADA training organization.

D. Screening for Disability & Disability-Related Needs

III.D.1 - Substantial Compliance

"The County shall conduct adequate screening of prisoners to be housed in the Jail in order to identify disabilities and disability-related accommodation, housing, classification, and other needs. All individuals detained at the Jail for any period of time will be assessed for Effective Communication needs, consistent with the provisions herein."

County ACH conducts an Intake Health Screening for anyone who will be housed in the Jails. The Health Intake Screening includes forms and questions to identify essential information regarding disabilities, accommodations, and effective communication needs consistent with policy and this Remedial Plan requirement. All individuals detained at the Jail for any period of time will be assessed for Effective Communication needs, consistent with the provisions herein.

III.D.2 - Substantial Compliance ↑

"The County shall take steps to identify and verify each prisoner's disability and disability-related needs during medical intake screening, including based on:

a) The individual's self-identification or claim to have a disability;
b) Documentation of a disability in the individual's health record;
c) Staff observation that the individual may have a disability that affects placement, program access, or Effective Communication; or
d) The request of a third party (such as a family member) for an evaluation of the individual for an alleged disability."

ACH's Health Intake Screening process includes forms and questions to identify and verify disability-related needs based on an individual's self-identification or claim to have a disability, documentation of a disability in the individual's health record, and staff observation, or collateral (family report) information – information that indicates someone may have a disability that affects housing needs, program access, or Effective Communication needs.

Intake training is provided to Intake Registered Nursing (RNs) annually. Automatic referrals or prompts are triggered at intake based on responses to specific questions to mental health for post-intake assessment of psychiatric, developmental, or intellectual disabilities.

ACH QI conducts quarterly ADA audits. Over time, intake nurses have improved with respect to identifying and documenting disabilities and related needs. Staff developed and refined a tool to audit disabilities, accommodations, and effective communication. Data indicates that staff are improving with regard to identifying and documenting disabilities,

accommodations, and effective communication. Audits will continue on a regular basis and data/trends will be reviewed for errors, systemic issues, and opportunities to improve detection and create individualized care plans. Data is reviewed during QIC meetings. ACH continues to conduct the Intake ADA Audits to determine compliance with this provision. For the Q1 Audit for FY 24/25 completed on 11/15/24, nearly all findings showed a positive increase in measures. They are as follows:

- 100 % (30/30) EC form completion - increased from 91%.
- 67% (20/30) ADA Assessment Medical form completion - increased from 50%.
- 100% (30/30) ID Screening reached 100% compliance - increased from 85%.
- 92% (110/120) Forms completion rate - increased from 82%.
- 90% (130/144) Total compliance threshold – increased from 84%.
- 75% (3/4) Medical disability proper documentation - decreased from 100%.
- 75% (3/4) AD/DME proper documentation - increased from 67%.
- 67% (2/3) Medical referrals were seen within policy timeframes.

To reduce barriers to care due to communication issues, in January 2024, ACH completed a project so every patient computer/tablet had access to the Language Line app which provides access to interpretation services in various languages—including American Sign Language. Additionally, web cameras were installed on every computer used for patient-facing encounters, including COWS, and had an individual from the Language Line company provide an in-person training to our providers and nurses. The training was recorded and is available for all ACH and ACMH staff to review at any given time. The new Nurse Educator will incorporate this training into the onboarding process for new hires. In September 2024, the Nurse Intake was revised to include automatic referral generation to MH when a patient responded positively to having an intellectual disability. Per ACH, the compliance rating should be increased to reflect Substantial Compliance.

E. Orientation

III.E.1 - Substantial Compliance

"The County shall ensure that, for the population to be housed in the Jails, prisoners with disabilities are adequately informed of their rights under the ADA, including but not limited to:

a) Accommodations available to prisoners;
b) The process for requesting a reasonable accommodation;
c) The role of the ADA coordinator(s) and method to contact them;
d) The grievance process, location of the forms; and process for getting assistance in completing grievance process;
e) Instructions on how prisoners with disabilities can access health care services, including the provision of Effective Communication and other accommodations available in accessing those services."

The inmate handbook advises prisoners with disabilities of their rights under the ADA. The inmate handbook is provided to all incarcerated persons either in a physical form or digitally available on the inmate tablet. Both facilities have signage posted in each pod which includes ADA information. The posting is directed to individuals who have difficulty seeing, hearing, talking, walking, moving, breathing, or learning.

Regarding sub-provision III.E.1.b, the inmate handbook outlines the process for requesting accommodation for non-medical related disabilities. Regarding sub-provision III.E.1.c, the role of the ADA Coordinator and the method of contacting the ADA Compliance teams is located in the inmate handbook and on a poster in each housing area. In both facilities, inmates can call a toll-free hotline and leave a message for the ADA Compliance Teams. Regarding sub-provision III.E.1.d, the grievance process and the process for requesting assistance by writing is outlined in the digital and physical copies of the inmate handbook. Regarding sub-provision III.E.1.e, the inmate handbook also outlines how to access health care services. Accommodation needs and effective communication are addressed as it relates to these services through the following language: "If you have vision, speech, hearing, intellectual, learning, or other disabilities, please let staff know so they may assist you."

III.E.2 - Substantial Compliance

"Upon processing and classification, prisoners with disabilities shall receive, in an accessible format, the jail rulebook; orientation handbook; and a verbal orientation or orientation video regarding rules of expectations."

Verbal and written communications are presented by compliance officers upon request. The inmate handbook is received at intake and available upon request; however, only one format/version of the handbook is available on the inmate tablet. SSO can print the Handbook in an 8x11 inch size. Inmates are also given a verbal orientation by deputies.

III.E.3 - Substantial Compliance ↑

"The County shall accommodate individuals with disabilities in the orientation process through the use of alternative formats (e.g. verbal communication, large print, audio/video presentation), when necessary for Effective Communication of the information."

The inmate handbook is available on inmate tablets and may also be printed. SSO has developed alternative formats, including a large print inmate handbook. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.E.4 - Substantial Compliance

"The County shall develop an Americans with Disabilities Act Inmate Notice. The Notice shall be prominently posted in all prisoner housing units, in the booking/intake areas, in

medical/mental health/dental treatment areas, and at the public entrances of all Jail facilities."

There is ADA signage posted in all inmate housing units, the booking/intake areas, the medical/mental health/dental treatment areas, and at the public entrances of the facilities. The signage is compliant with ADA federal requirements.

F. Health Care Appliances, Assistive Devices, Durable Medical Equipment
III.F.1 - Substantial Compliance ↑

"The County shall establish a written policy to ensure provision of safe and operational HCA/AD/DME, with a process for repair and replacement."

ACH has established a written policy (ACH PP 06-07, effective 02-08-21, revised 02-09-24) to ensure the provision of safe and operational HCA/AD/DME, with a process for repair and replacement. SSO Policy 710 (Aids to Impairment) has been completed. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.F.2 - Substantial Compliance ↑

"The County shall timely provide HCA/AD/DME to prisoners with disabilities who require such assistance. The County shall ensure an individualized assessment by medical staff to determine whether HCA/AD/DME is warranted to ensure equal and meaningful access to programs, services, and activities in the Jail."

Electronic forms were completed to assist in identification and tracking of assistive devices and durable medical equipment (DME). Policy and EHR forms allow providers to select "other" when ordering assistive devices and/or DME in addition to the pre-determined list. Staff developed a process to ensure newly ordered devices are provided to patients in a timely manner. This includes the use of a DME note that is used to track delivery and pick up of the DME.

A flag has been created in ATIMS to identify health care appliances, assistive devices, and durable medical equipment. Nursing or Provider staff orders a DME flag in AthenaPractice which transmits to ATIMS. SSO runs a report in ATIMS to show patients with a medical equipment and device flag.

The ability to use CPAPs and their availability have long been an area of non-compliance with the jails. Patients in need of CPAP machines were previously housed in the same area (2 East) due to the need for electrical outlets. ACH secured a contract and ordered battery-operated CPAP machines, so that these patients can be housed in the general population. The ACH Medical Director programmed the machines, helped create the workflow and assisted nursing in training staff. All battery-operated CPAPs are now in use and have been distributed to all inmates who need them; more patients can now use CPAPs in general

population. Per ACH and SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.F.3 - Substantial Compliance

"The County shall allow prisoners to retain personal HCAs/ADs/DME (which will include reading glasses), unless there is an individualized determination that doing so would create an articulated safety or security risk.

a) Where Jail staff determine it is necessary to remove a prisoner's personal HCA/AD/DME for security reasons, the County shall provide an equivalent Jail-issued device unless custody staff, with supervisory review, determine and document, based on an individualized assessment, that the device constitutes a risk of bodily harm or threatens the security of the facility.

b) If such a determination is made, the ADA coordinator or supervisory-level designee shall document the decision and reasons for it, in writing, and shall consult with medical staff to determine an appropriate alternative accommodation."

Medical staff approves/authorizes medical equipment. Medical and custody work together to determine appropriate alternative accommodations when needed for safety reasons such as when a patient has a history of turning equipment into contraband and/or weapons. These instances will be documented in the patient record.

III.F.4 - Substantial Compliance ↑

"The County shall, in consultation with Plaintiffs' counsel, implement a written policy governing the release of prisoners who need assistive devices upon release.

a) The County will ensure that any personal mobility device belonging to a prisoner is returned to the prisoner prior to release from custody.

b) If a prisoner does not have a personal mobility device, but is ambulatory with the assistance of a cane, crutch, or walker, the prisoner will be permitted to retain such device that was used while in custody upon release, or will be provided a comparable device, upon release.

c) If a prisoner who is due for release requires a wheelchair, but does not have a personal wheelchair, Jail staff shall coordinate with the prisoner, the prisoner's family or friends, and other County agencies as needed to secure a wheelchair or take other steps to address the individual's needs upon release. The County shall document this process in the ADA Tracking System for purposes of individual tracking and quality assurance."

ACH policy 06-07 covers this provision. It was last revised in Feb. 2024. If a patient who is due for release from custody requires a wheelchair but does not have a personal wheelchair, ACH nursing will, as part of the discharge planning process, coordinate with the patient, the patient's family or friends, and other County agencies as needed to secure a wheelchair, or take other steps to address the patient's needs upon release. Discharge

Planning/Reentry nursing staff monitors the above steps to ensure patients who require a wheelchair have one upon release.

SSO will return any personal mobility device to the inmate upon release from custody. If a patient does not have a personal mobility device, but is ambulatory with the assistance of a cane, crutch, or walker, SSO will permit the patient to retain such device that was used while in custody or provide a comparable device upon release.

SSO Policy 519 & Procedure 519 were published on 04/18/2024. If an inmate does not have a family member or program coordinator available to meet them with the assistive device they require, SSO allows them to be released from the facility with the equipment they require. Custody works together with medical staff and the inmate to ensure all steps are taken to meet the inmate's needs upon release.

Per ACH, the compliance rating should be increased to reflect Substantial Compliance.

G. Housing Placements

III.G.1 - Partial Compliance

"The County shall house prisoners with disabilities in facilities that accommodate their disabilities."

SSO and ACH provide appropriate housing to the fullest extent possible with the structural limitations of the current facilities.

III.G.2 - Partial Compliance

"The County shall implement a housing assignment system that includes an individualized assessment of each individual's functioning limitations and restrictions, including but not limited to:

a) The need for ground floor housing;
b) The need for a lower bunk;
c) The need for grab bars in the cell and/or shower;
d) The need for accessible toilets;
e) The need for no stairs in the path of travel; and
f) The need for level terrain."

SSO accommodates inmate disabilities as recommended by ACH. Through their Electronic Health Record, ACH transmits an alert flag to SSO's Jail Management System, ATIMS. The alert flag determines the individual's housing assignment with a lower bunk, no stairs, or other requirements.

All RCCC housing facilities have shower chairs available for inmates upon request from their control and/or floor officers. MJ 2E & 2M have grab bars; shower chairs are on every floor available upon request. On December 8, 2022, the Sacramento Board of Supervisors

approved to build a Jail Intake and health Services Facility (IHSF) as well as make ADA facility improvement to the currently Jail to include more accessible cells and showers. While the IHSF is undergoing peer review, plans are also in place for renovating the Main Jail to create accessible showers and cells for wheelchairs and accessible toilets. Interim measures are being explored to adapt the existing infrastructure for those with accessibility needs.

Social and Attorney visits continue to overwhelm the current Main Jail as there is only one Attorney Visit booth, and two Social Visit booths that are easily accessed without utilizing stairs (located on the 2-East housing unit). The IHSF programming intends to expand the availability of these spaces. RCCC has visiting areas and medical areas with no stairs in the path of travel. An interim wheelchair accessible attorney visit booth was created in the court booking area which can be used during business hours.

III.G.3 - Substantial Compliance ↑

"Prisoners with disabilities shall be housed in the Jail consistent with their individual security classification. Prisoners prescribed or possessing HCAs/Ads/DME will not automatically be housed in a medical housing unit. Placement in a medical housing unit will be based on individual clinical determination of need for treatment."

SSO and ACH provide appropriate housing to the fullest extent possible with the structural limitations of the current facilities. Security classification is not determined by disability or HCA/AD/DME; Medical Housing Unit (MHU) housing is determined by ACH based on an individual assessment. ACH advises/makes recommendations about housing. People with mobility issues or that require the use of wheelchairs are housed on the MJ second floor. However, others are housed throughout the facility depending on security classification. Per ACH, the compliance rating should be increased to reflect Substantial Compliance.

III.G.4 - Partial Compliance

"Classification staff shall not place prisoners with disabilities in:

a) Inappropriate security classifications simply because no ADA-accessible cells or beds are available;
b) Designated medical areas unless the prisoner is currently receiving medical care or treatment that necessitates placement in a medical setting; or
c) Any location that does not offer the same or equivalent programs, services or activities as the facilities where they would be housed absent a disability."

RCCC and MJ programs and services are available based on eligibility and classification.

H. Access to Programs, Services, and Activities

III.H.1 - Partial Compliance

"The County shall ensure prisoners with disabilities, including those housed in specialized medical units or mental health units (e.g., OPP, IOP, Acute) have equal access to programs

services, and activities available to similarly situated prisoners without disabilities, consistent with their health and security needs. Such programs, services, and activities include, but are not limited to:

a) *Educational, vocational, reentry, and substance abuse programs*
b) *Work Assignments*
c) *Dayroom and other out-of-cell time*
d) *Outdoor recreation and fitted exercise equipment*
e) *Showers*
f) *Telephones*
g) *Reading materials*
h) *Social visiting*
i) *Attorney Visiting*
j) *Religious services*
k) *Medical, mental health, and dental services and treatment"*

RCCC offers in-person learning based on eligibility criteria being met. Reentry programs are not offered to inmates in specialized mental health units. The Main Jail has introduced reentry services and have been mirroring that of RCCC.

RCCC and MJ work assignments are based on ACH medical clearance and ability to perform the essential functions of the job with or without an accommodation. Reasonable accommodations are made based on ACH recommendations. Out-of-cell time determined by the Consent Decree is currently met by all housing facilities at RCCC. Inmates in specialized MH units such as IOP and JBCT receive additional out-of-cell and dayroom time due to the nature of their program. At Main Jail, SSO is at or near the out-of-cell times on a weekly basis. The Main Jail Compliance unit conducts weekly audits of out-of-cell time and publishes these results to all four shifts to ensure continued compliance or highlighting those areas that are nearing compliance.

Recreational schedules are based on security classification and not on the inmate's disability. At the MJ, there is elevator access to the outdoor recreation area for those with disabilities.

SSO recreation staff does not provide reading materials for special needs (Braille, large print) on a regular basis. Occasionally, they receive large print books and distribute them to the inmates. Reading glasses can be purchased through commissary. RCCC and MJ have magnifying cards on commissary. The compliance teams will provide them on a needs-based assessment as well. Each inmate has a tablet reading material capable of being magnified to make the text larger.

Social and Attorney visits continue to overwhelm the current Main Jail as there is only one Attorney Visit booth, and two Social Visit booths that can be accessed without utilizing stairs (located on the 2-East housing unit). Any individual who cannot climb stairs is required to use the visiting area on 2-East. RCCC is able to offer greater access.

RCCC and MJ Inmates assigned to specialized MH units (APU, IOP, JBCT) receive additional, individualized, specialized mental health services through their program. Health Service Request (HSR) forms are available for additional treatment requests.

III.H.2 - Partial Compliance ↓

"The County shall provide reasonable accommodations and modifications as necessary to ensure that prisoners with disabilities have equal access to programs, services, and activities available to similarly situated prisoners without disabilities."

Programs and activity availability differ based on the inmate's security classification. This provision remains in Partial Compliance during ongoing efforts to increase programming on all floors.

III.H.3 - Substantial Compliance ↑

"The County shall develop and implement a written policy for staff to provide appropriate assistance to prisoners with psychiatric, developmental, or cognitive disabilities so that they can fully participate in programs, services, and activities provided at the jail."

In February 2023, the Sheriff's Office formed a new Legal and Policy Bureau. A Lieutenant position was added to lead the unit. One of the core duties of this unit is to update all policies and procedures to the Lexipol system with a focus on policies and procedures related to the *Mays* Consent Decree. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.H.4 - Substantial Compliance ↑

"The County shall implement a written policy for staff to provide assistance to prisoners with disabilities in reading or scribing documents."

In February 2023, the Sheriff's Office formed a new Legal and Policy Bureau. A Lieutenant position was added to lead the unit. One of the core duties of this unit is to update all policies and procedures to the Lexipol system with a focus on policies and procedures related to the Mays Consent Decree.

Staff will assist inmates with disabilities with reading and scribing documents as needed. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.H.5 - Substantial Compliance

"The County shall provide equal access to library, recreational, and educational reading materials for prisoners with disabilities, including easy reading and large print books for individuals who require such accommodations."

SSO provides equal access to reading materials, including the purchase of keep-on-person magnifiers.

III.H.6 - Substantial Compliance ↑

"The County shall ensure equitable inmate worker opportunities for prisoners with disabilities, including by:

a) Ensuring clear job duty statements, with essential functions and specific criteria, for each Worker position;

b) Ensuring that medical staff conduct an individualized assessment to identify work duty restrictions and/or physical limitations to facilitate appropriate work/industry assignments and to prevent improper exclusions from work opportunities;

c) Providing reasonable accommodations to enable prisoners with disabilities to participate in inmate worker opportunities."

Job duties for various worker assignments (laundry, kitchen, etc.) have been established. SSO, in coordination with ACH (who completes an individualized review to identify any restrictions), has provided job opportunities with appropriate accommodations for those with certain disabilities. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

I. Effective Communication

III.I.1 - Substantial Compliance ↑

"The County shall assess all individuals detained at the Jail for any period of time for Effective Communication needs, and shall take steps to provide Effective Communication based on individual need."

ACH assesses all individuals for Effective Communication needs and takes steps to provide Effective Communication based on individual need consistent with policy. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.2 - Substantial Compliance ↑

"The County's ADA policies shall include comprehensive guidance to ensure Effective Communication for prisoners with vision, speech, hearing, intellectual, learning, or other disabilities. The County shall, in consultation with Plaintiffs' counsel, ensure that sufficient guidance on the provision of Effective Communication is included in Jail custody and health care policies and procedures."

ACH's Effective Communication policy was completed with approval from Class Counsel and court-appointed Experts, and modified in 2021 to include additional questions for identifying EC needs and to simplify the language used in the inquiry. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. ACH Policy 06-03 also addresses Effective Communication and was last revised in January 2024. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.3 - Partial Compliance

"Standard for Provision of Effective Communication in Due Process Events and Clinical Encounters

a) A higher standard for the provision of Effective Communication shall apply in the following situations:
   i. Due Process Events, including the following:
      - *Classification processes*
      - *Prisoner disciplinary hearing and related processes*
      - *Service of notice (to appear and/or for new charges)*
      - *Release processes*
      - *Probation encounters/meetings in custody*

   ii. Clinical Encounters, including the following:
      - *Determination of medical history or description of ailment or injury*
      - *Diagnosis or prognosis*
      - *Medical care and medical evaluations*
      - *Provision of mental health evaluations, rounds, group and individual therapy, counseling and other therapeutic activities*
      - *Provision of the patient's rights, informed consent, or permission for treatment*
      - *Explanation of medications, procedures, treatment, treatment options, or surgery*
      - *Discharge instructions*

b) In the situations described in subsection (a), above, Jail staff shall:
   i. Identify each prisoner's disability where there may be a barrier to comprehension or communication requiring reasonable accommodation(s);
   ii. Provide effective reasonable accommodation(s) to overcome the communication barrier; and
   iii. Document the method used to achieve Effective Communication and how the staff person determined that the prisoner understood the encounter, process, and/or proceeding."

SSO Policy 602, Incarcerated Persons with Disabilities, and Policy 600 Discipline addresses Effective Communication during due process events. ACH Policy 06-03 Effective Communication addresses communication during clinical encounters. This

provision remains in Partial Compliance while SSO and ACH work on documentation to demonstrate proof of practice.

III.I.4 - Substantial Compliance ↑

"Effective auxiliary aids and services that are appropriate to the needs of a prisoner with Effective Communication needs shall be provided when simple written or oral communication is not effective. Such aids may include bilingual aides, SLIs, readers, sound amplification devices, captioned television/video text displays, Videophones and other telecommunication devices for deaf persons (TDDs), audiotaped texts, Braille materials, large print materials, writing materials, and signage."

SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Multiple devices for visual and hearing aids are available. At RCCC, a VRI system is installed that provides interpretation for SLI as well as multiple spoken languages. Video visitation is in process. RCCC also employs TDD and signage for hearing impaired inmates to communicate with friends and family. The use of SLI is authorized through policy; bilingual aides are also available. MJ has VRS & TDD SLI. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.5 - Substantial Compliance ↑

"In determining what auxiliary aid service to provide, the County shall give primary consideration to the request of prisoner with Effective Communication needs."

RCCC and MJ offers a variety of auxiliary aids for inmates with effective communication needs and gives primary consideration to the request of the inmate. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.6 - Partial Compliance

"Education providers (e.g., Elk Grove Unified School District) at the Jail will ensure Effective Communication for prisoners participating in education programs, including by providing necessary assistive equipment and take steps to accommodate learning strategies of those prisoner-students who have special needs, such as those with developmental, learning, vision, hearing, and speech disabilities."

RCCC Compliance Unit tracks inmates with special needs and works with the Elk Grove Unified School District to provide accommodations. VRI has been used to assist in the past. Currently, SSO is awaiting a response from EGUSD for their practices/policies on this subject.

III.I.7 - Substantial Compliance ↑

"The County shall assist prisoners who are unable to complete necessary paperwork (e.g., related to health care, due process, Jail processes) on their own with reading and/or writing as needed."

SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.8 - Substantial Compliance ↑

"The County shall permit prisoners, including those who are illiterate, non-English speaking, or otherwise unable to submit written or electronic sick call requests, to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified mental health or medical professional for response in the same priority as those sick call requests received in writing."

SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.I.9 - Substantial Compliance ↑

"The County shall post and disseminate notices, policies, job announcements, and other written material in alternative formats to promote Effective Communication."

SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

J. Effective Communication and Access for Individuals with Hearing Impairments

III.J.1 - Substantial Compliance ↑

"The County shall develop and implement a policy for newly arrived and newly identified prisoners with hearing disabilities to determine each prisoner's preferred method of communication."

ACH developed and implemented an Effective Communication policy for newly arrived and newly identified prisoners with hearing disabilities to determine each prisoner's preferred method of communication. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance. Preferred methods of communication for patients requiring effective communication are documented in the patient's record.

III.J.2 - Substantial Compliance ↑

"Qualified Sign Language Interpreters (SLIs) will be provided during intake and for due process functions, health care encounters, and Jail programming, when sign language is the prisoner's primary or only means of Effective Communication, unless the prisoner waives the assistance of an interpreter and/or delay would pose a safety or security risk.

a) *The County shall maintain a contract or service agreement with interpreter services in order to provide such services for deaf or hearing impaired prisoners. Jail staff will be informed of the availability of contract interpreter services.*

b) *Lip reading will not be the sole method of Effective Communication used by staff, unless the prisoner has no other means of communication.*

c) *In cases where the use of an SLI is not practicable, or is waived by the prisoner, Jail staff shall employ the most effective form of communication available.*

d) *The County will maintain a log of (a) when, for whom, and for what purpose an SLI was used; and (b) when, for whom, and why a SLI was not used for a prisoner with an identified need for SLI services (e.g., prisoner waived SLI or delay would have posed safety or security risk).*

e) *When a prisoner waives an SLI, the log must document (a) the method of communication of the waiver, and (b) the method staff used to determine that the waiver was knowing and freely given."*

Qualified Sign Language Interpreters (SLIs) are accessible and provided during Intake and health care encounters. The County maintains a contract with LanguageLine interpreter services and patients are informed of this service at all clinical encounters. The language line provides 24/7 interpretation services in a multitude of languages-including American Sign language. ACH utilizes video interpreting services for patients who need SLI.

All patient facing computers have a camera installed and a necessary icon to access the LanguageLine InSight application as of February 2024. ACH and ACMH received training on the use of the LanguageLine. The training was provided by a representative of the LanguageLine. The training was recorded and is available to all staff via a shared drive. Since July 2024, the language line received 842 calls with an average of 14 minutes per call from Main Jail. Since July 2024, the language line received 844 audio calls with an average of 14 minutes per call. 392 video calls with an average of 16 min per call. 28 of the video calls required an American Sign Language interpreter.

MH utilizes tablets for all Language Line encounters. During the initial MH assessment, patients are asked preferred language for medical and mental health appointments, this is noted in the patient chart and a flag is created to alert all staff of the patient's preferred language.

SSO Policy 602.6 addresses SLI distribution. Video Remote Interpreting (VRI) tablets provide live interactive SLI services. The tablet is located in Booking and in the Classification office. The service is available 24/7 for use by officers for any procedure. "Operations Order 6/14 - Interpreter Services" details contracted services to support this area.

RCCC and MJ offer a variety of auxiliary aids for inmates with effective communication needs and gives primary consideration to the request of the inmate with E.C. needs. VRI keeps a log by name and x-reference, spoken language and SLI on device. At MJ, the floor officer & 2 east officer log in book when VRS is used.

Per ACH, the compliance rating for this provision should be raised to Substantial Compliance.

III.J.3 - Substantial Compliance

"Jail Staff shall effectively communicate the contents of the Inmate Handbook and other materials providing information on Jail rules and procedures to all prisoners to be housed in the Jail who are deaf or hard of hearing. For those prisoners for whom written language is not an effective means of communication, Jail Staff may meet this obligation by providing a video of an SLI signing the contents of the Inmate Handbook, along with appropriate technology for viewing, or by providing an SLI to interpret the contents of the Inmate Handbook to the prisoner who is deaf or hard of hearing."

At RCCC and MJ, all inmates are provided with a copy of the inmate handbook however, there is no video with an SLI signing the contents. Assistance would be provided by staff as necessary with the use of the VRI or by reading information needed.

III.J.4 - Substantial Compliance

"The County shall, within 12 months from court approval of the Settlement, make Videophones available for deaf and hard of hearing prisoners. The Videophones shall provide for calls through the use of Video-Relay Services (VRS) at no cost to deaf and hard of hearing prisoners or for calls directly to another Videophone."

VRS/VRI system installed at RCCC and VRS at MJ. The VRS is provided at no cost to inmates.

III.J.5 - Substantial Compliance

"Deaf/hard of hearing prisoners who use telecommunication relay services, such as Videophone or TDD/TTY machine, in lieu of the telephone shall receive equal access to the Videophone or TDD/TTY services as non-disabled prisoners are afforded for regular telephone usage."

VRS services were added through Securus contract.

III.J.6 - Substantial Compliance

"The County shall provide deaf/hard of hearing prisoners with additional time for calls using telecommunication relay services, such as a Videophone or TDD/TTY, to account for the fact that signed and typed conversations take longer than spoken conversations. The County shall document the time that each prisoner uses and has access to such equipment."

Telephone call times are not limited.

III.J.7 - Substantial Compliance ↑

"Prisoners who require an SLI as their primary method of communication shall be provided an SLI for education, vocational, or religious programs and services."

SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. 602.6 addresses SLIs. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.J.8 - Substantial Compliance ↑

"Public verbal announcements in housing units where individuals who are deaf or hard of hearing reside shall be delivered on the public address system (if applicable) and by flicking the unit lights on and off several times to alert prisoners that an announcement is imminent. This includes announcements regarding visiting, meals, recreation release and recall, count, lock-up, and unlock. Verbal announcements may be effectively communicated via written messages on a chalkboard or by personal notification, as consistent with individual need. These procedures shall be communicated to prisoners during the orientation process and also shall be incorporated into relevant policies and post orders."

Officers assigned to housing units where a deaf inmate is housed are advised by the Compliance Unit officers of the need for special accommodations regarding verbal announcements. At the Main Jail, officers will go to the door if they know an individual is deaf or hard of hearing and needs to come out. SSO Policy 602, Incarcerated Persons with Disabilities, was updated to address this provision. 602.6 addresses effective communication for incarcerated persons with disabilities. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

K. Disability-Related Grievance Process

III.K.1 – Partial Compliance

"The County shall implement a grievance system for prisoners with disabilities to report any disability-based discrimination or violation of the ADA, this Remedial Plan, or Jail ADA-

related policy, and shall provide a prompt response and equitable resolution in each case."

ACH has implemented a grievance process as outlined in policy approved by Class Counsel and court-appointed Experts where patients with disabilities can report any disability-based discrimination or violation of the ADA, the Remedial Plan, or ACH's ADA policy. This item will be in Substantial Compliance once a "prompt response" is consistently provided.

The Nursing Director redirected staff and grievances are assigned at each facility to designated staff. See III.K.3 for additional detail. A dedicated SRN was added during this reporting period to track and manage the grievance process. This person is in the background process.

Medical Grievance boxes were installed, and ADA was added to grievance forms. SSO Policy 602, Incarcerated Persons with Disabilities and 607, Grievances, have been updated and support this provision.

III.K.2 - Substantial Compliance ↑

"The County shall ensure that the grievance procedures are readily available and accessible to all prisoners.

- *a) The County shall make reasonable efforts to ensure all prisoners are aware of the disability grievance procedures, including the availability of accommodations and staff assistance to submit a grievance and/or appeal.*
- *b) The County shall ensure the prisoners with disabilities have meaningful access to grievance forms, including through provision of staff assistance and large print materials."*

The medical grievance process is outlined in the Sheriff's Inmate Handbook that is given at booking. Medical staff review and update the Handbook prior to each revision to ensure all pertinent medical information is included. ACH has grievance forms available in each pod. As staff collect grievances daily, they ensure forms are re-stocked. To allow for secure submission, confidential grievance lock boxes are also in each pod.

Reading glasses can be purchased on commissary as well as keep on person self-magnifying cards at RCCC and MJ.

SSO Policy 602, Incarcerated Persons with Disabilities and 607, Grievances, have been updated and support this provision. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.K.3 - Partial Compliance

"Response to Grievances

a) *The County shall develop and implement an ADA grievance process that includes (1) a reasonable timeline for response to ADA-related grievances and appeals, including an expedited process for urgent ADA grievance (e.g., involving prisoner safety or physical well-being); and (2) provision for interim accommodations pending review of the individual's grievances/appeals.*
b) *The County shall ensure that prisoners with communication needs are interviewed and provided assistance as part of the grievance/appeal process where necessary to ensure meaningful access and Effective Communication.*
c) *The County shall document each denial of a reasonable accommodation request and shall record the basis for such determination.*
d) *The County shall provide in writing a copy of the grievance (or appeal) response to the prisoner, including the resolution, the basis for a denial (if applicable), and the process for appeal.*
e) *The County shall ensure that completed grievance responses are effectively communicated to prisoners with disabilities."*

The Grievance policy and forms were substantially revised based on Medical Expert feedback. Key additions include immediate review of each grievance by a nurse and immediate action when indicated, specific timeframes for requesting and responding to appeals, and more detail on the grievance and appeal forms.

ACH QI has developed and implemented a Grievance Corrective Action Plan to support greater compliance in meeting response timeframes. A shared folder was created for both jail nursing staff and QI staff. Both facilities maintain a combined spreadsheet of open grievances and a copy scanned to the secured folder for review by nursing and QI. QI is able to view all open grievances based on the information in the shared folder. Corrective actions and updates are discussed at a monthly multi-disciplinary meeting.

The grievance disposition form was updated. A grievance collection tool was developed to ensure the grievances are being collected timely and was implemented 07/01/24. The process was reviewed and the policy was updated to improve compliance. The revised policy was sent to the SMEs for review on 06/06/2024. The Grievance CAP will be completed once the policy is finalized.

ACH has designated two SRNs and two MAs to assist with grievance tracking and responses. Progress on grievance response timeframes has improved and the backlog of grievances has been addressed. With the backlog addressed, staff are currently meeting the 14-day timeframe. The County recognizes the importance of patient grievances and compliance with this provision and has approved a new position for a fully dedicated SRN to oversee the grievance process for both jails. An offer was made to a highly qualified RN from another correctional facility, and she is anticipated to start in January 2025. After further consultation with the SMEs, ACH is updating the grievance forms to provide a more appropriate response and better tracking indicators. Forms are in production and will capture higher quality data moving forward.

SSO Policy 602, Incarcerated Persons with Disabilities and 607, Grievances, have been updated and support this provision. Compliance staff provide assistance and find resources as needed to support this provision. The process for appeals is contained in the inmate handbook and orientation video.

III.K.4 - Partial Compliance

"The submission, processing, and responses for disability-related grievances and complaints shall be tracked."

SSO Policy 602, Incarcerated Persons with Disabilities and 607, Grievances, support this provision. Grievances are entered into ATIMS and searchable.

A grievances tracking system is in place and overseen by ACH QI. ACH and SSO Custody continue to discuss an electronic Grievance form process – which will support more accurate tracking. Staff violations of the ADA/disability process resulting in grievances are also tracked in a Staff Complaint category that is reported on quarterly. Staff complaints are monitored and follow-up on by management as appropriate. ACH QI continues to monitor medical staff scanning grievances as they are collected; this was previously an area of deficiency.

L. Alarms/Emergencies

III.L.1 - Substantial Compliance ↑

"The County shall ensure that all written policies regarding alarms and emergencies contain mandatory provisions to accommodate prisoners with disabilities."

SSO Policy 400.13 includes provisions to accommodate prisoners with disabilities during emergencies and alarms. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.L.2 - Substantial Compliance ↑

"The County shall implement written policies regarding the expectations of staff as to prisoners with identified disabilities during emergencies and alarms, including as to disabilities that may affect prisoners' ability to comply with orders or otherwise respond to emergencies and alarms. For example, the policies shall ensure appropriate handling of prisoners with mobility-related disabilities who are unable to prone or take a seated position on the ground during an alarm or emergency. Such policies shall be communicated to staff, incorporated into the relevant Operations Orders, and communicated to prisoners with disabilities using Effective Communication."

SSO Policy 400.13 describes the expectations of staff for prisoners with identified disabilities during emergencies and alarms. Optional inmate disability identification vests

create further awareness of individuals' needs during emergencies. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.L.3 - Substantial Compliance ↑

"The County shall implement written policies for staff regarding communicating effectively and appropriately with prisoners who have disabilities that may present barriers to communication during emergencies or alarms."

SSO Policy 400.13 describes the verbal and visual communication methods to be used during emergencies or alarms to support notification of individuals with disabilities that present barriers to communication. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.L.4 - Substantial Compliance ↑

"In order to facilitate appropriate accommodations during alarms or emergencies, the County shall offer, but shall not require, individuals who have disabilities visible markers to identify their disability needs (e.g., identification vests). The County shall maintain a list, posted in such a way to be readily available to Jail staff in each unit, of prisoners with disabilities that may require accommodations during an alarm or emergency."

MJ and RCCC have implemented the use of identification vests for those inmates who choose to do so. Prisoners with disabilities that may require accommodations during an alarm or emergency are tracked on the ADA tracking system and logged in ATIMS. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.L.5 - Substantial Compliance

"The County shall install visual alarms appropriate for individuals who are deaf or hard of hearing, which shall comply with relevant fire code regulations."

At RCCC and MJ, visual alarms are currently installed compliant with relevant fire code regulations.

III.L.6 - Substantial Compliance

"All housing units shall post notices for emergency and fire exit routes."

Emergency and fire exit routes are posted at both facilities.

M. Searches, Restraints, and Extractions

III.M.1 - Substantial Compliance ↑

"The County shall modify its written policies to ensure that prisoners with mobility impairments, including those with prosthetic devices, receive reasonable

accommodations with the respect to the following: (1) Pat searches and unclothed body searches; (2) Application of restraints devices, including Pro-Straint Chair; and (3) Cell extractions."

In February 2023, the Sheriff's Office formed a new Legal and Policy Bureau. A Lieutenant position was added to lead the unit. One of the core duties of this unit it to update all policies and procedures to the Lexipol system with a focus on policies and procedures related to the Mays Consent Decree. MJ and RCCC Compliance Lieutenants have continued their commitment to policy and procedure revisions during 2024. Procedure 521, Body Scanner, addresses searches for individuals with mobility impairments. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

N. Transportation

III.N.1 - Substantial Compliance

"The County shall provide reasonable accommodations for prisoners with disabilities when they are in transit, including during transport to court or outside health care services."

Per SSO Policy 516.5, the Sheriff's Office shall provide reasonable accommodations for incarcerated persons with disabilities when they are in transit, including during transport to court or outside health care services. Policy 516 was published in February 2024.

III.N.2 - Substantial Compliance

"Prescribed HCAs/ADs/DME, including canes, for prisoners with disabilities shall be available to the prisoner at all times during the transport process, including in temporary holding cells, consistent with procedures outlined in Part VII."

Per SSO Policy 516.5, prescribed health care appliances, assistive devices, and/or durable medical equipment, including canes, for incarcerated persons with disabilities shall be available to the person at all times during the transport process, including in temporary holding cells.

III.N.3 - Substantial Compliance

"The County shall use accessible vehicles to transport prisoners in wheelchairs and other prisoners whose disabilities necessitate special transportation, including by maintaining a sufficient number of accessible vehicles."

Per SSO Policy 516.5, staff must use accessible vehicles to transport incarcerated persons in wheelchairs and other incarcerated persons whose disabilities necessitate special transportation. The Sheriff's Office is required to maintain a sufficient number of accessible vehicles. RCCC received an ADA Compliant Van in August 2021. Main Jail has ADA compliant vans.

III.N.4 - Substantial Compliance

"Prisoners with mobility impairments shall be provided assistance onto transport vehicles."

Per SSO Policy 516.5, incarcerated persons with mobility impairments or other relevant disability-related needs shall be provided assistance on and off the transport vehicles, and as needed during the transport process.

O. Prisoners with Intellectual Disabilities

III.O.1 - Substantial Compliance ↑

"The County shall, in consultation with Plaintiffs' counsel, develop and implement a comprehensive written policy and procedure regarding prisoners with an Intellectual Disability, including:

a) Screening for Intellectual Disabilities;
b) Identification of prisoners' adaptive support needs and adaptive functioning deficits; and
c) Monitoring, management, and accommodations for prisoners with Intellectual Disabilities."

The Nurse Intake policy and Mental Health Adaptive Support Program policy were completed with approval with Class Counsel and the court-appointed Experts.

As part of the Intake Health Screening, Nursing gathers information through screening, past history, self-identification, third party report or observation noting possible intellectual disability and refers patients identified to mental health staff for an assessment and treatment plan. ACH Policies 06-02 and 06-06 address this provision.

SSO policies that support monitoring, management, and accommodations for prisoners, including those with Intellectual Disabilities, are as follows:

- Policy 503 (Orientation)
- Policy 505 (Special Management Incarcerated Persons)
- Policy 509 (Control of Incarcerated Person Movement)
- Policy and Procedure 510 (CERT response)
- Policy 511 (Use of Restraints)
- Policy 512 (Searches)
- Procedure 519 (End of Term Release)
- Procedure 600 (Discipline)
- Policy 601 (Disciplinary Separation)
- Policy 602 (Incarcerated Persons with Disabilities)
- Policy 606 (Grooming)
- Policy 716 (Incarcerated Person Health Care Communication)

With these policies, the compliance rating for this provision should be increased to reflect Substantial Compliance.

III.O.2 - Partial Compliance

"A multidisciplinary team that includes appropriate health care staff will monitor and ensure appropriate care for prisoners with an Intellectual Disability. The multidisciplinary team will develop an individualized plan for each prisoner with an Intellectual Disability, which addresses: (1) safety, vulnerability, and victimization concerns, (2) adaptive support needs, (3) programming, housing, and accommodation needs. The multidisciplinary team's plan will be regularly reviewed and updated as needed."

Mental Health began staff training and implementation of the Mental Health Adaptive Support Program in September 2022. Adaptive Support Plans (ASPs) are entered into patient charts as well as a copy provided to housing unit Custody. The ASP is also entered on the patient Problems and Conditions in the EHR. Mental Health completes an ASP for every patient with a confirmed diagnosed with an Intellectual Disability.

Trained core staff to complete MoCA assessments to identify patients with cognitive impairments who require adaptive supports. MH assigned a MH supervisor to review patient caseload on a weekly basis to ensure that ASP is in place for all patients diagnosed with ID and the patient is referred to EOP.

MH worked with SSO to place male patients at the Main Jail with ID in 3W and 3E in designated housing. Females with ID are mostly housed in 7W 100. This allows for easier access to patients who need additional assistance and is an added layer of security for patient safety.

A patient's mental health ASP indicates the additional assistance a patient needs in order to program in the jail, based on diagnosis and identified needs. Once a patient has a mental health ASP, it is required that all staff interacting with the patient provide the adaptive supports identified in the ASP during encounters and document to such in the encounter note. This information has been messaged to all service lines in multiple ways, including the ACH Newsletter.

Custody staff assigned to IOP and APU received training on MH ASP (ACMH provided Brain Development/Intellectual Disability training to all MJ and RCCC deputies).

MH creates an alert in the patient's chart to inform medical and custody that the patient has adaptive supports in place. Custody receives the alert via ATIMS.

In April 2024, the ASP form was added to the EHR and replaced the paper form that was previously utilized. The ASP immediately becomes a part of the medical record and

transmits ASP data to ATIMS that includes an intellectual disability or suspected cognitive impairment flag, the ASP and needed accommodations.

In April 2024, per the MH SME recommendation, MH added ID specific items to the MDT audit and will integrate the findings in the next QI study. Per the MH SME recommendation, MH will include ID as a component of the RVR and UOF review/QI.

III.O.3 - Substantial Compliance ↑

"Prisoners with an Intellectual Disability assigned to a work/industry position will be provided additional supervision and training as necessary to help them meet the requirements of the assignment."

SSO Policy 602 (Incarcerated Persons with Disabilities) was published and outlines accommodations for workers with disabilities. SSO has several workers with disabilities who are being accommodated. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

P. ADA Training, Accountability, and Quality Assurance

III.P.1 - Partial Compliance

"The County shall ensure all custody, health care, facility maintenance, and other Jail staff receive ADA training appropriate to their position.

a) The County shall provide to all staff appropriate training on disability awareness, including the use and purpose of accommodations and modifications in accordance with the ADA.
b) The ADA training shall include: formalized lesson plans and in-classroom or virtual training for staff (including managers, supervisors, and rank-and-file staff) provided by certified or otherwise qualified ADA trainers."

ADA and Effective Communication (EC) Training and Documentation PowerPoints were developed and approved. The documentation PowerPoint has been updated to include changes to EHR templates. Training is mandatory for all ACH staff, including contracted mental health staff, in the jails as well as administrative positions (Case Management and Quality Improvement) working offsite.

For SSO, all deputies receive a 15-hour course discussing disabilities and accommodations in the POST Basic Academy. All staff assigned to corrections (sworn staff and records officers) are assigned consent decree training. As new hires are onboarded, they are assigned the training and must attest to the completion of the training. This section remains in Partial Compliance while SSO continues to develop the training plan with certified/qualified ADA trainers.

III.P.2 - Substantial Compliance ↑

"ADA instructors shall have appropriate ADA training and subject matter expertise necessary to effectively provide ADA training to staff."

SSO ADA/Compliance team members are provided with advanced, formal ADA training. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.P.3 - Substantial Compliance ↑

"The County shall, in consultation with Plaintiffs' counsel, develop and implement written policies and procedures regarding monitoring, investigating, and tracking staff violations (or allegations of violations) of ADA requirements and Jail ADA policies."

ACH has, in consultation with Class Counsel, developed and implemented written policies and procedures regarding monitoring, investigating, and tracking staff violations (or allegations of violations) of ADA requirements and jail ADA policies.
Alleged staff violations of ADA requirements are captured through the Grievance Process. See Disability-Related Grievance Process (Provision K.) for further detail. SSO Policy 602 (Incarcerated Persons with Disabilities) was published and outlines accommodations for workers with disabilities. The grievance tracking system is used for investigating and tracking ADA issues (as well as other complaints). Staff determined to be in violation are addressed within the guidelines of the progressive discipline system. SSO Policy 320 covers Standards of Conduct. Per SSO, the compliance rating should be increased to reflect Substantial Compliance.

III.P.4 - Partial Compliance

"The County shall develop an ADA accountability plan that will ensure quality assurance and establish staff accountability for egregious, serious, or repeated violations of the ADA and Jail ADA-related policies and procedures."

ACH has created an ADA Accountability Plan and has established ADA related audits and patient grievances concerning ADA related issues as methods for identifying violations of policy. This element of the provision remains in Partial Compliance due to the delays in responses to patient grievances that may hinder immediate and appropriate actions resulting from grievance reviews.

If any egregious or repeated violations are identified, corrective actions that include staff disciplinary measures will be enforced. See explanations of policies in III.P.3. SSO Policy 724 Continuous Quality Improvement also applies to this provision.

Q. Accessibility Remedial Plan to Address Physical Plant Deficiencies

III.Q.1 - Partial Compliance

"The County shall, within 24 months from court approval of the Settlement and in consultation with Plaintiffs' counsel, develop and fully implement an Accessibility Remedial Plan to address Jail physical plant deficiencies that result in access barriers for prisoners with disabilities. In the interim, the Sheriff's Office shall house prisoners with disabilities in the most integrated and appropriate housing possible, providing reasonable accommodations and assistance where necessary to ensure appropriate accessibility to Jail programs, services, and activities."

At RCCC and MJ, inmates with disabilities are housed according to their security classification and granted access to programs according to their classification. Reasonable accommodations are made where necessary to ensure special needs are met. Due to facility space limitations, this provision remains in Partial Compliance.

III.Q.2 - Non-Compliance

"The Accessibility Remedial Plan shall ensure the following:

a) Adequate provision of accessible cells and housing areas with required maneuvering clearances and accessible toilet fixtures, sanitary facilities, showers, dining/dayroom seating, and recreation/yard areas.

b) Accessible paths of travel that are compliant with the ADA."

Due to facility space limitations, this provision remains in Non-Compliance. On December 8, 2022, the Sacramento Board of Supervisors approved to build a Jail Intake and health Services Facility as well as make ADA facility improvement to the current Jail system. While the IHSF programming and conceptual plan is undergoing peer review, current plans are in process for renovating the existing Main Jail infrastructure for accessibility needs. Interim plans are explored to address issues while waiting for these facility improvements.

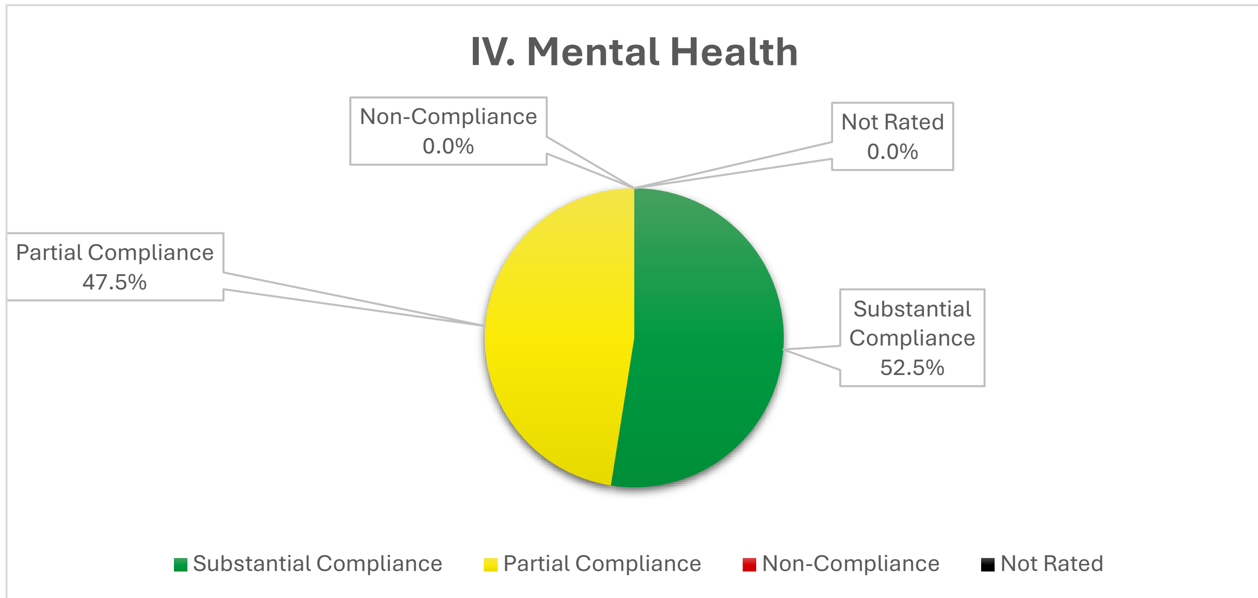
At RCCC, legal visitation areas provide equal and adequate access for inmates with disabilities. RCCC social visitation areas provide inmates with disabilities the same opportunity to visit with their family. Social and Attorney visits continue to overwhelm the current Main Jail as there is only one Attorney Visit booth, and two Social Visit booths that may be accessed without stairs (located on the 2-East housing unit). Any individual who cannot climb stairs is required to use the visiting area on 2-East.

III.Q.3 - Partial Compliance ↑

"Equal and adequate access for all prisoners with disabilities to Family and Attorney Visiting areas in reasonable proximity to their housing location."

Prior to this status report, no rating was assigned to this provision. A compliance rating of Partial Compliance is being assigned to this provision. While both jail facilities provide access to Family and Attorney Visiting areas for individuals with disabilities, space is limited.

IV. Mental Health



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	17 (42.5%)	21 (52.5%)
Partial Compliance	23 (57.5%)	19 (47.5%)
Non-Compliance	0 (0%)	0 (0%)
Not Rated	0 (0%)	0 (0%)
Total Provisions	**40**	**40**

Attachment 7, Mental Health Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

IV.A. Policies and Procedures

IV.A.1 - Substantial Compliance ↑

"The County shall establish policies and procedures that are consistent with the provisions of this Remedial Plan and include the following:

a) *A written document reflecting the complete spectrum of mental healthcare programming and services provided to prisoners;*
b) *Minimum and maximum timeframes for when each type of mental healthcare service will be completed, including but not limited to laboratory tracking and psychiatry follow-up services, in accordance with prevailing community and professional standards;*
c) *An intake and referral triage system to ensure timely and effective resolution of inmate requests and staff referrals for mental healthcare;*

d) *Specific credentialing requirements for the delivery of mental healthcare services, including but not limited to only qualified mental health professionals may make critical treatment decisions.*
e) *Clinical monitoring of inmates, including but not limited to those who are involuntarily medicated, clinically restrained or secluded, segregated, or on suicide watch;*
f) *Descriptions of specialized mental health programming that specifically identify admitting and discharge criteria and the staff members who have the authority to place inmates in specialized mental health housing;*
g) *Procedures for involuntary medications and other appropriate measures for the management of inmates with serious mental illness who lack the capacity to give informed consent, in accordance with relevant state law;*
h) *Training for all staff members who are working with inmates with mental illness in all aspects of their respective duty assignments."*

The County ACH and ACH Mental Health established policies and procedures that are consistent with the provisions of this Remedial Plan requirement as listed above. For SSO, relevant portions of IV.A.1.g are included in Use of Force and CERT Procedure 510. For IV.A.1.h, all custody staff are required to take four hours of suicide prevention training, and will be attending four hours combined of Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports. This training is in addition to mental health training received in the POST Basic academy, Corrections Supplemental Core Course, and SSO mandated 24-hour Crisis Intervention Training.

IV.A.2 - Substantial Compliance ↑

"The County's policies and procedures shall be revised, as necessary, to reflect all of the remedial measures described in this Remedial Plan."

ACH policies and procedures are revised as necessary, to reflect all the Remedial Plan measures described in this Remedial Plan.

In February 2023, the Sheriff's Office formed a new Legal and Policy Bureau. A Lieutenant position was added to lead the unit. One of the core duties of this unit is to update all policies and procedures to the Lexipol system with a focus on policies and procedures related to the Mays Consent Decree. MJ and RCCC Compliance Lieutenants have continued their commitment to policy and procedure revisions throughout 2024. The compliance rating for this provision is increased from Partial Compliance to Substantial Compliance due to policy revisions and updates by SSO.

IV.A.3 – Substantial Compliance ↑

"The County shall continue to operate its acute inpatient program and its Outpatient Psychiatric Pod (OPP) program. The County shall establish a new Intensive Outpatient

Program (IOP) for inmates who require a higher level of outpatient psychiatric care than what is provided in the OPP program."

ACH Mental Health continues to operate its Acute Psychiatric Unit (APU), Intensive Outpatient Program, and Enhanced Outpatient Program. With the implementation of the Intensive Outpatient and Enhanced Outpatient Programs, MH no longer utilizes the Outpatient Psychiatric Pod (OPP) as a service level. OPP is now only a housing classification designation for patients on the MH caseload with SMI.

MH administration has daily bed assignment/utilization meetings with SSO Custody to review movement between the IOP, APU, and OPP housing. This includes admissions, discharges, and MH recommendations for housing. The APU includes social work staff who provide therapeutic interventions, crisis intervention, group therapy, case management, and coordination of MDTs. The County recognizes the need to expand the APU due to a high level of demand; ACH Medical, MH, and SSO Custody continue to coordinate on efforts to increase Acute Psychiatric Unit (APU) beds.

Additional high security/high acuity IOP beds designed to serve patients with SMI who are housed in Administrative Segregation were implemented in 2022. IOP services have been found to effectively decrease the number of disciplinary write-ups, emergent referrals and number of days a patient stayed in the APU.

MH reallocated EOP staff to support expansion of the high acuity/high security IOP as staffing for the additional IOP beds was not included in the budget augmentation for FY 2022/23. Reallocation of EOP staff reduced the capacity of patients that can be served in EOP in FY 2022/23. MH received mid-year budget augmentation in FY 2023/24, which restored EOP positions and increased EOP service capacity to 525 patients. EOP services have assisted in decreasing the number of disciplinary write ups, emergent referrals and the number of days a patient stayed in the APU.

Currently, the Main Jail IOP has 20 male and 23 female beds. RCCC IOP has 48 male beds. MH expects to receive mid-year augmentation in FY 24/25 to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. The anticipated implementation date is May 2025; ongoing coordination continues between SSO, ACH, and DGS to complete this project.

Beyond APU, IOP, and EOP, the jail system has beds dedicated to mental health-related programming. RCCC has 32 male and 12 female beds for JBCT and 32 male beds for EASS. Between the two facilities, there are 13 EASS beds for incarcerated females.

While more APU and IOP beds are needed to serve the level of demand, the compliance rating for this provision is being increased from Partial Compliance to Substantial Compliance as the County continues operation of the APU and has developed the IOP unit as described.

IV.A.4 - Partial Compliance

"The County shall operate its non-acute mental health programs – IOP, OPP, and General Population-Mental Health – consistent with the JPS Psychiatric Services overview, attached as Exhibit A-2 [in the Remedial Plan]."

ACH Mental Health continues to operate its Outpatient Program, Acute Psychiatric Unit (APU), Intensive Outpatient and Enhanced Outpatient Programs. With the implementation of the Intensive Outpatient and Enhanced Outpatient Programs, MH no longer utilizes the Outpatient Psychiatric Pod (OPP) as a service level. OPP is only used as a housing classification designation for patients on the MH caseload with SMI.

All patients on the MH caseload will eventually be assigned to an EOP level of care. Within the EOP program there are three levels of care, intensive, moderate and general population. Patients will be assigned to an EOP level of care based on diagnosis and functional impairments. IOP and EOP replaced the OPP and General Population-Mental Health Caseload programs.

EOP is budgeted to serve 400 patients; services include crisis intervention, case management, care coordination, advocacy, discharge planning, and therapeutic interventions including 1:1 and group programming. MH received mid-year budget augmentation in FY 2023/24 which restored EOP positions and increased EOP service capacity to 525 patients; services are being titrated as staff are hired.

In FY 2024/25, 7.0 EOP vacant positions were placed on pause. MH expects to receive mid-year budget augmentation to restore the EOP positions. EOP expanded therapeutic group services for EOP patients housed on 3E & 3W, 7W, 4E & 4W and 8E. EOP participants are also supported by MDTs.

MH no longer utilizes manual tracking logs to track canceled groups. Supervisors and staff are responsible for entering offered and canceled groups directly into the EHR.
From July 2024 to September 2024, 1,182 groups were scheduled in APU, EOP, and IOP.

Summary: July 2024-September 2024 Groups Scheduled and Cancelled

Programs	Number of Groups Scheduled	Number of Groups Cancelled
APU	196	66 (34%)
EOP	111	6 (5%)
IOP Main Jail: Female	253	33 (13%)
IOP Main Jail: Male	254	56 (22%)
IOP RCCC: 400 Pod	183	12 (7%)
IOP RCCC: 500 Pod	185	11 (6%)
Total	**1,182**	**184 (16%)**

- 16% (184/1182) of groups scheduled for this report period were cancelled due to:
  - 35% (65/184) custody staffing
  - 24% (45/184) other
  - 22% (40/184) MH staffing
  - 14% (26/184) unavailable space
  - 4% (8/184) facility lockdown
- MH staffing as a reason for group cancellation decreased by 14% from last reporting period.

ACMH will continue to address and identify barriers that interfere with scheduled groups with Supervisors. ACHM is working on refining the automated Group Participation report which will assist with tracking the average number of hours of structured treatment offered per patient per week, the average number of hours of structured treatment received/attended per patient per week, and the actual number of groups scheduled and canceled.

The assigned rating of Partial Compliance is due to titration of EOP services with long-term plan for all patients on the MH caseload to be assigned to an EOP level of care. Titration of EOP services were paused in FY 24/25; however, MH expects to receive mid-year budget augmentation to restore the EOP positions. MH continues to actively recruit to fill vacant positions.

IV.B. Organizational Structure

IV.B.1 - Substantial Compliance

"The County shall develop and implement a comprehensive organizational chart that includes the Sheriff's Department ("Department"), Correctional Health Services ("CHS"), Jail Psychiatric Services ("JPS"), Chief Administrative Officer, Medical Director of the JPS Program, and any other mental health staff, and clearly defines the scope of services, chains of authority, performance expectations, and consequences for deficiencies in the delivery of mental health care services."

The County maintains a comprehensive organizational chart for Adult Correctional Health (ACH) and ACH Mental Health provided by UCD that clearly outlines the chains of authority. ACH also developed and implemented Position Standards and job descriptions, outlining scope of services and performance expectations for each position. Both the County and UCD have County and UCD-wide policies and disciplinary processes as it relates to not meeting standard performance and duties. SSO also maintains an organizational chart.

IV.B.2 - Substantial Compliance

"A Medical Director of Jail Psychiatric Services shall be designated and shall oversee all mental health care functions in the jails, including psychiatric prescribers and psychiatric nurses. The Director shall possess clinical experience and a doctoral degree."

ACH Mental Health (MH) has a Medical Director designated to oversee all mental health care functions in the jails, including psychiatric prescribers and psychiatric nurses. The ACH Mental Health Medical Director possesses clinical experience and a doctoral degree. ACH MH reorganized the leadership structure to address Consent Decree requirements and support program and staff expansion.

IV.B.3 - Substantial Compliance

"The Medical Director of Jail Psychiatric Services shall participate in jail executive leadership and shall be responsible for overseeing program development, clinical practice, and policy, as well as interfacing with jail and medical leadership and community mental health."

The ACH MH Medical Director and MH Program Director participate in ACH Executive Team leadership meetings as well as a variety of meetings including Quality Improvement, Multidisciplinary Team Meetings, ACH leadership and SSO Custody leadership meetings, and ad hoc meetings.

IV.C Patient Privacy

IV.C.1 - Partial Compliance

"All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be based on housing placement or custodial classification.

a) For any determination that a clinical interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.

b) *If the presence of custody staff is determined to be necessary to ensure the safety of medical staff for any clinical counter, steps shall be taken to ensure auditory privacy of the encounter.*
c) *The County's patient privacy policies, as described in this section, shall apply to contacts between inmates and Triage Navigator Program staff and/or other staff that provide mental health-related services on site at the Jail."*

MH understands the importance of seeing all patients confidentially; however, due to facility infrastructure and lack of confidential interview space, this area remains in Partial Compliance.

MH staff document the confidential status of encounters including rationale when it is not confidential. As a result of audit findings, MH has further defined a drop-down menu of common reasons for the lack of confidentiality for uniformity and data purposes. The form was in production in June 2023 and is used by all service lines.

MH supervisors monitor the use of confidential space in booking, classrooms, confidential attorney booths, and new privacy "pods" installed on MJ floors 3-8, and have regular discussions with staff regarding challenges/barriers to use of confidential space. MH supervisors continuously reinforce the importance and requirements of confidential individual interviews and group programming during staff meetings and huddles.

MH and SSO Custody meet regularly to discuss challenges/barriers preventing confidential encounters. ACMH and both Compliance Lieutenants have a standing monthly meeting to discuss confidentiality issues and review for QA/QI. MH and Custody are developing plans to increase efficiency of using attorney booths on all floors, confidential interviews with patients who present with assaultive or high security/safety issues, and Custody standby while ensuring auditory privacy.

Due to ongoing collaboration and training between MH and SSO, audits of confidential encounters have shown a decrease in the number of "safety and security" reasons for non-confidential contacts. Lack of available confidential space continues to be the primary reason for non-confidential encounters.

At the Main Jail, there is a secluded privacy interview room created on the first floor for booking related clinical interactions. Classrooms (with the door shut) and confidential visit booths may also be used for housing unit clinical interactions. Designated MH outpatient staff moved to a nearby G St office. Staff vacated a classroom on the third floor that was converted into IOP office space. This increased confidential programming space for groups and individual assessments and interventions. In addition, Mental Health (MH) staff use designated attorney booths as available for confidential interviews. MH developed a workflow outlining the process for utilizing attorney booths.

SSO and MH consulted with the office furniture distributor to discuss the construction of confidential interview booths for each floor. SSO received approval for proof of concept and a confidential booth was installed on 3W in October 2023. This booth is in frequent use and offers excellent auditory privacy. During this reporting period, confidential booths comprised of plexiglass enclosures with doors were installed in the indoor area of each housing unit. Privacy curtains will be added in the upcoming reporting period to increase privacy in some booths. With the installation of interview booths completed in October 2024, MH has seen an increase in the number of confidential contacts at the Main Jail. In September 2024, an average of 66% of contacts were confidential. Following installation of the booths, in November 2024, an average of 81% of contacts were confidential. On many floors confidential contacts were in the 90% range.

At RCCC, MH obtained a custody escort two hours a day, three days a week to support confidential contacts for patients housed in the barracks. MH and ACH collaborated to develop a schedule for JKF/KBF interview room use to support both medical and MH with obtaining access to confidential interview space. MH expanded the use of the attorney booths at RCCC to increase confidential encounters. RCCC facilities have ACMH offices available for interviews. These areas are private and are not audio recorded. The doors to these offices were changed so they can be closed and the officer can see what is going on inside through windows, if needed. Officers standby as needed based on the inmate's classification/behavior while offering the highest amount of privacy possible.

SSO has purchased a security desk/chair (the same type used at Santa Clara Sheriff's Office), which allows leg shackles to be secured. This allows clinicians to safely speak to higher security inmates in privacy without custody staff standing nearby.
Although the confidentiality booths have been added at the Main Jail, there are still areas of the jail with inadequate confidential space (APU, 2E, RCCC). ACH and SSO have requested installation of a confidential booth on 2E to support confidential contacts for the APU and 2E patient population.

IV.C.2 - Substantial Compliance

"Jail policies that mandate custody staff to be present for any mental health treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and mental health staff shall be trained accordingly."

No policies exist mandating custody to be present for mental health treatment.

IV.C.3 - Partial Compliance

"It shall be the policy of the County that mental health clinicians shall not conduct their patient contacts at cell front except pursuant to documented refusals or specific, documented security concerns that warrant cell front contacts."

Due to ongoing collaboration and training between MH and SSO, audits of confidential encounters have shown a decrease the number of "safety and security" reasons for non-confidential contacts. Lack of available confidential space continues to be the primary reason for non-confidential encounters. MH staff document the confidential status of encounters including rationale when it is not confidential.

The SSO's Case Management Post Order covers this provision. At RCCC, MH patients are seen in the attorney booth or one of the offices where the doors have been changed so they can be closed and officers can still see what is taking place inside, if needed. ACMH and the Compliance Lieutenant meet regularly to discuss MH assessments and confidentiality. Custody and ACMH staff are reminded that specific documented security concerns must exist for cell front contacts otherwise MH contacts must occur inside the classroom or a confidential visit booth.

Confidential interview booths were installed on floors 3-8 at the Main Jail during this reporting period. Privacy curtains will be installed in some booths during the next reporting period.

Security chairs are being piloted on 8W to help with the issue of safety and security. Also, MH and SSO have discussed safety and security challenges and SSO messaged deputies about these types of denials without documentation in ATIMS that supports cell front contact. This provision will remain in partial compliance until there is a reduction in safety and security reasons used as justification for completing a cell front contact instead of a confidential encounter.

IV.C.4 – Substantial Compliance

"For each clinical contact, mental health staff shall document whether the encounter was confidential, including whether it took place at cell front. If the contact occurred at cell front or otherwise was non-confidential, the reasons shall be clearly documented in the individual patient record and for purposes of Quality Assurance review procedures."

MH staff document confidential status of encounters including rationale when it is not confidential. As a result of audit findings, MH has further defined a drop-down menu of common reasons for lack of confidentiality for uniformity and data purposes. The form will be used by all service lines and was implemented in June 2023. Several reports have been conducted for Quality Assurance review procedures.

Supervisors are completing spot-checks daily to ensure staff are appropriately utilizing confidential space.

MH continues to audit confidential contacts and the reason for a non-confidential contact. For the period of Jul-Sep 2024, the following was reported for the Main Jail:

- Facility wide, 57 patient encounters were completed in non-confidential setting due to medical quarantine.
- A total of 11,847 patient encounters were completed during this report period. 61% (7,187/11,847) occurred in a confidential setting.
- 3W continues to have the highest patient encounters, 3,005. 70% (2,090/3,005) occurring in a confidential setting.
- 8E, 2E and Booking all have high non-confidential encounters compared to other floors. On 8E and 2E, the most common reason for nonconfidential encounters was "confidential space unavailable," and in booking, the reason for nonconfidential encounters was that the patient "refused to leave cell."
- Confidential booths have been installed on all floors as of October 2024. This will aid in increasing confidential contacts for clinical encounters. In November 2024, an average of 81% of contacts were confidential. On many floors, confidential contacts were in the 90% range.

At RCCC, for the period of Jul-Sept 2024:

- Facility wide, 66 patient encounters were completed in non-confidential setting due to medical quarantine.
- A total of 4,938 patient encounters were completed during this report period. 74% (3,634/4,938) occurred in a confidential setting.
- Christopher Boone Facility (CBF) continues to have the highest total patient encounters, 2,175. 78% (1,698/2,175) of encounters were completed in a confidential setting.
- Barracks (A/B/J/K) and Stuart Baird Facility (SBF) continue to experience high non-confidential encounters. Currently, for Barracks, there is custody escort assigned to MH on Tuesdays, Wednesdays and Thursdays between 7:00AM-9:00AM to ensure confidential encounters occur. Reasons for non-confidential encounters:
  - Barracks: 60% (187/311) safety and security
  - SBF: 55% (256/462) refused to leave cell

IV.C.5 – Substantial Compliance

"A process shall exist for sick call slips or other mental health treatment-related requests to be collected without the involvement of custody staff."

The Health Services Request policy outlines the process allowing patients to submit requests or other mental health treatment-related requests to be collected without the involvement of SSO Custody staff involvement.

IV.D. Clinical Practices

IV.D.1 – Substantial Compliance

"Mental health staff shall develop and maintain at each jail facility an accurate case list of all prisoners requiring mental health treatment services at the jail ("caseload") which, at a minimum, lists the patient's name, medical chart number, current psychiatric diagnoses,

date of booking, date of last appointment, date of next appointment, and the name of the treating prescriber."

ACH has developed an MH caseload report that includes relevant information regarding the current diagnosis and level of mental health services. MH can access all the above information via the patient's medical record in the EHR.

IV.D.2 – Substantial Compliance

"Qualified mental health professionals shall have access to the patient's medical record for all scheduled clinical encounters."

MH staff have full access to all areas of the EHR for pending clinical encounters.

IV.D.3 – Partial Compliance

"Qualified mental health professionals shall provide individual counseling, group counseling, and psychosocial/psychoeducational programs based on individual patients' clinical needs."

MH provides individual and group counseling and psychosocial/psychoeducational programs in the IOP, APU, and EOP. This area remains in Partial Compliance due to staffing and titrating EOP services to the entire MH caseload.

IV.D.4 – Partial Compliance

"A qualified mental health professional shall conduct and document a thorough assessment of each individual in need of mental health care following identification."

MH completes a full assessment of patients identified as needing mental health services. This area remains in Partial Compliance due to staffing and compliance with timelines to care.

IV.D.5 – Partial Compliance

"The County shall ensure prompt access to psychiatric prescribers following intake and in response to referrals and individual patient requests in accordance with the referral and triage timelines defined in the Access to Care provisions, below."

The County ensures prompt access to psychiatric prescribers following intake and in response to referrals and individual patient requests in accordance with the referral and triage timelines defined in the Access to Care provisions. MH increased psychiatric prescriber coverage to seven (7) days per week in the Outpatient Program. MH has also increased the number of prescribers from four to seven NPs and two to three psychiatrists.

A Psychiatrist with combined Internal Medicine/ Psychiatry training joined the acute psychiatric mental health team – allowing for enhanced diagnosis and treatment of patients with combined mental health and medical issues.

MH worked with ACH to create a hard stop in Intake assessment to ensure nursing staff was documenting the last known pharmacy if patient reported using community medication. Following this update, MH continues to improve timeliness to medication verification.

MH revised the medication verification workflow to streamline the process for triaging and verifying community medications. MH continues to audit the timeliness to medication verification to ensure patients are receiving community medication within the designated timeframe.

MH continues to address barriers in meeting the 48-hour timeline for medication verification. Overall, compliance continues to improve. Audit results from Mar-May 2024 indicate:

- 100% (60/60) patients at intake reported taking MH medication(s) in the community.
- MH verified 100% (60/60) of referrals made for medication verification.
- MH verified 95% (57/60) of medications within 48 hours. (This is a 5% increase from the last reporting period). Three patients' community MH medications were not verified within 48 hours, however, 67% (2/3) of those patients' medication was verified within 72 hours. For one patient, it took 13 days for MH to verify their medication.

For medications verified and initiated by MH NP, the first dose was administered:

- 45% (15/33) within 24 hours of being initiated.
- 36% (12/33) same day it was initiated (includes patients with LAI)
- 15% (5/33) medication not administered because patient was released
- 3% (1/33), after 10 days

MH worked with ACH to develop an MH Essential Medication question in the nursing intake to automatically generate a medication verification order. This change has streamlined the verification process and increased compliance with timelines to medication verification.

IV.D.6 – Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, implement an electronic system for tracking mental health evaluation, treatment, and other clinical contacts, as well as sick call slips and other mental health treatment related requests or referrals."

The County has implemented an electronic system for tracking mental health evaluation, treatment, and other clinical contacts, as well as sick call slips and other mental health treatment-related requests or referrals.

MH utilizes ACHs EHR to track mental health treatment, encounters, HSRs, and other MH treatment-related requests or referrals.

IV.D.7 – Partial Compliance

"The County shall develop and implement an electronic tracking system with alert and scheduling functions to ensure timely delivery of mental health services to individual patients."

MH utilizes ACHs EHR to schedule all MH encounters.

Mental Health EHR Updates:

- The Confidential Encounter Form has been enhanced to include the facility along with encounter location and reason(s) for a non-confidential encounter. This form is included in every medical and mental health encounter.
- MH Encounters and Confidentiality Report is in production (completed and in use) and utilized by MH to track MH encounters for patients.
- Discharge Planning: Report in production (completed and in use) tracking patient roster for Discharge Linkages to community MH resources.
- MH Group Participation Report: The Fusion Group Notes application is being further enhanced and tested to track attendance as well as scheduled and canceled groups. Additionally, a report is being developed to track groups that are offered and refused, average number of hours of structured treatment offered per patient per week, average number of hours of structured treatment received/attended per week and average number of hours of structured treatment canceled per patient per week.
- Timelines to Care: Report is in production (completed and in use). MH completed audits of referrals and timelines to care and will continue to utilize the report to monitor compliance with timelines to care.
- Suicide Precautions EHR form: The most recent enhancements are in production (completed and in use). Enhancements include communication with custody jail management system (ATIMS) to alert as to observation type, item/privilege restrictions, Danger to Self/Other, etc.
- Confidential Contacts Report: A report is in production (completed and in use) to audit compliance with confidential MH contacts. ACH is able to utilize this information to highlight facility infrastructure limitations and other challenges that impede confidential services with patients.
- MH worked with ACH to develop SMI and MH Caseload flags that transmit to ATIMS. These flags are in production (completed and in use) and alert custody of patients who have SMI and/or are on the MH Caseload. Additionally, the flags ensure that SSO is aware of and can refer timely for MH RVR referrals and Planned Use of Force events.
- MH is worked with ACH to embed the Suicide Risk Assessment into the MH Clinical SOAP note. This change is in production (completed and in use) and improves the

consistency of documentation, ease of locating the SRA, and eliminates duplication/redundancy of documentation.

This area remains in Partial Compliance due to staffing, compliance with timelines to care, and ongoing report development.

IV.D.8 – Partial Compliance

"Treatment planning:

a) The County shall ensure that each prisoner on the mental health caseload receives a comprehensive, individualized treatment plan based on the input of the Multi-Disciplinary Treatment Team (MDT). The MDT shall include multiple clinical disciplines with appropriate custody and counseling staff involvement.
b) The treatment plan shall reflect individual clinical need, and the County shall ensure that all clinically indicated services are available and provided.
c) The treatment plan shall include, at a minimum, the frequency of follow-up for clinical evaluation and adjustment of treatment modality, the type and frequency of diagnostic testing and therapeutic regimens (which may include clinical contacts more frequent than the minimum intervals described herein), and instructions about adaptation to the correctional environment.
d) This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.
e) Custody staff shall be informed of a patient's treatment plan where appropriate to ensure coordination and cooperation in the ongoing care of the patient.
f) The County shall, in consultation with Plaintiffs' counsel, develop and implement a Treatment Plan Form that will be used to select and document individualized services for prisoners who require mental health treatment.
g) The County shall implement guidelines and timelines for the initiation and review of individual treatment plans, consistent with the JPS Psychiatric Services overview, attached as Exhibit A-2."

Treatment Planning remains in Partial Compliance due to staffing and titrating EOP services to the entire MH caseload.

Improvements to treatment planning efforts are as follows:

- MH established a workgroup to review treatment planning module in EHR and develop a workflow to guide staff in treatment planning requirements.
- Clinical Multidisciplinary Team (MDT) meetings began in IOP August 2021 with full implementation November 2021.
- IOP and EOP staff received training on completing treatment plans and MDTs in December 2021. Workflows were developed to help staff understand processes and policies.
- Provided training to staff on the process for completing MDT meetings and documenting patient's absence at MDT in instances where patients refuse to attend.

- Comprehensive treatment plans utilizing the EHR template were implemented for EOP patients in March 2021.
- Prescribers began attending EOP MDTs in March 2023.
- Began training SSO Custody working in MH programs on the MH Adaptive Support Program (November 2022).
- MH updated the treatment planning workflow and training to ensure all staff were utilizing the treatment planning module appropriately and identifying treatment goals, interventions and objectives.
- In December 2023, MH begin a new process of documenting MDTs and Treatment Plans within the same note in the EHR to ensure both are completed on the same day.
- MH completed baseline study of MDTs and treatment planning in IOP and APU.
- In August 2023, the MH QA Supervisor began observing and auditing IOP MDTs to identify strengths, challenges and barriers of MDT process and staff coordination and completion of all MDT requirements.
- Social work clinicians were embedded in the APU in January 2023. MH anticipates that treatment planning and MDT compliance will increase in the future reporting periods
- In January 2024, MH Treatment Planning, Part 2 was provided to IOP, APU and EOP staff with a focus on SMART goals and interventions. Documentation was streamlined and included embedding the clinical assessment and findings in the treatment plan document as well as inclusion of standardized headings to increase compliance with treatment planning requirements.

VI.E. Medication Administration and Monitoring

IV.E.1 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws and through the following:

a) The County shall ensure that initial doses of prescribed medications are delivered to inmates within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner;

b) The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health care records relating to ongoing care needs. The policy shall ensure that any ongoing medication, or a clinically appropriate alternative, shall be provided within 48 hours of verification of the prescription or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple prescribers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.

c) *The County shall ensure that medical staff who administer medications to inmates document in the inmate's Medical Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, and (3) the date and time for any refusal of medication."*

ACH staff document all required medication administration information in the eMAR. MH revised the medication verification workflow to streamline the process for triaging and verifying community medications. MH continues to audit the timeliness to medication verification to ensure patients are receiving community medication within the designated timeframe.

IV.E.2 - Substantial Compliance

"Qualified mental health professionals shall, for each individual patient, establish targets for treatment with respect to the use of psychotropic medication and shall assess and document progress toward those targets at each clinical visit."

Qualified mental health professionals establish targets for treatment with respect to the use of psychotropic medication and shall assess and document progress toward those targets at each clinical visit. QMHPs establish targets for treatment with respect to psychotropic medication and assess and document progress toward those targets at each clinical visit.

MDT meetings in APU and IOP settings include targets for treatment with respect to the use of psychotropic medication and assessment of progress towards those targets.
ACMH established a MH Prescriber Meeting in August 2021 to improve communication, patient care practices, and standards related to the Consent Decree.

MH hired an NP Supervisor in 11/2023 to oversee clinical activities of NP staff.

IV.E.3 - Substantial Compliance

"Qualified mental health professionals shall, for each individual patient, monitor and document the following with respect to psychotropic mediations: (1) levels of medications, (2) adverse impacts (including through renal and liver function tests where indicated), (3) side effects, and (4) efficacy."

QMHPs monitor and document levels of medications, and adverse impacts, order labs, and document side effects and treatment efficacy as appropriate. MH continues to complete peer reviews and report findings through the Psychiatric Prescriber Audit. For the period of Jun-Aug 2024, the following areas had Substantial Compliance:

- 100% (17/17) conducting in person meetings, if indicated, when making medication changes.
- 100% (8/8) completing routine labs for patients prescribed antidepressants.
- 96% (26/27) entering, reviewing, and updating diagnosis in patient charts.

IV.E.4 - Partial Compliance

"Qualified mental health professionals shall, for each individual patient, conduct and document baseline studies, including ECG, blood, urine, and other studies, as clinically appropriate, prior to the initiation of treatment."

Psychotropic treatment may be started prior to labs for a variety of reasons including emergency need, patient noncompliance, phlebotomist unavailability or other security issues within the facility. MH continues to review prescriber compliance though the Psychiatric Prescriber Audit and has identified areas for improvement related to ordering ECG for patients on antipsychotics and ensuring completion of routine labs for patients prescribed antipsychotics, mood stabilizers.

IV.E.5 - Partial Compliance

"The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication."

All RNs and LVNs have been cross-trained to administer medications allowing RNs to fill critical staffing shortages and avoid medication administration delays. A minimum number of staff has been established to cover pill call and when there are shortages, RNs will assist to ensure coverage.

Medication administration times outline acceptable dosing times supporting timely delivery of medications. Established distribution areas support efficient delivery of medications.

A staffing matrix has been developed to reflect 12-hour shifts to maximize staffing.

Previously, ACH management met with the LVN Union to make necessary changes to medication administration schedules to achieve substantial compliance. Required meetings occurred, and a Notice was sent out to all LVN's assigned to medication administration on 12/12/23 informing them that they will be moving to the day shift. Both medication administration times will occur on the dayshift to ensure safer medication practices and an abundance of staff to cover medication administration.

In January 2024, ACH leadership rolled out the new pill call process and new medication administration times. The two heaviest pill calls (AM and PM) are on the same shift. ACH transferred the majority of LVN staffing to this shift so ensure adequate staffing. Due to this change, there is always enough staff to cover pill call.

ACH leadership and SSO leadership have met multiple times to coordinate medication administration efforts. The Main Jail Captain wrote his operations order to align with the

ACH workflow. This ensures SSO and nursing staff have the same information which creates less confusion and/or conflict.

Training on the new medication administration workflow took place at a nursing all staff meeting on 12/20/23 and has been ongoing since then.

Hiring efforts have significantly increased.

Specialty programs like APU, IOP and SITHU have additional custody staff available to help with medication administration.

Since April 2023, the Main Jail has been staffing medical escorts allowing medical staff better access to patients. While most of the escorts are for doctor and nurse sick-call, these escorts allow floor custody staff more time for other responsibilities such as medication administration.

RCCC has at least four dedicated medical escorts. Deputies assigned to facilities are also available.

IV.E.6 - Partial Compliance

"Medication adherence checks that serve a clinical function shall be conducted by nursing staff, not custody staff. Custody staff shall conduct mouth checks when necessary to ensure institutional safety and security."

In-person observation audits have begun, and QI will work on additional review tools in the next monitoring period as well as in-person audits on medication administration and mouth-check adherence.

ACH, ACMH and Compliance Lieutenants meet regularly to discuss and rectify any issues related to medication distribution and medication diversion by inmates as well as reviewing efforts for staff to complete required checks. SSO now has an audit system in place and will be able to compile data for future reports and evaluations.

IV.E.7 - Substantial Compliance

"Psychiatric prescribers shall consider clinically indicated considerations and conduct an in-person consultation, with the patient prior to changing or initiating medications. In the event there is no in-person consultation before prescribing or changing medications the psychiatric prescriber shall note and document the reasons for why there was not an in-person consultation with the patient."

MH completed a Psychiatric Prescriber Audit for the period of Jun-Aug 2024, and found that MH conducted an in-person meeting, if indicated, when making medication changes in 100% of the charts reviewed. Telepsychiatric visits may occur due to a variety of reasons

and medications may be restarted when confirmed from community/ other collateral or as clinically indicated.

IV.F. Placement Conditions, Privileges, and Programming

IV.F.1 - Partial Compliance

"Placement:

a) It shall be the policy of the County to place and treat all prisoners on the mental health caseload in the least restrictive setting appropriate to their needs.

b) Placement in and discharge from Designated Mental Health Units shall be determined by qualified mental health professionals, with consultation with custody staff as appropriate.

c) Absent emergency circumstances, the County shall obtain the assent of qualified mental health professionals before transferring prisoners with SMI into or out of Designated Mental Health Units.

d) It shall be the policy of the County to place prisoners with SMI in appropriate settings that ensure provision of mental health services, patient safety, and the facilitation of appropriate programs, activities, and out-of-cell time. Co-housing with other populations shall be avoided to the extent that such a practice prevents or hinders any of the above.

e) All patients requiring placement in a Designated Mental Health Unit shall be provided access to such placement and care based on current clinical need and without any requirement for director-level approval."

This provision remains in Partial Compliance due to insufficient APU and IOP beds which prevent placing some patients on the MH caseload in the least restrictive setting appropriate to their needs. MH determines placement and discharge from Designated Mental Health Units (DMHU). Absent emergency circumstances, custody obtains consent of MH before transferring patients with SMI out of DMHU. Patients requiring placement in a DMHU do not require director level approval.

ACH developed a plan and process with SSO Custody to ensure MH is determining which patients are placed in Outpatient Psychiatric Pod (OPP) housing (OPP is an SSO housing classification designation). ACH further coordinated with SSO Custody to update Custody's classification form to better communicate MH recommendations regarding housing of patients served by MH. A single-cell housing unit was established on 3E for patients with SMI who require a single-cell due to clinical or behavioral factors.

MH expected to receive mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring the total number of IOP beds to 125. This is anticipated to be completed in the next reporting period.

IV.F.2 - Partial Compliance

"Programming and Privileges:

a) All Designated Mental Health Units shall offer a minimum of 7 hours of unstructured out-of-cell time per week and 10 hours of structured out-of-cell time per week for each prisoner. While out-of-cell hours per prisoner may vary from day to day, each prisoner will be offered some amount of out-of-cell time every day of the week. All treatment and out-of-cell time shall be documented for each prisoner, and reviewed as part of Quality Assurance procedures.

b) The County shall ensure that prisoners on the mental health caseload have access and opportunity to participate in jail programming, work opportunities, and education programs, consistent with individual clinical input.

c) The County shall develop and implement, in the 2P inpatient unit and the IOP unit, a program for progressive privileges (including time out-of-cell, property allowances, etc.) for patients as they demonstrate behavioral progress. A patient's level of privileges and restrictions shall be based on both clinical and custody input regarding current individual needs. The County shall ensure a process to review custody classification factors when necessary, so that placement, privileges, and restrictions match current individual circumstances and needs.

d) Individuals on a mental health caseload shall receive, at minimum, privileges consistent with their classification levels, absent specific, documented factors which necessitate the withholding of such privileges. Clinical staff shall be informed of the withholding of privileges and the reasons for the withdrawal shall be documented and regularly reviewed by clinical and custody staff. The restoration of privileges shall occur at the earliest time appropriate based on individual factors.

e) Where a prisoner in a Designated Mental Health Unit is subject to any restrictions of property, privileges, or out-of-cell time, the mental health treatment provider and Multi-Disciplinary Treatment Team will, on a weekly basis, assess and discuss with the prisoner progress and compliance with the prisoner's individual case plan. This process will include clinical contact in a private, face-to-face, out-of-cell setting. The Multi-Disciplinary Treatment Team will provide input to classification staff regarding the prisoner's mental health and appropriateness for removal of imposed restrictions. Classification staff will follow the recommendation of the Multi-Disciplinary Treatment Team to remove restrictions unless there is a clear, documented security reason to maintain the restriction."

In Designated MH Units (APU, IOP, JBCT), structured (group treatment) out-of-cell time is scheduled by MH in conjunction with SSO. Patients in these programs generally have more than seven hours of unstructured out-of-cell time and more than ten hours of structured time per week. Both Main Jail and RCCC Compliance monitor out-of-cell times. IOP offers 10 hours of structured out-of-cell time per week to each patient.

MH placed three social work staff on the APU which has increased structured out-of-cell time. APU offers 19 hours of group therapy/programming per week.

MH determines the level of privileges and restrictions for patients in the APU. Any removal or reinstatement of privileges, property or clothing is by MD order and follows LPS Denial

and Restoration of Patient's Rights requirements. On an operational level, the IOP and Acute Unit custody staff work with ACMH on property and privileges. The IOP Sergeant monitors compliance.

IOP patients who are subject to restrictions of property, privileges, or out-of-cell time are placed on an Alternative Treatment Plan. The multidisciplinary team meets daily to discuss the patient's progress and the transition of the patient from ATP to general programming.

Regarding work opportunities, work assignments are based on an individual's ability to safely perform those functions given the appropriate level of supervision.
This provision remains in Partial Compliance as SSO is working to develop reports to better track out-of-cell time.

IV.F.3 - Substantial Compliance

"Conditions:

a) Staff shall provide prisoners in Designated Mental Health Units with the opportunity to maintain cell cleanliness and the opportunity to meet their hygiene needs. Custody and clinical staff shall provide assistance to prisoners on these matters, as appropriate to individual patient needs.

b) The County shall ensure uniformity of practice with respect to cell searches, such that searches are not done for punitive or harassment reasons. The County shall monitor whether cell search practices may be serving as a disincentive for prisoners in Designated Mental Health Units to leave their cells for treatment or other out-of-cell activities, and shall take steps to address the issue as appropriate."

MH and Custody assist patients in IOP and APU with maintaining cell cleanliness and promoting personal hygiene. Cell searches are done randomly on a revolving basis. They are not done for punitive or harassment reasons. They are done to ensure the inmates do not have any contraband or weapons that can harm themselves, ACMH staff or SSO staff. SSO Policy 512 was published on 05/03/2024.

IV.F.4 - Partial Compliance

"Bed Planning:

a) The County shall provide a sufficient number of beds in Designated Mental Health Unit, at all necessary levels of clinical care and levels of security, to meet the needs of the population of prisoners with SMI.

b) The County shall conduct a bed needs assessment, to be updated as appropriate, in order to determine demand for each category of Designated Mental Health Unit beds and shall ensure timely access to all levels of mental health care, consistent with individual treatment needs.

c) The County shall establish mental health programming for women that ensures timely access to all levels of care and is equivalent to the range of services offered to men."

Although IOP has significantly increased its bed capacity, this provision remains in Partial Compliance due to insufficient APU and IOP beds. MH expects to receive mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. It is anticipated that this will be implemented in the upcoming reporting period. An expansion to the APU is also in development.

MH provides mental health programming and access to all levels of care to female patients. MH recently increased female IOP beds from eight to 23. APU and EOP services are also provided to female patients.

During this reporting period, a peer review was conducted on plans for an Intake Health Services Facility (IHSF) building which would substantially increase bed capacity for patients with mental health needs. The outcome of this peer review is anticipated to occur during the upcoming reporting period.

IV.F.5 - Substantial Compliance ↑

"General Exclusion of Prisoners with Serious Mental Illness from Segregation

a) *Prisoners with Serious Mental Illness will not be housed in Segregation units, except in rare cases where the prisoner presents an immediate danger or significant disruption to the therapeutic setting, and there is no reasonable alternative, in which cases the provisions of Section VIII.D of the Segregation/Restrictive Housing Remedial Plan shall apply.*
b) *Where prisoners with a mental health condition meeting criteria for placement in a Designated Mental Health Unit are assessed a Disciplinary Segregation term, they will serve the term in a Designated Mental Health Unit, except in rare cases where the prisoner presents an immediate danger or significant disruption to the therapeutic setting, and shall receive structured out-of-cell time and programming as determined by the Multi-Disciplinary Treatment Team."*

Multidisciplinary Intervention Plans are utilized for patients served in the Outpatient Program and EOP to address significant or dangerous behaviors or significant disruptions to the therapeutic milieu. Patients housed in IOP or APU are not placed in disciplinary segregation. Patients unable to program or engaging in assaultive behaviors or posing a security concern will be placed on an Alternative Treatment Plan. Daily meetings are held with the treatment team to determine interventions and transition the patient back to general programming.

Fewer and fewer Administrative Segregation inmates are on the SMI caseload. Main Jail has implemented a 23-bed female IOP in the 3W 100 pod. RCCC has 48 male high security IOP beds. Main Jail has also implemented a male OPP (SSO housing classification) single cell housing unit in the 3E 100 Pod.

All discipline hearings in IOP and APU and in OPP housing on 3W & 3E are conducted by the IOP Sergeant. Before implementing discipline, the IOP Sergeant confers with an ACMH staff member about the proposed discipline. SSO recommended increasing the compliance rating from Partial Compliance to Substantial Compliance.

IV.F.6 - Partial Compliance

"Access to Care:

a) The County shall designate and make available custody escorts for mental health staff in order to facilitate timely completion of appointments and any other clinical contacts or treatment-related events.

b) The County shall ensure sufficient and suitable treatment and office space for mental health care services, including the Triage Navigator Program and other mental health-related services provided on site at the Jail.

c) Locations shall be arranged in advance for all scheduled clinical encounters.

d) The County shall track and document all completed, delayed, and canceled mental health appointments, including reasons for delays and cancelations. Such documentation shall be reviewed as part of the Quality Assurance process.

e) Referrals and triage:

i. The County shall maintain a staff referral process (custody and medical) and a kite system for prisoners to request mental health services. Referrals by staff or prisoners must be triaged within 24 hours.

ii. Referrals and requests for mental health services shall be handled in accordance with the following timeframes, and based on the definitions and guidance in Exhibit A-2:

- *Prisoners with "Must See" (Emergent) mental health needs shall be seen for assessment or treatment by a qualified mental health professional as soon as possible, and within six (6) hours. Prisoners with emergent mental health needs shall be monitored through continuous observation until evaluated by a mental health professional.*
- *Prisoners with Priority (Urgent) mental health needs shall be seen for assessment or treatment by a qualified mental health professional within 36 hours.*
- *Prisoners with Routine mental health needs shall be seen for assessment or treatment by a qualified mental health professional within two (2) weeks;*
- *Prisoners whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication."*

IOP deputies have been structured to support MH treatment on the entire third floor. The JBCT/IOP and EASS programs at RCCC have 16 officers and one sergeant assigned to

them. These officers are responsible for supporting that the inmates receive what they need from a custody perspective. They act as escorts for the mental health staff. If the inmates need to be taken to an appointment off-site, that is facilitated by our medical escort team. This is also true for the Main Jail, where there are 20 deputies and a sergeant assigned to IOP.

At RCCC, office space for MH care providers and treatment is available and constantly being re-evaluated based on needs and advisement of ACMH administrators. At MJ, SSO works collaboratively with ACMH when space needs arise.

IOP and APU have designated custody support to facilitate clinical contacts and treatment-related activities. Patients may request mental health services through an HSR. SSO staff make ACMH referrals based on personal observations or at the request of the inmate. Patients are provided a written response after submitting an HSR.

MH completed audits of referrals and timelines to care and will continue to utilize the report to monitor compliance with timelines to care. MH continues to experience a high level of referrals for services.

In the MH HSR audit from Jun-Aug 2024, 4,148 HSRs were triaged by MH from June 2024 – August 2024.

- June 2024: 78% HSRs triaged within 24 hours.
- July 2024: 82% HSRs triaged within 24 hours.
- August 2024: 87% HSRs triaged within 24 hours.

MH has been working towards decreasing data entry errors. The HSR triage process was reviewed with the triage team. Data entry errors decreased by 47% from the last report period (127 errors to 67 errors this reporting period).

This area remains in partial compliance due to the high number of referrals, MH staffing challenges, limited confidential interview space, and custody escorts to facilitate efficient patient assessments.

IV.G. Medico-Legal Practices

IV.G.1 – Partial Compliance

"The County shall provide access to appropriate inpatient psychiatric beds to all patients who meet WIC § 5150 commitment criteria. At the time a patient's need for inpatient care is identified, commitment paperwork shall be initiated immediately. Placement in an inpatient unit shall occur at the earliest possible time, and in all cases within 24 hours. For individual prisoners placed on a pre-admit or wait list for inpatient placement, affirmative steps to process and place them shall begin immediately."

This area remains in Partial Compliance due to insufficient APU beds which prevents placing some patients on the MH caseload in the least restrictive setting appropriate to their needs.
MH provides access to inpatient psychiatric beds to patients who meet WIC § 5150 commitment criteria. Should a patient be unable to access the inpatient unit due to capacity, they receive daily status checks from MH outpatient services and receive mental health care, including psychiatric medications, while waiting for admission.

An expansion to the APU is in development to assist with managing waitlists. Additionally, the IHSF programming includes new and expanded inpatient beds.

IV.G.2 – Substantial Compliance

"The County shall not discharge patients from the LPS unit and immediately readmit them for the purpose of circumventing LPS Act requirements. For patients with continuing need for LPS commitment, the County shall follow all required procedures under the LPS Act."

MH follows all LPS Act requirements regarding LPS commitments and does not discharge and readmit patients to circumvent the LPS Act.

IV.G.3 – Substantial Compliance

"The County shall review all County and JPS policies and procedures for PREA compliance, and revise them as necessary to address all mental health-related requirements."

ACH has reviewed all County and JPS policies and procedures for PREA compliance and revised them as necessary to address all mental health-related requirements.

IV.H. Clinical Restraints and Seclusion

IV.H.1 – Substantial Compliance

"Generally:

a) It is the policy of the County to employ restraints and seclusion only when necessary and to remove restraints and seclusion as soon as possible.

b) It is the policy of the County to employ clinical restraints and seclusion only when less restrictive alternative methods are not sufficient to protect the inmate-patient or others from injury. Clinical restraint and seclusion shall not be used as punishment, in place of treatment, or for the convenience of staff.

c) The placement of a prisoner in clinical restraint or seclusion shall trigger an "emergent" mental health referral, and a qualified mental health professional shall evaluate the prisoner to assess immediate and/or long-term mental health treatment needs.

d) When clinical restraints or seclusion are used, Jail staff will document justification for their application and the times of application and removal of restraints.

e) *There shall be no "as needed" or "standing" orders for clinical restraint or seclusion.*
f) *Individuals in clinical restraints or on seclusion shall be on constant watch, or on constant video monitoring with direct visualization every 15 minutes. All checks will be documented.*
g) *Fluids shall be offered at least every four hours and at meal times."*

MH only employs restraints and seclusion when clinically necessary and removes restraints and seclusion as soon as possible.

IV.H.2 – Substantial Compliance

"Clinical Restraints:

a) *The opinion of a qualified health care professional or qualified mental health professional on placement and retention in restraints will be obtained within one hour from the time of placement.*
b) *A thorough clinical assessment shall be conducted by qualified health care professional or qualified mental health professional every four hours to determine the need for continued restraint.*
c) *Individuals in restraints shall be checked every two hours by a nurse for vital signs, neurovascular assessment, and limb range, and offered an opportunity for toileting."*

MH does not utilize "as needed" or "standing" orders for clinical restraint and seclusion. MH actively utilizes de-escalation and less restrictive means prior to initiating clinical restraints and only when other interventions are not sufficient to protect the patient or others from injury. MH rarely employs clinical restraints on the APU.

MH never uses clinical restraint or seclusion as a punishment, in place of treatment, or for the convenience of staff. Hourly documentation of clinical restraints and seclusion includes justification, time of application, monitoring of restraints, patient assessment and range of motion, opportunity for toileting, circulation checks, patient presentation, discussion with patient regarding behaviors necessary for release from restraints, rationale for not removing restraints and offering of food and fluids every two hours.

IV.H.3 – Partial Compliance

"Reentry Services:

a) *The County shall provide a 30-day supply of current psychotropic medications to inmates on the mental health caseload, who have been sentenced and have a scheduled released date, immediately upon release.*
b) *Within 24 hours of release of any inmate who is on the mental health caseload and classified as pre-sentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the inmate's current psychotropic medications.*

c) *The County, in consultation with Plaintiffs' counsel, develop and implement a reentry services policy governing the provision of assistance to prisoners on the mental health caseload, including outpatient referrals and appointments, public benefits, medical insurance, housing, substance abuse treatment, parenting and family services, inpatient treatment, and other reentry services.*
d) *The County agrees that, during the course of the implementation of the remedial plans contained in this agreement, it will consider Plaintiffs' input on measures to prevent unnecessary or avoidable incarceration of individuals with serious mental illness."*

Staff provide sentenced patients with a 30-day supply of prescribed medications upon release. Presentenced patients may obtain a prescription for a 30-day supply of medication at the County Primary Care Pharmacy.

The County is preparing to implement the CalAIM 90-day PreRelease Program in 2025. Through this initiative, Sacramento County is taking significant steps to address poor health outcomes of individuals incarcerated in Sacramento County Jails by establishing pre-release Medi-Cal enrollment strategies to ensure individuals have continuity of coverage upon their release, as well as access to key services to help them successfully return to their communities. This will include warm hand-off to Enhanced Care Management and In Reach services.

ACH meets internally and participates in County-wide meetings to address obstacles to improve discharge planning and successful linkage to ongoing care. Collaboration between ACH Medical and Mental health, SSO Custody, the Courts, community partners such as Community Health Works (formerly known as Sacramento Covered) for ongoing medical needs and County Behavioral Health for individuals with serious mental illness (SMI) is necessary for successful discharge planning.

County Behavioral Health established the Community Justice Support Program – a full-service partnership to serve justice-involved patients with serious mental illness. ACH Mental Health meets regularly with the program leadership to address barriers and collaborate on the referral process. A report was developed to capture the projected release date and level of care to identify patients with SMI and release dates within six weeks.

This provision remains in Partial Compliance due to the need for more discharge planners. The County will continue to review staffing for the CalAIM initiative in 2025, with anticipated additional positions to support discharge planning.

IV.I. Training

IV.I.1 – Partial Compliance

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:

a) All jail custody staff shall receive formal training in mental health, which shall encompass mental health policies, critical incident response, crisis intervention techniques, recognizing different types of mental illness, interacting with prisoners with mental illness, appropriate referral practices, suicide and self-harm detection and preventions, relevant bias and cultural competency issues, and confidentiality standards. Training shall be received every two years, at minimum.

b) Custody staff working in Designated Mental Health Units shall receive additional training, including additional information on mental illness, special medico-legal considerations, de-escalation techniques, working with individuals with mental health needs, relevant bias and cultural competency issues, and the jail's mental health treatment programs.

c) Mental health staff shall receive training on the correctional mental health system, correctional mental health policies, suicide assessment and intervention, relevant bias and cultural competency issues, and treatment modalities to be offered in the jails."

MH provides training to custody staff working in Designated Mental Health housing Units. MH has a training coordinator who monitors training compliance. Training was developed and provided on the following:

- Treatment Planning and MDT Meetings
- Brain Development/Intellectual Disability
- Effective Communication/ADA
- Consent Decree
- 5150 Certification
- Prison Rape Elimination Act
- Understanding Mental Health Symptoms in the Correctional Setting (Custody specific training)
- WPATH Transgender Care
- MH Adaptive Support Plan
- Suicide Prevention – 2-Hour Training
- Suicide Prevention – 4-Hour Training
- Suicide Risk Assessment
- Planned Use of Force and De-escalation
- Updated Safety Planning Training (January 2023)
- MH RVR and Segregation Assessments
- Cultural Intelligence in Healthcare: The Impact of Unconscious/Implicit Bias in Healthcare (October 2023)

ACH leadership was able to procure a guest trainer on the topic of "Documentation Practices and Litigation" who has been featured at the National Commission on Correctional Health Care (NCCHC). Attorney Doug Bitner is an attorney who has defended the County in over 2000 cases regarding inmate-patient lawsuits. He provided tailored training for Sacramento County Jail staff on the importance of documentation. This training will be included as part of new employee onboarding.

MH added Understanding Mental Health Symptoms in the Correctional Setting (Custody specific training) after each scheduled four-hour Suicide Prevention Training to provide all new SSO staff an opportunity to take the training.

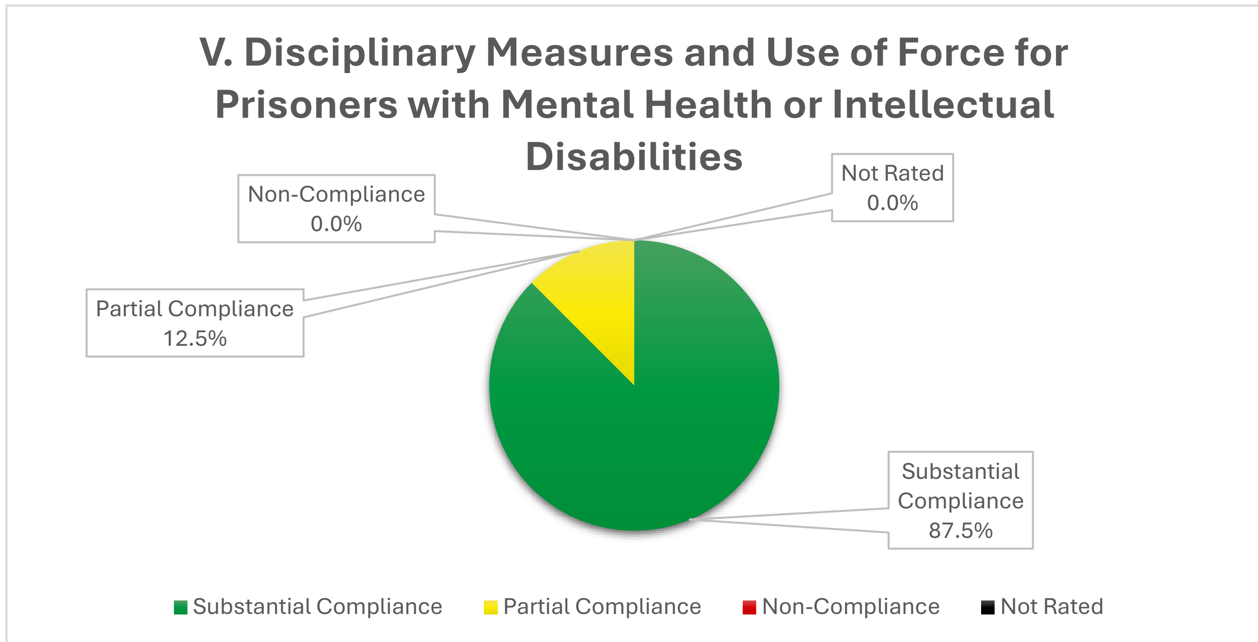
MH offered Brain Development/Intellectual Disability and Adaptive Support Plan training to all MJ and RCCC deputies.

MH staff have completed Cultural Intelligence in Healthcare: The Impact of Unconscious/Implicit Bias in Healthcare.

The SSO Academy now offers graduates the 24-hour CIT class, as well as an additional 20 hours of behavioral health as part of their final training before being employed. These classes cover many of the topics listed. Additionally, SSO staff will be assigned various classes through Lexipol, which they must complete online. Many of these topics are covered through these classes as well. All new employees receive 4-hours of in-person suicide prevention training developed in collaboration with the suicide prevention SME. Current employees will receive a two-hour refresher course annually. This was implemented in May 2021. IOP and JBCT deputies are given 24 hours of additional CIT training. Several deputies from the Main Jail and RCCC have received a two-hour negotiations class specific to a custody setting.

In November 2024, MH and SSO developed a training plan for all new deputies complete the following training over one day: Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports.

V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	15 (62.5%)	21 (87.5%)
Partial Compliance	9 (37.5%)	3 (12.5%)
Non-Compliance	0 (0%)	0 (0%)
Not Rated	0 (0%)	0 (0%)
Total Provisions	**24**	**24**

Attachment 8, Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

Attachment 9, SSO Disciplinary Process and MH Referral Flow Chart, describes procedures related to V.A and V.B.

A. Role of Mental Health Staff in Disciplinary Process
V.A.1 - Substantial Compliance

"The County's policies and procedures shall require meaningful consideration of the relationship of a prisoner's behavior to any mental health or intellectual disability, the efficacy of disciplinary measures versus alternative interventions, and the impact of disciplinary measures on the health and well-being of prisoners with disabilities."

MH policies and procedures contain meaningful consideration of the relationship of a patient's behavior to any mental health or intellectual disability, the efficacy of disciplinary measures versus alternative interventions, and the impact of disciplinary measures on the health and well-being of patients with disabilities, and are drafted in collaboration and coordination with ACMH, ACH, and the court-appointed expert(s).

All SSO policies related to the Consent Decree are drafted by the Lexipol project team, and in coordination with ACH/ACMH and County Counsel's office. A Chief Disciplinary Hearing Officer Post Order has been approved by Class Counsel. A Chief Disciplinary Hearing Officer, who works collaboratively with ACMH (formerly JPS) to identify mental health or intellectual disability needs and modify discipline to ensure health, well-being, and fairness, is involved with disciplinary processes at each facility. All discipline hearings on Designated Mental Health Unit housing areas (IOP and APU) and in OPP housing on 3W and 3E are conducted by the IOP Sergeant. Before implementing discipline, the IOP Sergeant confers with an ACMH staff member about the proposed discipline.

V.A.2 - Substantial Compliance ↑

"Prisoners who are alleged to have committed a rules violation shall be reviewed by a qualified mental health professional if any of the following apply:

- *a) Prisoner is housed in any Designated Mental Health Unit;*
- *b) Jail staff have reason to believe the prisoner's behavior was unusual, uncharacteristic, or a possible manifestation of mental illness;*
- *c) Prisoner is on the mental health caseload and may lose good time credit as a consequence of the disciplinary infraction with which he or she is charged."*

Custody consults MH staff concerning disciplinary measures when a patient is located in MH housing. MH collaborated with SSO Custody on development of a Rule Violation Review (RVR) and Administrative Segregation referral form and trained custody on the referral process and workflow for Administrative Segregation assessments (December 2021). MH began completing Administrative Segregation assessments for patients on MH caseload in November 2022 and in November 2023, for all patients placed in Administrative Segregation.

MH and SSO continue to meet and refine the referral process and update the RVR and Administrative Segregation referral form to ensure referrals are received timely and tracked appropriately.

MH received budget approval FY 2022/23 for additional clinicians to support RVR and Administrative Segregation reviews, assessments, and recommendations. MH continues to actively recruit for these positions. A supervisor and three clinicians are assigned to this area. MH has staff available seven days a week to complete RVR and Administrative Segregation Reviews. MH RVR/Ad Seg supervisor and clinicians access ATIMS to ensure that all patients placed on Administrative Segregation and/or full discipline are identified

and assessed by MH. MH assigned a MH RVR/Ad Seg clinician to complete assessments at RCCC. MH continues to increase the number of RVRs completed.

In April 2024, per the MH SME recommendation, MH included ID as a component of the RVR and UOF review/QI. MH completed an audit of MH RVR and Administrative Segregation Referrals and identified areas for improvement in coordination with SSO. JBCT, IOP, and EASS mental health workers are immediately notified of disciplinary write-ups that occur and they work closely with custodial staff to determine the best course of action. All discipline hearings on Designated Mental Health Unit housing areas (IOP and APU) are conducted by the IOP Sergeant. Before implementing discipline, the IOP Sergeant confers with an ACMH staff member about the proposed discipline.

A Chief Disciplinary Hearing Officer works collaboratively with ACMH to identify mental health or intellectual disability needs and modify discipline to ensure health, well-being, and fairness at each facility.

For the period of Jul-Sep 2024:

- Main Jail received 383 RVR referrals. 43 patients were not included in this report due to: restrictions were already imposed by the time MH received the RVR, the patient did not meet criteria for an RVR review, or the patient had been released.
- Main Jail completed 100% (340/340) of MH RVR referrals this report period.

In 2024, MH started tracking patients with RVRs that had Intellectual Disability and Serious Mental Illness (SMI) at Main Jail. In this audit:

- 10% (37/383) had Intellectual Disability
- 81% (309/383) had an SMI

RCCC received 74 RVR referrals for this report period. 14 patients were not included in report due to one or more of the following: restrictions were already imposed by the time MH received the RVR, the patient did not meet criteria for an RVR review, or the patient had been released.

RCCC completed 93% (56/60) of MH RVR referrals this report period.
MH is tracking patients with RVRs diagnosed with Intellectual Disability and Serious Mental Illness (SMI) at RCCC. In this audit:

- 11% (8/74) had Intellectual Disability
- 78% (58/74) had an SMI

Audit findings support MH/SSOs compliance with this provision. MH has 90-100% compliance with completing received referrals since Oct 2023. The last report from Jul-Sep 2024 showed 100% compliance at MJ and 93% compliance at RCCC.

In August 2024, MH and SSO developed a new process to ensure the timely review of patients placed on full discipline and in ADSEG. Custody granted the MH RVR/ADSEG team elevated rights to ATIMS and MH now checks ATIMS daily to identify individuals placed on full discipline or ADSEG and schedules required assessments.

In September 2024, a MH clinician began attending disciplinary hearings for patients diagnosed with an intellectual disability to provide support and advocacy.

Due to improvements in this area and audits demonstrating proof of practice, the compliance rating is being increased from Partial Compliance to Substantial Compliance.

V.A.3 - Substantial Compliance

"If any of the above criteria is met, the qualified mental health professional shall complete the form attached as Exhibit A-3 (JPS-Rules Violation Mental Health Review) and indicate:

a) Whether or not the reported behavior was related to mental illness, adaptive functioning deficits, or other disability;

b) Whether the prisoner's behavior is, or may be, connected to any of the following circumstances:

i. An act of self-harm or attempted suicide

ii. A cell extraction related to transfer to a medical/mental health unit or provision of involuntary treatment

iii. Placement in clinical restraints or seclusion.

c) Any other mitigating factors regarding the prisoner's behavior, disability, and/or circumstances that should be considered and whether certain sanctions should be avoided in light of the prisoner's mental health disability or intellectual disability, treatment plan, or adaptive support needs."

MH completes the MH RVR form for every patient assessed for a rule violation. The review form was developed in consultation with Class Counsel and SME and incorporates all of the above assessment factors. See V.A.3 for more information.

In July 2024, MH and SSO developed a process to remove discipline sanctions for patients exhibiting decompensation while on discipline. Any MH clinician can request a review to remove sanctions.

B. Consideration of Mental Health Input and Other Disability Information in Disciplinary Process

V.B.1. - Substantial Compliance

"The County shall designate one Chief Disciplinary Hearing Officer for each jail facility, who shall be responsible for ensuring consistency in disciplinary practices and procedures."

Policy 600, Discipline, was issued on 05/14/2024. Each facility has appointed a Chief Disciplinary Hearing Officer (CDHO), who works collaboratively with ACMH to identify

mental health or intellectual disability needs and modify discipline to ensure health, well-being, and fairness. After the last Court-Appointed Monitor report, the CDHO process was changed and all areas of section V.B.1-V.B.7 are now tracked.

V.B.2 - Substantial Compliance

"The Disciplinary Hearing Officer shall ensure that prisoners are not disciplined for conduct that is related to their mental health or intellectual disability."

This is accomplished through the RVR process and ACMH input prior to the hearing for those meeting certain criteria. The hearing does not take place until ACMH has the opportunity to opine on the inmate's mental health status. The CDHO oversees the disciplinary process.

V.B.3 - Substantial Compliance

"The Disciplinary Hearing Officer shall consider the qualified mental health professional's findings and any other available disability information when deciding what, if any, disciplinary action should be imposed."

This has been codified in the Discipline policy (600). After the RVR is received from ACMH, the hearing can continue. If the Disciplinary Hearing Officer does not follow ACMH's input, this is documented. The CDHO monitors the disciplinary process. The Main Jail tracks the outcome of these hearings.

V.B.4 - Substantial Compliance

"The Disciplinary Hearing Officer shall consider the qualified mental health professional's input on minimizing the deleterious effect of disciplinary measures on the prisoner in view of his or her mental health or adaptive support needs."

This has been codified in the Discipline policy (600).

V.B.5 - Substantial Compliance

"If the Disciplinary Hearing Officer does not follow the mental health staff's input regarding whether the behavior was related to symptoms of mental illness or intellectual disability, whether any mitigating factors should be considered, and whether certain sanctions should be avoided, the Disciplinary Hearing Officer shall explain in writing why it was not followed."

This has been codified in the Discipline policy (600). If the Disciplinary Hearing Officer does not follow mental health staff's input regarding the behavior, it is documented within ATIMS. The CDHO oversees this process. Additionally, the outcome of hearings is tracked on the Discipline Log, a database kept by the CDHO.

V.B.6 - Substantial Compliance

"Prisoners will not be subjected to discipline which prevents the delivery of mental health treatment or adaptive support needs, unless necessary for institutional safety."

This has been codified in the Discipline policy (600). If a level of discipline is required that would interfere with the delivery of mental health treatment or adaptive support needs, it will be documented in the ATIMS incident report.

V.B.7 - Substantial Compliance

"Prisoners shall not be subject to discipline for refusing treatment or medications, or for engaging in self-injurious behavior or threats of self-injurious behavior."

This has been codified in the Discipline policy (600). Inmates with suicidal ideations or self-injurious tendencies are closely evaluated and monitored by ACMH staff. ACMH and SSO document the behaviors of these inmates; however, no disciplinary actions are taken. Inmates may refuse medications at any time unless the administration of medication is mandated by the court through a valid order. ACMH is heavily involved in these processes.

C. Accommodations for Prisoners with Mental Health or Intellectual Disabilities During the Disciplinary Process

V.C.1 - Substantial Compliance

"The County shall provide reasonable accommodations during the hearing process for prisoners with mental health or intellectual disabilities."

Per SSO, this is current practice.

V.C.2 - Substantial Compliance ↑

"The County shall take reasonable steps to ensure the provision of effective communication and necessary assistance to prisoners with disabilities at all stages of the disciplinary process."

A Chief Disciplinary Hearing Officer works collaboratively with ACMH (formerly JPS) to identify mental health or intellectual disability needs, support the effective communication needs of those individuals, and modify discipline as appropriate to ensure health, well-being, and fairness. Per SSO, the compliance rating for this provision is being raised from Partial Compliance to Substantial Compliance.

D. Use of Force for Prisoners with Mental Health or Intellectual Disabilities

V.D.1 - Partial Compliance

"The County's Correctional Services Operations Orders shall include language that ensures meaningful consideration of whether a prisoner's behavior is a manifestation of mental health or intellectual disability."

SSO's Discipline Policy (600) was updated in May 2024 and includes this language. The CDHO monitors the application of discipline and the recommendation of mental health. The outcome of discipline is tracked by the CDHO.

V.D.2 - Substantial Compliance

"For prisoners with a known mental health or intellectual disability, and absent an imminent threat to safety, staff shall employ de-escalation methods that take into account the individual's mental health or adaptive support needs."

At both facilities, ACMH is consulted and given the opportunity to participate in de-escalation during all preplanned use of force with inmates under MH care. At the MJ, inmates with intellectual disabilities are housed on the IOP floor where additional trained custody staff are available. Several staff members from both facilities have received a two-hour negotiations class specific to a custody setting which can help facilitate de-escalation.

V.D.3 – Substantial Compliance

"The County's Correctional Services Use of Force policies shall include a definition and a protocol for a planned Use of Force that provides appropriate guidance for a planned Use of Force that involves a prisoner with mental health or intellectual disability."

SSO's Use of Force Policy (300) was updated and includes language about de-escalation and pre-planned use of force.

V.D.4 - Partial Compliance

"Prior to any planned Use of Force, such as a cell extraction, against a prisoner with mental health or intellectual disabilities, there will be a "cooling down period," consistent with safety and security needs. This period includes a structured attempt by mental health staff (and other staff if appropriate), to de-escalate the situation and to reach a resolution without Use of Force. Such efforts, including the use of adaptive supports, will be documented in writing. Medical and/or mental health staff should be consulted if the purpose of the cell extraction is related to the delivery of treatment."

For SSO, this is the current practice with all planned use of force incidents, including those involving inmates in specialized units. The officers assigned to MH units work closely with ACMH staff when incidents requiring a planned use of force arise, including consultation with ACMH staff and ample opportunities for inmate consultation and intervention by ACMH.

MH implemented training for clinicians "UOF policy and MH's role in Planned UOF" incidents in November 2022.

In April 2023, SSO published a POST Order on Planned Use of Force and training was conducted by ACMH for CERT members and Sergeants. MH and SSO collaborated to develop a referral process for Planned UOF incidents with implementation in May 2023. SSO developed a report in ATIMS to track both planned and unplanned UOF incidents. MH responds to custody referrals for Planned UOF incidents.

MH provided "Planned Use of Force with Mental Health Patients" training to custody staff in IOP, APU, JBCT and the CERT teams and Sgts in November 2022 and May – June 2023. MH and SSO Custody meet regularly to discuss planned UOF to develop a multidisciplinary approach to address UOF incidents. MH and SSO training coordinators are developing custody specific training on Planned UOF.

In February 2024, MH began auditing PUOF and UOF incidents utilizing data from both MH and SSO.

Six incidents of PUOF were completed in September 2024. 50% (3/6) of PUOF was averted after the clinician met with the patient. 100% (6/6) of PUOF were patients on the MH caseload. Of these six patients, 83% (5/6) had an SMI and one had an Intellectual Disability.

Diagnosis for 5 patients with SMI:

- 17% (1/6) Bipolar I Disorder
- 50% (3/6) Schizoaffective Disorder
- 17% (1/6) Unspecified Schizophrenia

83% (5/6) of PUOF events were referred to MH. Of the 5 patients referred to MH, 60% (3/5) of PUOF was averted after the clinician met with the patient.

In April 2024, per the MH SME recommendation, MH included ID as a component of the RVR and UOF review/QI.

This provision remains in Partial Compliance as there remains a need to continue coordination and planning between ACMH and custody staff.

V.D.5 - Substantial Compliance

"The County shall require video documentation for any planned Use of Force, absent exigent circumstances. Jail staff shall endeavor to record the specific actions, behavior, or threats leading to the need for Use of Force, as well as efforts to resolve the situation without Use of Force."

SSO updated the Use of Force Policy (300) which requires such video documentation. Please also see the supervisor review process in V.D.6.

V.D.6 - Substantial Compliance

"The County shall ensure the completion of supervisory review of Use of Force incidents, including video (for any planned Use of Force), interviews, and written incident documentation, in order to ensure appropriateness of Use of Force practices including de-escalation efforts. The County shall take corrective action when necessary."

SSO updated the Use of Force Policy (300) and outlines the supervisory review process. A supervisor, a Sheriff's Sergeant, reviews the written reports and video documentation. A manager, a Sheriff's Lieutenant, the shift Watch Commander, reviews this as well. The final review takes place at the division command level where the Assistant Commander of the Jail reviews the entire incident and determines the appropriateness of the use of force.

V.D.7 - Substantial Compliance ↑

"The County shall review and amend as appropriate its policies on Use of Force, including its policies on Custody Emergency Response Team (CERT) and Cell Extraction Procedures."

SSO's Use of Force Policy (300) was updated in May 2024. The Policy and Procedure (510) for the Custody Emergency Response Team (CERT) and Force Application on Incarcerated Persons was updated in April 2024. Procedure 510 includes a section on cell extractions.

E. Training & Quality Assurance

V.E.1 - Substantial Compliance

"All custody staff, and mental health staff, shall be trained on the policies and procedures outlined herein that are relevant to their job and classification requirements. Custody staff will receive periodic training on identifying behaviors that may be manifestations of mental illness and other situations warranting a referral to mental health staff, including for a Rules Violation Mental Health Review or other mental health assessment."

All mental health staff have been trained on the policies and procedures relevant to their job and classification requirements. All staff assigned to corrections (sworn staff and records officers) have received consent decree training since September of 2021. As new hires are onboarded, they are assigned the training and must attest to the completion of the training.

SSO in-service training required on a 2-year cycle often includes mental health topics. Custody-specific mental health training topics are received through the initial housing unit and booking training with new employees. An updated training plan has been developed in combination with ACMH to further support ongoing compliance with this provision.

V.E.2 - Partial Compliance

"All custody staff shall be trained on the identification of symptoms of mental illness, the provision of adaptive supports, and the use of de-escalation methods appropriate for prisoners with mental health or intellectual disabilities."

MH added a training module for all staff, including SSO deputies, to follow the 4-hour Suicide Prevention Training. This will ensure all new employees receive training on understanding and working with patients who have a mental health disorder.

Many aspects of this training are already covered during in-service and pre-service training for SSO. Every year, sworn and professional staff receive a 2-hour course provided by mental health. A comprehensive review of current training offerings, compared against the needs of this element was reviewed.

In November 2024, MH and SSO developed a training plan to ensure all new deputies complete the following training over one day: Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports.

Once proof of practice is established, the County expects the compliance rating for this provision will be increased to Substantial Compliance.

V.E.3 - Substantial Compliance ↑

"The County shall track the outcomes of all disciplinary hearings for prisoners who are on the mental health caseload or who have intellectual disabilities, including whether the recommendation of the mental health professional was followed."

MH and SSO continue to meet regularly to discuss the MH RVR process and are developing an audit that will include whether SSO followed the recommendation(s) of the MH professional.

In September of 2024, a MH clinician began attending disciplinary hearings for patients diagnosed with intellectual disability to provide support and advocacy.

Disciplinary hearing outcomes are tracked by the Chief Disciplinary Hearing Officer for each facility. With these changes, the compliance rating for this provision is being raised from Partial Compliance to Substantial Compliance.

V.E.4 - Substantial Compliance ↑

"The County shall track all Uses of Force (planned and reactive) involving prisoners who are on the mental health caseload or who have intellectual disabilities, including the number of Uses of Force and the number of cell extractions by facility."

In February 2024, MH began auditing PUOF and UOF incidents utilizing data from both MH and SSO. There continue to be regular meetings to discuss UOF and PUOF events.
Per SSO, this is current practice. All use of force is reviewed and tracked up to and including the Division Commander or designee. An ATIMS alert flag is added for those with mental health or intellectual disabilities.

Between the use of force review process, ATIMS alert flag, and the ATIMS incident report tracking, all portions of this provision are now being tracked. The compliance rating for this provision is being raised from Partial Compliance to Substantial Compliance.

V.E.5 - Substantial Compliance ↑

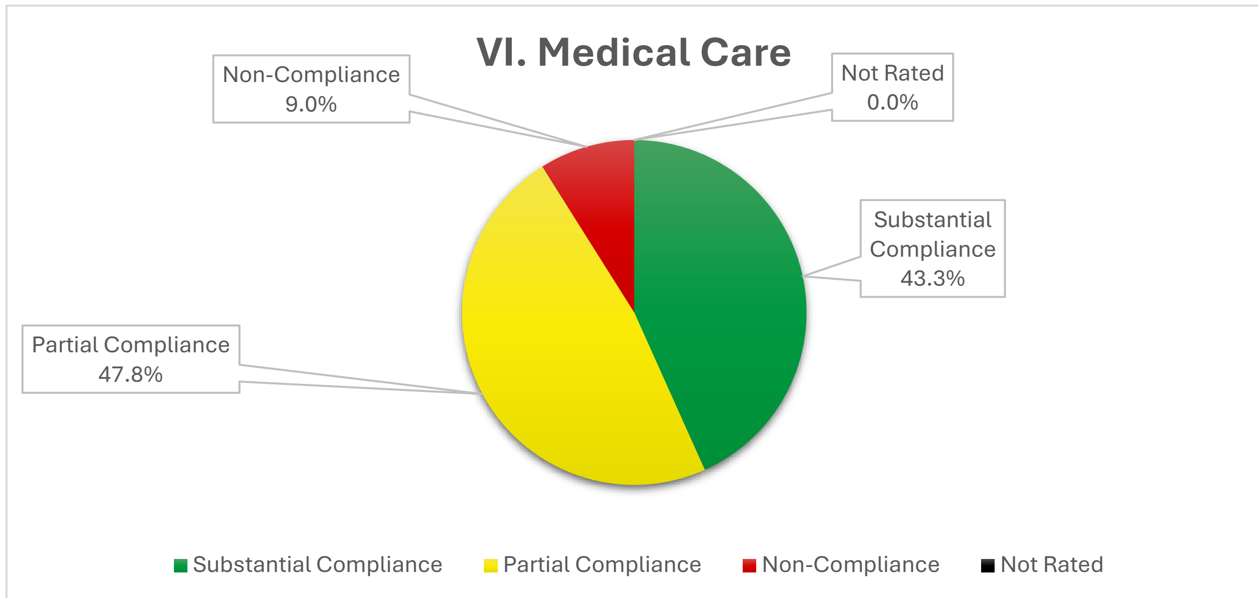
"The County shall implement a continuous quality assurance/quality improvement plan to periodically audit disciplinary and Use of Force practices as they apply to prisoners who are on the mental health caseload or who have intellectual disabilities."

In February 2024, MH began auditing PUOF and UOF incidents utilizing data from both MH and SSO. All use of force incidents are reviewed by SSO at a supervisory and management level for quality assurance.

In April 2024, per the MH SME recommendation, MH included ID as a component of the RVR and UOF review/QI.

As MH and SSO are auditing UOF/WRAP/PUOF and disciplinary incidents and reporting findings to the Mental Health Quality Improvement Subcommittee, the compliance rating for this provision is being raised from Partial Compliance to Substantial Compliance.

VI. Medical Care



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	20 (29.9%)	29 (43.3%)
Partial Compliance	42 (62.7%)	32 (47.8%)
Non-Compliance	4 (6%)	6 (9%)
Not Rated	1 (1.5%)	0 (0%)
Total Provisions	**67**	**67**

Attachment 10, Medical Care Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

A. Staffing

VI.A.1 - Partial Compliance

"The County shall maintain sufficient medical, mental health and custody staffing to meet professional standards of care to execute the requirements of this remedial plan, including clinical staff, office and technological support, QA/QI units and custody staff for escorts and transportation."

County ACH Medical staff and Administrative FTEs has increased from 112.5 pre-Consent Decree to a total of 252.5 permanent allocated FTEs in FY 24/25.

County ACH Mental Health & Administrative staff has increased from 50.3 (FY 17/18) pre-Consent Decree to a total of 136.7 allocated positions in FY 24/25.

SSO custody FTEs have increased from 650 pre-Consent Decree to a total of 809 permanent allocated FTEs in FY 24/25.

During this reporting period, ACH reallocated eight vacant Licensed Vocational Nurses positions and created two SRN and three RN positions. These positions became available in November 2024 and ACH is now actively hiring to fill them. Also in this reporting period, County leadership approved a second Nursing Director and an additional SRN position to assist with compliance. The second Nursing Director will oversee the operations of RCCC and the SRN will oversee grievance monitoring and tracking. ACH has focused heavily on filling vacant nursing positions, despite the difficulty in filling these positions, and the vacancy rate remains very low (the large majority of the vacancies are the new positions mentioned).

In November 2024, ACH started the contracting process with a third-party consultant (Health Management Associates) to complete the required staffing analysis. However following the MH SME visit, the directive was to have a needs assessment conducted first. The vendor is updating the scope and estimate of cost to meet both of these requirements. ACH hopes to have the contract for both services secured early in the next reporting period. Regarding provider coverage, ACH has increased its onsite physician coverage to seven days per week, including evening hours to meet the demands of the facilities. This includes both MAT and primary care providers. ACH maintains 24/7 on-call provider availability after hours.

In 2024, SSO added staffing dedicated to facilitating access to medical appointments. These were primarily accomplished through overtime and reserve (on-call) deputies or by reassigning deputies from the shift into full-time positions. In mid-2024, the County approved four FTE Deputy Sheriff positions dedicated to medical escorts.

VI.A.2 - Partial Compliance

"Provider quality shall be evaluated regularly to ensure that relevant quality of care standards is maintained. This review shall be in addition to peer review and quality improvement processes described in this plan. The parties shall meet and confer regarding any deficiencies identified in the evaluation. Should the parties disagree regarding matters of provider quality, the Court Expert shall evaluate the quality of provider care and to complete a written report."

During this reporting period, the Medical Director has initiated peer review of individual patient charts by Medical Director, Asst. Medical Director and the lead physicians. A standardized form was created based on a recommendation and review of the provider consultant Dr. Radha Sadacharan and is being utilized. The policy has been drafted and will be sent to the SMEs in early January for review. The policy has been revised to address chronic care needs by reviewing the chart for adherence to VHA clinical practice

guidelines. Pending policy review and approval, the medical director and lead physicians have been using the draft template to conduct reviews. Feedback is being given to providers. When issues are identified, corrective actions are outlined including progressive disciplinary when needed. Implementation of in-facility bedside procedures that can be safely performed, such as suturing, drain removal, IV fluids and other minor procedures, have reduced emergency department send outs.

In the upcoming reporting period, the providers will use AHRQ Quality Prevention Indicators when selecting records to review pre-hospital and post-hospital care. Also in the next reporting period, the Medical Director and Pharmacy Director will implement point of care testing with a Piccolo Machine (similar to I-Stat) to rapidly evaluate blood samples for abnormalities.

The Medical Director now reports directly to the Health Services Administrator. They meet weekly to evaluate progress and set priorities.

B. Intake

VI.B.1 - Substantial Compliance

"All prisoners who are to be housed shall be screened upon arrival in custody by Registered Nurses (RNs). RN screening shall take place prior to placement in jail housing."

All patients booked into the Jails are screened upon arrival by a Registered Nurse prior to placement in jail housing. ACH worked closely with the medical SMEs to create a two-phased nurse intake format and streamline the questions for better flow and reduce redundancy. This new system was implemented in September 2024 with phase 1 being a brief, 10-minute screening to determine if the arrestee needs clearance from the hospital first or can proceed to phase 2.

One nurse has been designated at all times for phase 1, and the fit/unfit criteria is utilized. At this stage, a color-coded wristband is used to help inform decisions on the arrestee's needs.

- Green - meets all the fit criteria during phase 1 and has no medical issues.
- Red - needs expedite to detox, MAT, or type 1 diabetes, etc. This patient will have priority to move through phase 2.
- Yellow - those having identified issues that may need follow up or orders.

Phase 2 contains the majority of the questions but has been shortened and changed to have better flow. The redundant questions were removed and questions were made clearer and in a more thoughtful order.

VI.B.2 - Substantial Compliance ↑

"Health Care intake screening shall take place in a setting that ensures confidentiality of communications between nurses and individual patients. Custody staff may maintain

visual communication, unless security concerns based upon an individualized determination of risk that includes a consideration of requests by the health care staff that custody staff be closer at hand. There shall be visual and auditory privacy from other prisoners."

Beginning August 2024, ACH now has four private nurse intake rooms at the Main Jail, therefore meeting all privacy requirements. Each room has a door with a large window that allows the arresting officer to standby for safety. This allows for auditory privacy from both officers and other arrestees.

Arrestees who are combative have their intake completed in an open nurse station, ensuring their safety. Rooms are equipped with alarms, restraint points and lights that indicate when the nurse is ready for the next arrestee.

A trailer was added at RCCC. This trailer has been designated for intakes, therefore reducing the impact at the Main Jail. DGS is currently in the process of making the trailer ADA compliant with the addition of a bathroom installation.

With the installation of the private nurse intake rooms during this monitoring period, this provision is being raised from Non-Compliance to Substantial Compliance.

VI.B.3 - Substantial Compliance

"The County shall, in consultation with Plaintiffs, revise the content of its intake screening, medical intake screening, and special needs documentation to reflect community standards and ensure proper identification of medical and disability related concerns."

ACH worked closely with the medical SMEs to create a two-phased nurse intake format and streamline the questions for better flow and reduce redundancy. This new system was implemented in September 2024 with phase 1 being a brief, 10-minute screening to determine if the arrestee needs clearance from the hospital first or can proceed to phase 2.

One nurse has been designated at all times for phase 1, and the fit/unfit criteria is utilized. At this stage, a color-coded wristband is used to help inform decisions on the arrestee's needs.

- Green - meets all the fit criteria during phase 1 and has no medical issues.
- Red - needs expedite to detox, MAT, or type 1 diabetes, etc. This patient will have priority to move through phase 2.
- Yellow - those having identified issues that may need follow up or orders.

Phase 2 has the majority of the questions but has been shortened and changed to have better flow. The redundant questions were removed and questions were made clearer and in a more thoughtful order. Criteria has been included to assign patients to the medical

observation cell and for withdrawal monitoring. In conjunction with the SMEs, ACH revised the current intake policy to ensure efficiency as described above. Staff were trained on the new process and it has been working extremely well. Two SRNs have been stationed at intake to cover day shift seven days per week. They assist with the flow of arrestees, troubleshoot any issues and ensure patient safety in the arrest report room, medical intake, medical observation cell and the booking loop in general. ACH is in process of recruiting and hiring two NOC shift SRNs for intake that were recently approved.

ACH's EHR has been updated to accommodate all the changes needed for this new process. ACH is working on an electronic tracking system to ensure patients are timely seen in accordance with their medical acuity and duration in the booking process. ACH anticipates having this tracking and reporting ability in the next reporting period.

VI.B.4 - Substantial Compliance

"Nurses who perform intake screening shall consult any available electronic health care records from prior incarcerations or other county agencies. The form shall include a check box to confirm that such a review was done."

Nurses check the box in the EHR to confirm previous records were reviewed. QI has observed in-person nursing intake and found previous history is reviewed consistently, meeting this requirement.

VI.B.5 - Substantial Compliance

"The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health records related to ongoing care needs. The policy shall ensure that any ongoing medication, or clinically appropriate alternative, shall be provided within 48 hours of verification or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple providers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking."

ACH Intake policy outlines that any ongoing medication, or a clinically appropriate alternative, shall be provided within 48 hours of verification of the prescription or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple prescribers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.

Through QI audits of this provision, ACH has determined that ACH has maintained Substantial Compliance (above 90%) since 08/17/2022 for meeting timeliness standards for patients receiving initial medications. Regarding renewal medication, ACH has

remained at 100% compliance since the audit conducted on 02/16/2024. See recent data from the Medication Initiation and Renewal Audit below.

Medication Initiation and Renewal Audit

Medication Initiation and Renewal					
Indicator	**Data Period**				
	08/17/22 (N=42)	02/16-17/23 (N=44)	08/16/23 (N=52)	02/16/24 (N=48)	10/10/24 (N=52)
Timely initial medication (<48 hours from order)	35/35 (100%)	23/24 (96%)	44/44 (100%)	37/37 (100%)	32/33 (97%)
Timely renewal (no missed doses)	6/7 (86%)	18/20 (90%)	5/8 (62%)	11/11 (100%)	19/19 (100%)

VI.B.6 - Substantial Compliance ↑

"The County shall follow a triage process in which intake nurses schedule patients for follow-up appointments based upon their medical needs and acuity at intake and shall not rely solely on patients to submit Health Services Requests once housed. The policy shall, in consultation with Plaintiff's counsel, establish clear protocols that include appropriate intervals of care based on clinical guidelines, and that intake nurses shall schedule follow-up appointments at the time of intake based upon those protocols."

The policies listed above are consistent with this requirement and were implemented with approval of the court-appointed experts. The nurse intake encounter has been configured to have recommended orders based on responses to intake questions. Each order has a priority level dependent upon the response and to all service lines. Orders can be easily made by clicking the button within the nurse intake encounter.

In consultation with the SMEs, significant changes have been made to the "Sobering Cell", now called "Medical Observation Cell (MOC)". ACH has developed criteria that regulates which patients should be placed in the MOC, what provider can authorize placing a patient in the MOC, the frequency of rounds monitoring the MOC, and criteria for releasing patients from the monitoring cell. Regulations have also been created in consultation with the SMEs and implemented that address maximum hours the patient can be in the sobering cell. Beginning late November, a nurse assigned to the intake team began completing a welfare check on each patient housed in the MOC, every 30 minutes. The

intake rounding nurse also completes an assessment every two hours while the patient is housed in MOC. This assessment will ensure that there is a face-to-face encounter between the medical staff and the patient which allows ACH to ensure patient safety during this potentially high-risk time. ACH and SSO meet weekly to problem-solve and discuss any issues that arise.

As part of the changes to the two phased intake process, ACH refined the automatic orders for nurse and provider sick call based on answers given at intake. This allows the patient to be seen for their issues without having to submit an HSR.

During the next reporting period, ACH will work closely with SSO leadership to pilot stationing a provider near the booking loop. The patients will be flagged at intake as having more critical needs, such as chronic care issues and withdrawal monitoring concerns, and they will be seen for a full H&P prior to being housed. Nurses will send referrals to providers based on the acuity of patient needs. The orders are built into the Nurse Intake Encounter. Order sets for detox monitoring exist within the nurse intake encounter. Orders for withdrawal monitoring are automatically ordered when the patient scores a CIWA or COWS score of 0 or above.

ACH meets the Consent Decree required timeframes for initial medication review and first dose. As a result of progress made during this monitoring period, this provision is being raised from Partial Compliance to Substantial Compliance.

VI.B.7 - Substantial Compliance

"All nurses who perform intake screenings will be trained annually on how to perform that function."

The QI RN developed a new nurse intake training that incorporated all the changes and trained staff prior to implementation. The QI RN transitioned to the SRN Nurse Educator in mid-December and will ensure compliance in this area.

QI staff developed several audit tools to assess the nurse intake process. Intake Continuous Quality Improvement (CQI) studies occur on a regular basis and are sent to SME. QI began in-person observation audits of the nurse intake process in January 2023 to ensure all screening questions are asked and will continue with each Intake Audit.

Intake Referral Audit

Type of Referral Needed	Patients Referred as Needed				
	FY 23/24 Q1 (N=33)	FY 23/34 Q2 (N=30)	FY 23/24 Q3 (N=30)	FY 23/24 Q4 (N=34)	FY 24/25 Q1 (N=30)
Provider	13/17 (76%)	19/23 (83%)	17/21 (81%)	16/21 (76%)	12/14 (86%)
Mental Health	18/18 (100%)	6/9 (67%)	11/12 (92%)	15/17 (88%)	13/13 (100%)
SUD Counselor	5/10 (50%)	7/9 (78%)	9/14 (64%)	6/6 (100%)	3/5 (60%)
Dental	30/33 (91%)	28/30 (93%)	26/30 (87%)	33/3 (97%)	59/64 (92%)

C. Access to Care

VI.C.1 - Substantial Compliance

"The County shall ensure that Health Service Requests (HSRs) are readily available to all prisoners, including those in segregation housing, from nurses and custody officers."

Health Service Requests (HSRs) are readily available to all patients throughout the facility, including those in segregation housing from ACH or SSO Custody. SRs are available at medical appointments, pill call, and in housing units. Nursing collects health service requests (HSRs) at least twice daily, once in the morning and once in the evening, and designated staff are responsible to ensure adequate supplies.

VI.C.2 - Substantial Compliance ↑

"The County shall provide patients with a mechanism for submitting HSRs that does not require them to share confidential information with custody staff. The county shall install lockboxes or other secure physical or electronic mechanism for the submission of HSRs (as well as health care grievances) in every housing unit. Designated staff shall collect (if submitted physically) or review (if submitted electronically) HSRs at least two times per day in order to ensure that CHS receives critical health information in a timely manner. Designated health care staff shall also collect HSRs during pill call and go door to door in all restricted housing units at least once a day to collect HSRs. HSRs and health care grievances will be promptly date- and time-stamped. The county may implement an accessible electronic solution for secure and confidential submission of HSRs and grievances."

Confidential locked boxes labeled "Health Service Requests" are installed in multiple locations at both jail facilities for patients to submit HSRs to protect confidentiality. Locked boxes are also throughout both facility's housing units to submit grievances. Designated staff collect HSRs at least two times per day as well as during medication administration and door to door in all restricted housing units at least once a day. QI

completes in-person observations as well as chart audits to ensure that HSR collection and time-stamping processes are occurring accordingly.

ACH has created a HSR and Grievance collection form for staff to fill out each time they make rounds to collect both forms in the housing units. This provides supervisors and QI a mechanism to ensure HSRs and Grievances are being collected regularly and timely. Use and tracking of this form was implemented this reporting period.

HSRs are turned in directly to nursing staff during pill call twice a day, seven days a week. Nursing staff promptly date and time stamp all HSRs (within two hours) of receipt. Lock boxes for Medical Grievances and HSR's have been in installed in all housing units at RCCC and Main Jail to ensure privacy. The lock boxes are checked twice a day.

As there is now consistent time-stamping and timely collection as evidenced by designated nursing staff physically scanning HSR forms immediately after collecting, this rating can be raised from Partial Compliance to Substantial Compliance.

VI.C.3 - Partial Compliance

"The County shall establish clear time frames to respond to HSRs:

- *a) All patients whose HSRs raise emergent concerns shall be seen by the RN immediately upon receipt of the HSR. For all others, a triage RN shall, within 24 hours of receipt of the form (for urgent concerns) or 72 hours of receipt of the form (for routine concerns).*
    - *i. Conduct a brief face-to-face visit with the patient in a confidential clinical setting.*
    - *ii. Take a full set of vital signs, if appropriate.*
    - *iii. Conduct a physical exam, if appropriate.*
    - *iv. Assign a triage level for a provider appointment of emergent, urgent, routine, or written response only.*
    - *v. Inform the patient of his or her triage level and response time frames.*
    - *vi. Provide over-the-counter medications pursuant to protocols; and*
    - *vii. Consult with providers regarding patient care pursuant to protocols, as appropriate.*
- *b) If the triage nurse determines that the patient should be seen by a provider:*
    - *i. Patients with emergent conditions shall be treated or sent out for emergency treatment immediately.*
    - *ii. Patients with urgent conditions shall be seen within 24 hours of the RN face-to-face; and*
    - *iii. Patients with only routine concerns shall be seen within two weeks of the RN face-to-face.*
- *c) Patients whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication, within two weeks of receipt of the form.*

d) *The County shall permit patients, including those that are illiterate, non-English speaking, or otherwise unable to submit verbal or electronic HSR's to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified medical professional for response in the same priority as those HSRs received in writing."*

ACH has established clear time frames to respond to HSRs in accordance with the remedial plan. Supervising nurse or designee see the emergent concerns immediately. All other urgent and routine concerns are triaged and seen face-to-face for their nurse sick call (NSC) visit within 24 hours for urgent concerns and 24-48 hours for routine concerns. NSC numbers have remained consistently low during this reporting period, as most new requests are seen by the next day. Staffing for NSC is prioritized and HSRs are being followed up on timely. NSC numbers are tracked for the daily huddle data that is provided to the SMEs.

HSR policy has been updated this reporting period to streamline the access to care process and remove obstacles to timely care. It has been reviewed by the contracted nurse consultant recommended by the SMEs and is near finalization. ACH anticipates sending to the SMEs for their review and approval early January 2025. Trainings on this process have occurred in nurse staff meetings but once the policy is finalized, the nurse educator will create an official training for staff.

ACH is working closely with DTech on a "Timelines to Care report" that will capture all of the data indicators to determine if required timeframes were met for the entire patient population rather than a small sample size that currently occurs with audits. ACH is in the testing phase and is working through data validation and anticipate that this report will be live in the upcoming reporting period.

The Medical Director and lead physicians review routine provider requests in the EHR every week to ensure provider resources are allocated where needed. Although a backlog of provider sick call visits still remains, the Medical Director has implemented weekly efforts with designated physicians, a MA and a dedicated medical escort to review the oldest outstanding routine HSRs. During these reviews, providers re-triage as appropriate and combine duplicate requests.

ACH developed a new ACH activity schedule to clearly identify times and location needs for Custody Escorts to meet access to care timelines. In order to implement a team-based approach to increase the access to care, ACH strives to assign a doctor, MA, RN, or Ancillary staff to each floor at MJ or each housing location at RCCC.

ACH and SSO started meeting for daily huddles in April 2023, where ACH and ACMH escort needs are identified and SSO provides daily escort allocation for each facility. An assigned medical staff coordinates daily with the escorts to ensure coverage for identified priorities.

For the upcoming reporting period, a chronic care team will be established (discussed more in the next section) that will assist in reducing the backlog of provider visits. Also, continued discussions are occurring to establish a way for custody to stage patients, thereby creating a better flow of patients to providers thus increasing productivity of the providers.

Since the start of the Consent Decree, efforts have been made to increase the quality of and access to care. These improvements and effort include:

- The new privacy enclosures on each floor/wing offer an additional space for nurse sick call to take place if an exam room is unavailable.
- Weekly inventory on medical equipment currently in stock as well as additional equipment needed to support additional fully functioning stations on each floor in each wing is in place.
- Outdated and broken medical beds have been replaced at both facilities.
- All portable sinks in the medical exam room and specialty clinic have been replaced at both facilities.
- Rolling medical bags and cart for LVNs to transport medical supplies to different medical floors have been replaced.
- The Main Jail 2 East provider exam room was completed.
- The Main Jail 2 medical provider charting office was completed.
- The Main Jail nursing station of 2 East and interview cubicles were completed.
- Desks in Medical Housing Unit at RCCC, all exam rooms, and in SRN office were replaced.
- Ramps were added at the Honors Unit in the main entrance at RCCC.
- Two intake workstations and an exam room were added to the intake trailer at RCCC.
- A utility room was created at 2 Medical (Main Jail) to use for lab work and CPAP charging station.
- The CBF clinic at RCCC was improved by adding a new desk, lockable cabinets, new flooring, and fresh paint.
- In the MD sick call room at SLF RCC, the exam bed was replaced as were the old cabinets that were replaced with new lockable cabinets.
- Purchased Autogen and manual heat press for “Keep on Patient” medication blister packaging for pharmacy.

iPads on wheels were purchased for video telehealth appointments and deployed November 2023. Initial purchase included eight units for pilot program. Wi-Fi connectivity for stronger Wi-Fi signal quality and Access Points project completed at Main Jail on April, 6th, 2023 and RCCC on September 1, 2023.

Regarding sub-provision VI.C.3.c, patients whose requests do not require formal clinical assessment or intervention are issued a Patient Notification Letter within two weeks of

receipt of the form. This Patient Notification Letter informs the patient that their request is being addressed and no appointment is needed.

Regarding sub-provision VI.C.3.d, ACH has practices in place that allows patients, including those that are illiterate, non- English speaking, or otherwise unable to submit verbal or electronic HSR's to verbally request care. Such verbal requests are documented by the staff member who receives the request on an HSR, and disposition provided in the same priority as those HSRs received in writing.

VI.C.4 - Partial Compliance ↓

"The County shall designate and make available custody escorts for medical staff in order to facilitate timely and confidential clinical contacts or treatment-related events."

Medical Escorts are independent of shift staffing and are dedicated to assisting medical staff for patient care. ACH determines their assignment depending on daily needs. While the escorts have continued to increase at both facilities, more coordination and expectation setting is needed to improve patient flow. ACH and SSO meet regularly to discuss these matters and problem solve. During the upcoming reporting period, it is expected this area will improve due to coordination on staging patients waiting to be seen and incorporating suboxone back into the normal pill call which frees up two dedicated escorts; however, the compliance rating has been reduced from Substantial Compliance to Partial Compliance to reflect the ongoing challenges.

VI.C.5 - Partial Compliance

"The County shall track and regularly review response times to ensure that the above timelines are met."

The electronic HSR form in the EHR was updated to better capture data helpful in monitoring timeliness at each step of the process. The electronic form also ensures HSR information is documented in the EHR to better support facilitate data reporting capabilities. The electronic HSR form in the EHR has been updated to further provide more detail for monitoring and quality improvement, including:

- Date/time received, entered, and triaged for improved tracking purposes.
- Disposition criteria specific to the service line assigned to the HSR.
- Fields created to capture the ACH response to the patient and action(s) to be taken.

Tracking data is then generated to monitor the following response timelines:

- When the HSR was completed by the patient.
- When the HSR is in receipt by ACH
- When ACH entered the HSR data into the EHR
- When the service line received the HSR for response
- Details as to the disposition and needed action(s).

ACH QI tracks and regularly reviews response times to ensure that the above timelines are met. QI studies will continue quarterly. Currently, the QI nurses complete audits to ensure HSR timelines to care are met through chart review. This only allows for a small sample size due to the amount of time this method takes. However, ACH is working closely with DTech on a "Timelines to Care Report" that will capture all the data indicators to determine if required timeframes were met for the entire patient population rather than a small sample size that currently occurs with audits. ACH is in the testing phase and is working through data validation and anticipate that this report will be live in the upcoming reporting period.

Both nursing and provider leadership review the lists of sick call orders at least weekly to monitor timeframes. Sick call numbers are discussed on a daily huddle and staff are aware of where there are backlogs.

Findings for MH HSR audit from Jun-Aug 2024:

- 4,148 HSRs were triaged by MH from June 2024 – August 2024.
    - June 2024: 78% HSRs triaged within 24 hours.
    - July 2024: 82% HSRs triaged within 24 hours.
    - August 2024: 87% HSRs triaged within 24 hours.

MH has been working towards decreasing data entry errors. The HSR triage process was reviewed with the triage team. Data entry errors decreased by 47% from the last report period (127 errors to 67 errors this reporting period).

VI.C.6 - Substantial Compliance

"The County shall discontinue its policy of prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment."

ACH discontinued prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment shortly after execution of the Consent Decree. Patients are permitted to report or inquire about multiple medical needs on a single HSR or during a single appointment.

VI.C.7 - Partial Compliance

"When a patient refuses a medical evaluation or appointment, such refusal will not indicate a waiver of subsequent health care.

a) When a patient refuses a service that was ordered by medical staff based on an identified clinical need, medical staff will follow-up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse a service.

b) Any such refusal will be documented by medical staff and must include: (1) a description of the nature of the service being refused, (2) confirmation that the

patient was made aware of and understands any adverse health consequences by medical staff, and (3) the signature of the patient, and (4) the signature of the medical staff. In the event the signature of the patient is not possible, the staff will document the circumstances."

Ongoing healthcare is offered and provided as medically indicated, regardless of previous refusals for services. ACH staff are required to follow-up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse service per policy. The follow-up discussion is also documented in the EHR. The Informed Consent and Right to Refuse Policy has been updated to capture all requirements in this provision including use of the Refusal Form to document the refusal per policy.

The Refusal Form captures all requirements outlined in the Remedial Plan. ACH developed a Corrective Action Plan (CAP) in July 2022 to address deficiencies in the health service request system. The CAP is monitored in monthly meetings between nursing leadership and QI. As part of the CAP, ACH has revised the HSR and created a new Nurse Sick Call policy. They have been sent to the nurse consultant recommended by the SMEs for policy feedback. ACH anticipates finalizing them and sending to the SMEs early in the next reporting period.

ACH also developed an HSR collection tool that will ensure the HSR are collected according to the policy timeframes. The use and tracking of this form was implemented July 2024. Staff developed an audit tool for timely access to services and completed a baseline study prior to the policy revision. Staff will begin periodic audits of the HSR process after training and implementation.

When a patient refuses a NSC appointment, the nurse will go cell side to get speak to them, educate the patient on adverse health consequences and obtain a signed refusal. Adverse health consequences are discussed and it is documented in the EHR. Routine referrals that are refused are documented on a refusal form by the MA. Depending on the encounter type, the appointment may remain open despite the refusal. In areas such as a lab draw, multiple refusals may be required.

ACH has worked with SSO to increase the number of patients who report to medical in person rather than refusing in their cell.

D. Chronic Care

VI.D.1 - Partial Compliance

"Within three months of the date the Remedial plan is issued by the Court, the County shall, in consultation with Plaintiffs' counsel, develop and implement a chronic disease management program that is consistent with national clinical practice guidelines. The chronic disease program will include procedure for the identification and monitoring of

such patients and the establishment and implementation of individualized treatment plans consistent with national clinical practice guidelines.

- *a) The chronic disease management program shall ensure that patients with chronic illness shall be identified and seen after intake based upon acuity (on the day of arrival for patients with high acuity and not to exceed 30 days for all others). The County will timely provide clinically indicated diagnostic testing and treatment, including prior to this post-intake appointment. Follow-up appointments will be provided in intervals that do not exceed 90 days unless patients are clinically stable on at least two consecutive encounters, in which case, follow-up appointment intervals will not exceed 365 days (and sooner if clinically indicated), subject to a chart review every 6 months.*
- *b) The chronic disease management program shall ensure patients are screened for hepatitis C at intake. If medical staff recommend Hepatitis testing based upon screening results, such testing shall be offered on an "opt-out" basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing the refusal shall be documented in the health record. Patients found to have hepatitis C shall be offered immunizations against hepatitis A and B.*
- *c) The chronic disease management program shall include a comprehensive diabetic management program consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. The protocol shall be developed in coordination with custody administration to address normal circadian rhythms, food consumption times and insulin dosing times.*
- *d) The chronic disease management program shall ensure that patients who take medications for their chronic conditions shall have the medications automatically renewed unless the provider determines that it is necessary to see the patient before renewing the medication. In that case, the patient shall be scheduled to be seen in a reasonable time period to ensure medication continuity."*

ACH has implemented a chronic disease management program to be consistent with national clinical practice guidelines. ACH has expanded its Chronic Disease Monitoring Program and developed a quarterly Chronic Disease Management Audit. The Intake nurse places an order for a History and Physical (H&P) exam for anyone identified as having a chronic disease. At this initial H&P, the provider will assess the level of disease control and schedule chronic care follow-up appointments based on medical acuity and level of disease control.

The Chronic Disease Management Program includes a process to ensure chronic care patients are referred for an H&P based upon acuity. Monitoring to the adherence to this process is included in the Chronic Disease Management Audit. A corrective action plan has been implemented by QI to address a backlog in lab orders to ensure patients receive timely and effective treatment.

Providers have been trained and have started managing chronic diseases. As staffing improves, more dedicated chronic care providers will be assigned to manage patients with multiple chronic diseases and higher acuity. Given lower patient turnover and lower acuity patients, consistency in chronic care providers for individual patients has been very successful at RCCC. As more regular, full-time providers are working at the Main Jail, ACH expects to be able to have more consistency with assigning the same provider to a particular floor, which will aid in having an assigned provider to these patients.

ACH has hired a clinical pharmacist to provide Chronic Care Management for diabetes, hypertension, and hyperlipidemia (Metabolic Syndrome). The clinical pharmacist began seeing patients in June 2024 and will order labs, adjust medications and provide education to the patients on their disease state as appropriate.

Providers have been trained in all chronic disease policies or guidelines at past provider meetings and new providers are required to review it as part of onboarding. These policies are expected to be updated in the coming year as real-time feedback is received after implementation. Providers have been trained to use the right document type to capture the chronic care encounter and to address all chronic care problems during a provider sick call, as clinically appropriate.

Chronic care compliance will improve once there are dedicated chronic care nurses and they are able to monitor a panel of patients to ensure timely follow-up, including completion of labs, imaging, and other coordination of care as needed. ACH is recruiting registry nurses for this task until positions can be added in.

A primary care provider with additional training in HIV conducts a minimum of twice weekly HIV Clinics. Infectious disease consultation is also available through RubiconMD or an Infectious Disease specialist is contracted off-site as clinically necessary.

A primary care provider with additional training in gender affirming care conducts a Transgender Care Clinic every two weeks. Patients on hormones, prior to incarceration, have their medication continued as part of the essential medications process.
The Medical Director developed guidelines for routine vaccinations and health screenings (e.g., diabetes, breast cancer, and colorectal cancer screenings) and trained providers in December 2021.

Regarding sub-provision VI.D.1.b, the chronic disease management program ensures patients are screened for Hepatitis C, HIV, syphilis, and GC/CT at Intake and offered testing on an “opt- out” basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing, the refusal is documented in the patient’s health record. Patients found to have hepatitis C are offered immunizations against hepatitis A and B. A specialist provides onsite Gastroenterology and Hepatology clinics every other week since October 2021.

Regarding sub-provision VI.D.1.c, the chronic disease management program includes a diabetes management clinic consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. Diabetic medications are scheduled to coincide with food consumption times. The Assistant Medical Director is working with custody and case management to get continuous glucose monitors available to all type 1 diabetics.

Regarding sub-provision VI.D.1.d, currently, medications are prescribed for one year. Prior to expiration, pharmacy sends an EHR alert for the providers to renew. The Medical Director will work with Pharmacy Director to make renewals automatic when the clinical pharmacists are implemented into the chronic care program next fiscal year. Medication Initiation and Renewal Audits have been conducted to measure compliance of uninterrupted medication renewals. The audit conducted on August 2022 data showed 86% compliance, on February 2023 data showed 90%, on August 2023 data showed 62% compliance, and on February 2024 data showed 100% compliance with this provision. Chronic disease management has been an area of focus during this reporting period and will continue to be in the upcoming reporting period. ACH understands the extreme importance of the chronic care program.

Regarding chronic disease findings and recommendations when patients return from specialty services appointments, EDs and hospitalizations - The current procedure is for patients who return from outside services to be seen by either the MHU or 2M RN. They are to review the documentation that returns with the patient, scan documents to medical records for inclusion in the EHR, and contact the on-site or on-call provider for any orders that need to be immediately. They are to order an urgent MDSC for the provider to review the outside care and implement any recommendations. DCH reinforced with nursing staff on the need to follow this procedure. Patients being brought back by SSO from outside care are to be brought to 2M or MHU. The chart review process includes provider inclusion of outside care into the medical management of patients. An expectation for providers that will be reinforced is that they review lab, x-ray and imaging reports within three business days and document a plan for follow up.

During this reporting period, nurses have been directed and are contacting providers for elevated blood sugars (>350) positive ketones, and abnormal vital signs, and providers are working to timely see patients to adjust the treatment plan.

The clinical pharmacy program allows pharmacists to work under Collaborative Practice Agreement (CPA) under the Medical Director to manage chronic disease states. Currently, the program manages diabetes, hypertension and hyperlipidemia. The Clinical Pharmacist counsels, educates, prescribes new and adjusts medications following clinical guidelines to achieve optimum outcomes.

The Clinical Pharmacist also sees patients that are refusing medications. They educate patients on the importance of taking these medications daily and how missing doses can

affect the disease state. The pharmacist will change dosage of the medications if a patient is refusing medications during a certain pill time when possible. If a patient doesn't wish to take said medication, it will be discontinued. The patient will still be followed for their chronic condition and continually address the medication issue.

The Clinical Pharmacist works closely with the Medical Director, physicians, nurse practitioners and nursing staff. ACH is establishing a chronic care team that consists of a provider, nurse, medical assistant and clinical pharmacist that will be assigned to monitor the complex patients identified at intake or at any encounter thereafter. Policy will be written to define what chronic conditions will be closely monitored by the team. The policy will also direct data tracking and what will be included in a chronic disease database.

During the next reporting period, ACH will work closely with SSO leadership to pilot stationing a provider near the booking loop. The patients will be flagged at intake as having more critical needs, such as chronic conditions or substance withdrawal, and they will be seen for a full H&P prior to being housed. Priorities for an H&P include those identified with diabetes, hypertension, seizures, heart failure, liver disease (including cirrhosis), sickle cell, lung disease (COPD and asthma), and substance use. This will include those with abnormal vital signs or self-reported disease that is not immediately verifiable. Also included will be those hospitalized or had an emergency department visit in the last week.

A Hemoglobin A1C lab will be added the jail panel, a laboratory panel that will be ordered during the H&P. For every patient who comes through ACH and reports a chronic medical condition, once they have had their history and physical completed, they will be referred to a medical provider for a chronic disease initial visit within 30 days of their H&P. A chronic disease visit template will be created in the electronic health record system by February of 2025.

Two nurses are being recruited to the chronic care team from current ACH staff. Registry is being asked to provide possible candidates to fill short term needs. They will work with case management on specialty clinic appointments and with providers/MAs on primary care appointments. They will also follow labs and work with the provider and clinical pharmacist to ensure labs and studies are completed and medications ordered/monitored. They will schedule recurrent ninety-day chronic care visits. Nurse will schedule laboratory orders, as indicated, to be completed two weeks prior to these visits, so that labs may be reviewed by providers prior to the appointment.

By the end of January 2025, the plan is to order an adequate supply of peak flow meters and have them stocked in medical exam rooms in both facilities. Nurses and providers, as well as MAs, will be educated on the use of peak flow meters and the expectation that they will be used in the care of asthma and missed asthma/COPD patients.
Also in the next reporting period, ACH will work with SSO to identify and mitigate any obstacles to the timing of fingerstick blood sugars, and insulin administration.

VI.D.2 - Partial Compliance

"The County shall track compliance with the chronic disease management program requirements for timely provision of appointments, procedures, and medications. The County shall ensure that its electronic medical record system is adequate to support these critical functions."

ACH QI has conducts chronic care audits regularly on the compliance with diabetic chronic care requirements, the most recent audit completed for Q3 of FY 2023/2024 (March 2024). QI also implemented a new compliance audit on overall chronic disease management within the jails.

A chronic conditions report has been developed and is available to clinical staff. It can be run by ICD-10 code for a particular time period and/or facility. Data elements being tracked include:

- ICD-10 Code and Problem Description
- Degree of Control
- First PHP Visit
- Last provider visit details
- Recent Lab Reports and Future Lab Orders
- Follow up Chronic Care clinic dates.

Providers have been trained to create alerts in the EHR to ensure a particular patient will return to that provider for follow-up care when possible. Initial H&P and provider chronic care follow-up forms are active in the EHR. Both encounter types include several forms for data collection, such as periodic health assessment and patient education details. The asthma form in the EHR was updated to capture additional information during chronic care follow-up visits. The practitioner assessment & plan form in the EHR has been updated to include chronic care follow up reasons and automatically generated future appointment orders as well as a link to the necessary documentation should the patient require to be sent for an emergency room visit.

During this reporting period, the Medical Director has initiated peer review of charts by the Medical Director, Assistant Medical Director and the lead physicians. A standardized form was created based on a recommendation and review of the provider consultant Dr. Radha Sadacharan and is being utilized. The policy has been drafted and has been sent to the consultant for review. The policy has been revised to address chronic care needs by reviewing the chart for adherence to VHA clinical practice guidelines. Pending policy review and approval, the medical director and lead physicians have been using the draft template to conduct reviews. Feedback is being given to providers when issues are identified, including disciplinary actions when needed. Part of the chart review includes review of a provider's adherence to chronic care guidelines. At present, this is limited to the chronic care guidelines for asthma, diabetes, HIV/AIDS, and hypertension. ACH will

implement VHA/DoD Primary Care Clinical Practice Guidelines within the first three months of the new reporting period. This will include educating providers on these guidelines.

ACH has begun to work with DTech to develop a chronic care registry/PowerBI to track patients with complex medical problems. This will be a major area of focus in the upcoming reporting period. Meanwhile, ACH is creating an excel tracking sheet to monitor these complex patients. Staff are meeting twice monthly to discuss progress.
Also in the upcoming reporting period, the providers will use AHRQ Quality Prevention Indicators when selecting records to review pre-hospital and post-hospital care.

Staff are pulling data reports on chronic conditions and labs which will help with chronic disease management. See tables below:

Chronic Conditions Reports (June – December 2024)

Chronic Physical Health Conditions Report - Point in Time							
	6/26/24	**7/31/24**	**8/28/24**	**9/25/24**	**10/30/24**	**11/27/24**	**12/27/24**
% of Patients with chronic physical health conditions	43%	44%	43%	46%	45%	44%	45%
Of those with chronic physical health conditions, % have two or more conditions	39%	40%	40%	41%	41%	40%	40%
% of Patients on medication	85%	85%	84%	86%	86%	89%	89%

Chronic Conditions Report - Point in Time							
	6/26/24	**7/31/24**	**8/28/24**	**9/25/24**	**10/30/24**	**11/27/24**	**12/27/24**
% of Patients with chronic conditions	80%	80%	80%	84%	84%	83%	85%
Of those with a chronic condition, % have two or more conditions	70%	69%	70%	70%	69%	69%	69%
% of Patients on medication	85%	85%	84%	86%	86%	89%	89%

QI developed an audit tool for diabetes management and conducted a baseline audit in November 2021. The data shows that Providers are improving with respect to scheduling follow-up visits and HbA1c testing within appropriate timeframes. See table below.

Diabetes Management Audit

Indicator	Data Period *Sample of patients with diagnosis of diabetes*				
	FY 23/24 Q1 (N=29)	FY 23/24 Q2 (N=28)	FY 23/24 Q3 (N=28)	FY 23/24 Q4 (N=26)	FY 24/25 Q1 (N=26
Provider follow-up visit within timeframe based on degree of disease control	20/29 (69%)	17/28 (61%)	17/28 (61%)	13/26 (50%)	8/26 (31%)
Hemoglobin A1c (HbA1c) test scheduled within 6 months of last result	29/29 (100%)	24/28 (86%)	26/28 (93%)	24/26 (92%)	19/26 (73%)

VI.D.3 - Partial Compliance

"The County shall review its infection control policies and procedures for dialysis treatment to ensure that appropriate precautions are taken to minimize the risk of transmission of blood-borne pathogens, given the proximity of HCV+ and HCV- patients receiving dialysis in the same room."

ACH contracts with Spectrum to provide onsite dialysis treatment, who is required to maintain and follow regulations and policies surrounding appropriate precautions to minimize the risk of transmission of blood-borne pathogens while providing dialysis. ACH Infection Control has recently worked with the California Department of Public Health to update the infection control policies to be consistent with standards.

E. Specialty Services

VI.E.1 - Substantial Compliance

"The County shall develop and implement policies regarding specialty referrals using an algorithm with evidence-based referral criteria and guidelines."

ACH has implemented policies regarding specialty referrals in collaboration and agreement with court-appointed Experts. Specialty Care Referral Provider Guidelines were

developed, and training is provided ongoing to assist providers in submitting sufficient documentation when making referrals. Also see Utilization Management section.

VI.E.2 - Partial Compliance ↓

"Within 3 months of the date the Remedial plan is issued by the Court, the County shall develop and implement policies and procedures to ensure that emergency consultations and diagnostic treatment procedures, as determined by the medical provider; are provided immediately; high priority consultations and procedures, as determined by the medical provider are seen within 14 days of the date of the referral; and routine consultations and procedures, as determined by the provider are seen within 90 days of the date of the referral."

ACH has implemented policies regarding specialty referrals in collaboration and agreement with court-appointed Experts. Urgent referrals are required to be seen within 14 days of referral rather than the 21 days stated in the Remedial Plan.

Due to the volume of referrals coming into CM (approximately 500 per month), staff are not able to keep up with the timelines to process the referrals and send for appointments. Many of the referrals are incomplete, which takes time to go back and forth with the providers to get the information needed to move the referral forward.

Much education has been provided to providers on what is needed for referrals. CM has attended provider staff meetings, case reviews have been discussed and still many inappropriate or incomplete referrals continue to come through and slow down the process for CM.

Resolving the problems with specialty referrals has been a major area of focus during this reporting period. CM spoke with each specialty provider to determine what was specifically needed (labs, imaging, etc.) for each type of referral. Order sets were created and are required before the provider can send the referral. Providers follow up in two or three weeks via chart review to ensure the workup is complete, then submit the order so an appointment may be scheduled. Many providers alternatively schedule the order to go through in two weeks. Urgent referrals are automatically processed with no provider follow up.

This process has helped in reducing the number of referrals that are sent incomplete and unable to process. This has eliminated time for CM and providers to go back and forth with what is needed for the referral.

Staffing for CM was a major barrier to compliance previously, however in this reporting period ACH brought on a new CM SRN. This new SRN was previously a quality improvement nurse and immediately implemented system changes to reduce unnecessary work for CM staff. She began working closely with DTech to resolve the

tracking and reporting issues and hired new CM staff to help with the backlog. She works closely with the Medical Director (who now oversees CM) and they meet weekly to identify and resolve provider issues contributing to non-compliance.

This area will continue to be a major area of focus and ACH anticipates restoring compliance in all areas in the next reporting period. However, due to these challenges, the compliance rating for this provision has been reduced from Substantial Compliance to Partial Compliance.

VI.E.3 - Non-Compliance ↓

"Patients whose routine specialty consultation or procedure do not take place within 90 calendar days from the date of the referral shall be examined by a clinician monthly and evaluated to determine if urgent specialty care is indicated."

ACH Case Management (CM) has a system to schedule provider follow-up appointments for patients who have not yet had their specialty consultation or procedure and therefore fall outside of the 90-day timeframe. CM creates an order for the visit, indicates the purpose of the visit and has a system to track the number of follow-up visits that occur per policy. Providers have been trained on this requirement and how this visit is flagged in the health record.

Due to the volume of referrals and the backlog of provider encounters, providers do not consistently follow up with patients who have not had their appointment occur within the required timeframes.

When the referral numbers were lower and CM was manually tracking this data, they were able to monitor these monthly visits and ensure they occurred. However, CM staff do not have the capabilities to monitor this area manually at this time for the number of referrals coming in.

During the next reporting period, ACH anticipates this provision increasing in compliance. ACH is in process of recruiting a provider from registry with Utilization Management (UM) experience to assist with UM reviews until this position can be added. After much internal discussion, it has been decided that having a single provider conduct UM reviews on every referral that comes through is more cost-effective and timely than having a nurse run every referral through Interqual and then having both a nurse and a provider conduct UM reviews on all denials. ACH anticipates this process being in place by the next reporting period. Due to the real-time feedback from provider to provider, ACH anticipates the number of incomplete referrals decreasing and referrals that are elective or should be run through Rubicon MD first will also decrease. In turn, the volume of referrals to process and track will decrease and CM staff will be able to monitor appropriately. In addition, CM staffing has increased at the end of this reporting period so they can catch up on the backlog. Finally, the electronic tracking system should be complete in the upcoming reporting

period, allowing CM staff to easily monitor who is falling outside of the timeframes. They will then be able to schedule provider visits for this purpose, as was the practice in the past.

Due to the volume and backlog, the compliance rating for this provision is being reduced from Partial Compliance to Non-Compliance.

VI.E.4 - Partial Compliance

"Within 5 days of the completion of a high priority specialty consultation or procedure, or within 14 days of a routine specialty consultation or procedure, patients returning to the Sacramento County Jail shall have their specialty reports and follow-up recommendations reviewed by a jail nurse practitioner, physician assistant or physician."

ACH CM has a tracking system to ensure collection of the consult or procedure paperwork from the specialty provider and schedules the ACH provider follow-up appointment within the timeframe requirements (5 days of the completion of a high priority specialty consultation or procedure, or within 14 days of a routine) – which is tracked and reported out quarterly. There are sometimes difficulty in obtaining the paperwork timely. CM often has to follow-up with the outside provider multiple times, which causes delays in the follow up appointments with onsite providers.

CM has recently gained access to the following outside EHR's to search for and obtain paperwork:

- Cerner (San Joaquin General Hospital). At the moment, only the CM SRN has this access; ACH is in the process of gaining access for the other CM staff.
- Sutter Link
- Staff must fax requests for records for any UC Davis consults/procedures

CM staff will continue to work with the outside providers to get the reports back from the provider within the required timeframes.

VI.E.5 - Non-Compliance ↓

"Specialty care consultations and outside diagnostic and treatment procedures shall be tracked in a log that identifies the referral request date, the date the referral was sent to the specialty care provider, the appointment date for the consultation or procedure is scheduled, the date the appointment takes place, and, if the appointment is rescheduled or cancelled, the reason it was rescheduled or canceled."

See VI.E.6, below.

VI.E.6 - Non-Compliance ↓

"Requests for specialty consultations and outside diagnostic and treatment procedures shall also be tracked to determine the length of time it takes to grant or deny the requests and the circumstances and reasons for denials."

CM has been tracking and reporting on specialty care consultations and outside diagnostic and treatment procedures since February 2021 and continued to expand the tracking elements. All elements outlined in this Remedial Plan requirement were being tracked for offsite consults only, including the time it takes to grant or deny requests and the circumstances or reasons for denials, meeting this Remedial Plan requirement. Additional information has been added to the specialty referral tracker based on expert recommendations. This includes tracking of additional workup prior to appointment when needed, the date specialty documentation was received post specialty appointment, if a nurse visit occurred upon return from a specialty appointment, and if additional tests are needed post appointment.

In February 2024, CM began tracking all specialty consults on the tracker. However, due to the increase in providers, specialty referrals have increased significantly. CM is now receiving between 400-500 specialty referrals per month. Many of which are incomplete and need further workup before an appointment can be requested. CM was unable to keep up with the workload with the current practice of communicating back and forth with the provider to get the workup needed. The ACH executive team met multiple times on the changes needed to improve internal process. Following these meetings, the following was implemented:

- Providers were instructed to consult with Rubicon MD first before generating certain specialty referrals.
- CM spoke with each specialty provider to determine what was specifically needed (labs, imaging, etc.) for each type of referral. Order sets were created so the workup is automatically ordered urgently. Providers follow up in three weeks via chart review to ensure workup is complete, then submit the order so an appointment may be scheduled. Urgent referrals are automatically processed with no provider follow up.
- The EHR team worked with D-Tech to get the Specialty Tracker automated and pulled directly from order manager. This new tracker is in testing and should be finalized in 2025. This eliminates the burden of managing an extensive excel spreadsheet. The Specialty Data report will be compiled once live.
- ACH management is meeting regularly to discuss the changes and get updates on progress. This is a major step forward in tracking compliance in this area.

CM is doing their best to track all processed referrals; however there has been a delay in their initial review due to not having enough staff to meet the demand. At the end of this reporting period, there were several registry staff brought on to assist CM with the backlog of referrals and tracking. ACH anticipates that this area will be much improved in the upcoming reporting period. Due to the delay in tracking and auditing referrals, VI.E.5 and VI.E.6 are being reduced from Partial Compliance to Non-Compliance.

VI.E.7 - Non-Compliance ↓

"At least twice a year, the County shall conduct an audit of specialty care referral logs described in subsections (5) and (6), above, and complete a report as to whether each category of specialty care is provided in a reasonable timeframe, consistent with established timeframes. If any specialty care area has a record of untimely appointments as determined by the Correctional Health Service Continuous Quality Improvement Committee, the County shall report to Plaintiffs and the parties shall meet and confer to take prompt steps to address the issue. The County will provide Plaintiffs access to the specialty care referral logs and audit reports periodically and upon written request. The parties will work to resolve issues with untimely specialty care in individual patient cases and with respect to systemic trends, including through the dispute resolution process."

Auditing and reporting on off-site specialty care referral tracking as outlined above generally occurs quarterly – exceeding this Remedial Plan requirement of twice yearly. The exception is during this reporting period while ACH works with D-Tech to automate the report. These audit reports are gone over in the UM Subcommittee Meeting, and any issues are discussed with the goal of addressing at that time. In addition, the Medical Director now meets weekly with CM to discuss and review specialty referrals for priority level appropriateness. The specialty tracking sheet and/or specialty audit reports are provided to plaintiff's counsel and court-appointed experts upon written request. Data is always reported 90 days in arrears to accurately capture compliance timeframes.

The first audit of the off-site specialty referral data was completed on 07/28/21 for the months of February through April 2021. Comparison data shows improvement in appointments meeting the 90-day timeframe 63% of the time during the first report period to 74% in the most recent report period of FY 22/23 July 2022 through June 2023.
In February 2024 CM began tracking on-site and off-site referrals on the tracker, so the next specialty referral data will include both. Upon consultation with executive medical leadership and CM, ACH has created an "expedited" referral category where appointments should be completed within 45 days.

Historically, appointments have been scheduled by SSO transportation staff. Due to issues with prioritizing scheduling and booking appointments outside of required timeframes, ACH has developed a hybrid system with SSO. SSO assists in making the appointments but CM medical staff have complete authority on priority levels and decision making attached to the appointment.

During this reporting period, ACH was not able to conduct a formal audit of the specialty care referrals, as completed in the past. Due to the enormity of the referrals being sent by providers to CM (approximately 500 per month), the manual tracking system that previously existed (Excel tracking log) was no longer sustainable. ACH has been working with DTech during both this and the previous reporting period on an electronic report that

captures all the data required by the Consent Decree. ACH continues to make progress; however, during testing, there was inaccurate and missing data that is being addressed. ACH anticipates going live with this report early to mid-next reporting period. Once live, ACH will audit the entire data period missed during this timeframe.

DTech is also working on a PowerBI Dashboard that will provide a snapshot of specialty referrals/data at any given time. This dashboard may be ready by the end of the next reporting period. Due to the inability to complete the formal audit during this reporting period, the compliance rating has been decreased from Partial Compliance to Non-Compliance.

VI.E.8 - Partial Compliance

"The County shall consider implementing an e-referral system to reduce delays and facilitate communication between specialists and primary care providers, as well as reducing unnecessary transportation costs and unnecessary specialist appointments by ensuring that the specialist has all the information he or she needs before an appointment takes place."

See full detail under VI.E.5-6 above. ACH has implemented Rubicon MD, an e-referral system. Providers utilize Rubicon for clinical decision-making; however, more training has occurred this reporting period for providers to maximize the use of this platform. ACH anticipates Substantial Compliance in the upcoming reporting period as more providers are comfortable in using this system appropriately.

Earlier this year, providers were instructed to consult with Rubicon MD first before generating certain specialty referrals. CM spoke with each specialty provider to determine what was specifically needed (labs, imaging, etc.) for each type of referral. Order sets were created so the workup is automatically ordered urgently. Providers follow up in three weeks via chart review to ensure workup is complete, then submit the order so an appointment may be scheduled. Urgent referrals are automatically processed with no provider follow up. ACH management is meeting regularly to discuss the changes and get updates on progress. This is a major step forward in tracking compliance in this area.

VI.E.9 - Partial Compliance

"The County shall ensure that utilization management and/or scheduling staff provides notification of whether a patient's specialty care appointment is scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, including as follows:

a) Medical staff may request and obtain information as to whether any patient's specialty care appointment is scheduled, and as to the general timing of the appointment (e.g. within a one-week's date range).
b) If a specialty care appointment is denied or is not scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.

c) *If a previously scheduled specialty care appointment is postponed to a date that is outside the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient."*

There are weekly meetings with the Medical Director and CM to review all referrals over 30 days. There is an initial review of all new referrals to determine if they can move forward by ensuring they have the proper work-up completed to process the referral. The provider will decide what work up is needed, decide the appropriateness of the triage level, or if it should be denied.

Medical staff can request information at any time regarding specialty appointments. CM schedules a provider visit with each patient monthly if their appointment falls outside of the timeframes per policy. Providers are informed in the request why they are seeing the patient and determine if anything significant has changed during the wait time regarding the reason for referral. Providers are also informed when a referral is denied, and rationale is provided to them. They are instructed to meet with the patient to inform them.

A physical therapy clinic has been established and has been expanded to occur twice weekly to meet the demand and due to the length of time it takes to clear a patient from the list. CM is closely tracking provider visits post-appointment and ensuring results are reviewed. Telemedicine is currently being utilized for pulmonary and MAT consults and will continue to expand.

ACH is working with SSO on procuring and downloading physical therapy exercise videos onto patient tablets. This will allow more patients to exercise while in their cell. This will allow providers an option to work with patients on chronic pain relieving techniques prior to sending a physical therapy referral.

QI has been auditing specialty referrals, assessing timeliness, and identifying barriers since February 2021.

During this reporting period, providers were granted access to the specialty referral note within the EHR. This note contains all information on the progress of the referral, except when the appointment date is actually scheduled. This gives the provider enough information to keep the patient informed, decide whether the appointment is making progress quickly enough, determine if an ER send out is necessary or if CM hasn't followed up as they should have.

When referrals are denied, they are sent back to the ordering provider with the reason why they are denied so they can either follow up with the patient and provide more information to resubmit the referral or to simply inform the patient of the decision.

ACH is in process of recruiting a provider from registry with Utilization Management (UM) experience to assist with UM reviews until a position can be added. After much internal

discussion, it has been decided that having a single provider conduct UM reviews on every referral that comes through is more cost-effective and timely than having a nurse run every referral through Interqual and then having both a nurse and a provider conduct UM reviews on all denials. ACH anticipates this process being in place by the next reporting period.

VI.E.10 - Partial Compliance ↑

"The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the significant demand for this service."

A physical therapy clinic has been established and has been expanded to occur twice weekly. ACH has had a physical therapy contract in place for over a year and it has continued to increase due to the demand. As with other specialty referrals, there are too many referrals coming into CM for physical therapy. At the end of this reporting period, Dr. Abdalla begun working with CM to review all physical therapy referrals for appropriateness. Based on provider assessment, some physical therapy referrals may be able to be closed out and patients will be provided exercises to do in their cells instead.

Providers are continuously educated and reminded of the referrals that should be sent to PT and those that the providers themselves should be providing educational materials/demonstrating exercises that can help with many of the chronic pain issues. ACH is currently conducting UM on all physical therapy referrals, which will help filter out those referrals that are truly necessary vs those that should be handled with the primary care provider.

Prior to this reporting period, the County had not assigned a compliance rating for this provision.

F. Medication Administration and Monitoring
VI.F.1 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws through the following:

a) *Ensuring that initial doses of prescribed medications are delivered to patients within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner.*
b) *Ensure that medical staff who administer medications to patients document in the patient's Medication Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, (3) the date and time for any refusal of medication, and (4) in the event of patient refusal, documentation that the prisoner was made aware of and understands any adverse health consequences by medical staff."*

ACH has implemented policies regarding medication administration in collaboration and agreement with court-appointed experts. In addition, several key changes have been completed including changes in pharmacy schedules, deployment of new pill carts, reassigning some tasks, and improving the network capacity. Additional medical escorts are required to ensure efficient operations.

QI has begun auditing to this provision and found that staff have maintained Substantial Compliance in both the audit of August 2022 (100% compliance), February 2023 (96% compliance), August 2023 (100% compliance), and February 2024 (100% compliance) meeting timeliness standards for patients receiving initial medications.

Regarding VI.F.1.b, staff document each administered medication as required in the patient's MAR. The medication refusal form has been modified and staff have been trained on the requirement to educate patients on adverse health consequences upon refusal. Handheld tablets have been purchased and have been fully implemented in order for nurses to document in real-time when administering medications at the cell. The devices are HIPAA-compliant and compatible with the EHR.

Medication administration carts have been purchased and configured.

Both the Main Jail and RCCC have installed several additional Wi-Fi access points throughout both facilities. This has greatly improved the accessibility by both PC and laptop devices used by staff, thereby allowing more efficient and stable EHR access and documenting ability. However, Wi-Fi issues still slow down pill call processes at times. ACH leadership is working with DTech to identify and resolve the issue.

ACH has been engaged in regular meetings with the EHR vendor (Fusion) regarding business requirements for eMAR 4X. This includes the following:

- Barcode capability.
- Enabling bidirectional communication with the Pharmacy Management System (CIPS).
- Pharmacy Status field updates to reflect "Verified" or "Unverified" signifying if the medication order was verified by a pharmacist.
- "Note Change" alerts to alert nurses of a dosage change.

In the meantime, the user manual for the current eMAR 4 has been posted for reference on the ACH intranet site. Additionally, ACH tablets include barcode readers in anticipation of the barcode functionality available in eMAR.

Many of the medication errors noted by the SMEs should be corrected by a new version of the eMAR scheduled to come out the first quarter of 2025. The bidirectional communication will note whether medication was verified by a pharmacist or not and if any substitutions were made (i.e. substituted two 10mg tabs instead of one 20mg tab).

The new CPOE which is due in January will capture duplicates on medication renewals by automatically discontinuing the old order. There will be three options for a provider, new order, discharge and renew, and renew. All renewals will automatically discontinue the old order.

The pharmacy runs a report in the EHR that identifies incomplete orders several times per week. In a previous provider meeting, ACH messaged to the providers and the medical assistants at the end of their shift to run this report for the provider to fix the incomplete orders before they leave for the day. The new CPOE will require that fields be completed before they can submit the order which will eliminate incomplete orders. In addition, before submission, a review screen will pop up to ensure that information was entered correctly.

The pill call takes several hours to prep. The nurse is ultimately supposed to review the eMAR to verify the medication order is still active and the correct dose is given. First quarter of 2025, ACH will implement and enhanced version of the eMAR that allows barcode scanning that will prompt the user of the correct dose or inactive/active status. If there are any errors a pop up will occur in the eMAR real time and alert the nurse. ACH is currently hiring a night shift pharmacist to allow us to go to 24-hour pharmacy. Once services are available 24 hours, it will reduce, if not eliminate this kind of duplication on the am pill call. In addition, the new CPOE will allow providers to discontinue and renew much easier and without duplicate dosing. Currently, this subsection of the Consent Decree is rated as Partial Compliance.

VI.F.2 - Partial Compliance

"The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication."

Previously, ACH management met with the LVN Union to make necessary changes to medication administration schedules to achieve substantial compliance. Required meetings occurred, and a notice was sent out to all LVN's assigned to medication administration on 12/12/23 informing them that they will be moving to the day shift. Both BID medication administration times will occur on the dayshift in order to ensure safer medication practices and an abundance of staff to cover medication administration.
In January 2024, ACH leadership rolled out the new pill call process and new medication administration times. The two heaviest pill calls (AM and PM) are on the same shift. ACH has transferred the majority of LVN staffing to this shift so there is= adequate staffing. Due to this change, there is always enough staff to cover pill call. ACH will reach substantial compliance in this provision when administration times fall one hour before or after the scheduled timeframe on a consistent basis.

All RNs and LVNs have been cross trained to administer medications allowing RNs to fill staffing shortages and avoid medication administration delays.

ACH established distribution areas to ensure efficient delivery of medications.

Medication Assisted Treatment (suboxone) has been separated from the normal pill call and is administered separately due to the time it takes to monitor the patient appropriately while the medication dissolves. A designated custody escort is usually assigned to assist with monitoring this pill call due to the high diversion potential.

A staffing matrix has been developed to reflect 12-hour shifts to maximize staffing.

ACH leadership and SSO leadership have met multiple times to coordinate medication administration efforts. The Main Jail Captain wrote his operations order to align with the ACH workflow. This ensures SSO and nursing staff have the same information which creates less confusion and/or conflict.

Training on the new pill call workflow took place at a nursing all staff meeting on 12/20/23 and ongoing as the process rolled out.

Hiring efforts have significantly increased. Staffing numbers have increased for medication administration. ACH utilizes the registry to assist if there are any call-offs the day of.

Staff will be designated to specific assignments and stations daily. Regular assignments will increase efficiency and reduce patient load.

A third pill call was created for Hours of Sleep (HS) medication that needs to be administered before bedtime. Less staffing is needed for this since it is a smaller pill call consisting primarily of psychiatric medication.

Regular in-person audits of the pill call process are needed to ensure staff are following policy. Supervision of this process has greatly increased at the end of June and will continue due to staff not adhering to policy requirements.

VI.F.3 - Substantial Compliance

"The County shall provide pill call twice a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility security concerns. The County shall develop and implement policies and procedures to ensure that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician. Any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician."

ACH provides medication administration three times a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility

security concerns. ACH Medication Administration policy outlines that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician and that any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician. Medication administration times have been changed to improve efficiency.

VI.F.4 - Partial Compliance ↑

"The County shall develop and implement policies and procedures to ensure that patients are provided medications at therapeutically appropriate times when out to court, in transit to and from any outside appointment, or being transferred between facilities. If administration times occurs when a patient is in court, in transit, or at an outside appointment, medication will be administered as close as possible to the regular administration time. "

The ACH/ATIMS project team created "turn on" and "turn off" flags and alerts accordingly depending on the patient's current condition(s). This includes sending an alert when a patient is on medication so that custody staff can be readily aware. Currently, the team is enhancing the flag to identify the actual pill call schedule for individual patients to allow staffing. Three pill call schedules are identified: AM, PM, and HS.

The court medication process will be improved by the implementation of a 24-hour pharmacy. Employee growth has been approved for an additional pharmacist and pharmacy technician for the 24/25 budget year. These staff will be responsible for same day court medications and discharge medications.

During this reporting period, ACH has implemented a new court medications process at the Main Jail. With close collaboration between custody, pharmacy and nursing, ACH developed a method of daily court notification, medication preparation and administration prior to patients leaving for court in the morning. This new process ensures there are no issues with medications that would prevent the court process from occurring. Due to this improvement, the compliance rating is being raised from Non-Compliance to Partial Compliance.

VI.F.5 - Substantial Compliance ↑

"The County shall develop policies and procedures to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate intervals."

ACH developed policies and procedures listed above with approval from medical experts to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate levels. Due to this being the expectation and practice

of providers, the compliance rating for this provision is being raised from Partial Compliance to Substantial Compliance.

VI.F.6 - Substantial Compliance ↑

"The County shall explore the expansion of its Keep-on-Person medication program, (especially for inhalers and medications that are available over-the-counter in the community) and to facilitate provision of medications for people who are out to court, in transit, or at an outside appointment."

Keep on Person (KOP) Medications (PP 04-20) was approved by the medical experts in February 2022. KOP medications were expanded to include inhalers, chronic disease medications, over-the-counter medications, and others. Staff developed a Patient Medication Guide handout to inform patients of the KOP and discharge medication programs.

ACH has increased eligibility, including for patients on restricted medications, by only dispensing the non-restricted medications as KOP. Patients with restricted medications still go through the pill line for the restricted medications. ACH is also assessing all levalbuterol inhalers (rescue inhalers), thus increasing KOP.

The KOP medication program has been expanded to all eligible patients. Given the increase in eligibility, the Pharmacy started transitioning delivery of KOP medication to the nursing staff. RCCC nurses deliver the KOP, allowing more time to convert patients to KOP. During this reporting period, all inhalers are KOP by default unless contraindicated due to non-compliance or safety and security issues. All over the counter medications are KOP and/or available on commissary. KOP is based on the medication type, not necessarily the patient. Due to this development, the compliance rating is being increased from Partial Compliance to Substantial Compliance.

All rescue inhalers and nitroglycerin 0.4mg are provided KOP unless the patient is disqualified from the program. Scheduled inhalers are also provided to patients. Routine and chronic care medication are provided to eligible patients. If patients are on a restrictive medication, they will continue to go to pill line to receive the restrictive medication.

Pharmacy staff monitors compliance upon dispensing refilled medications and educate patients on proper use, use of the EHR to document participants' compliance, and use the Pharmacy Information System for data management.

ACH developed a new audit tool to evaluate the timeliness of medication initiation and renewal. An initial baseline audit assessed outcomes in February 2022, and additional audits are completed biannually. QI data is presented in the pharmacy and therapeutics subcommittee for review and recommendations. See table below:

Medication Initial and Renewal Audit

Medication Initiation and Renewal					
Indicator	Data Period				
	08/17/22 (N=42)	02/16-17/23 (N=44)	08/16/23 (N=52)	02/16/24 (N=48)	10/10/24 (N=52)
Timely initial medication (<48 hours from order)	35/35 (100%)	23/24 (96%)	44/44 (100%)	37/37 (100%)	32/33 (97%)
Timely renewal (no missed doses)	6/7 (86%)	18/20 (90%)	5/8 (62%)	11/11 (100%)	19/19 (100%)

G. Clinical Space and Medical Placements

VI.G.1 – Substantial Compliance ↑

"The County shall provide adequate space in every facility to support clinical operations while also securing appropriate privacy for patients. Adequate clinical space includes visual and auditory privacy from prisoners, and auditory privacy from staff, the space needed reasonably to perform clinical functions as well as an examination table, sink, proper lighting, proper equipment, and access to health records."

The following have been completed:

- ACH worked with SSO to identify additional exam room stationing areas to provide additional, confidential space to complete services on each floor in each wing – including NSC.
- Inventory medical equipment currently in stock as well as additional needed to support additional fully functioning stations on each floor in each wing, including, but not limited to:
    - Exam Carts with computers, stocked with exam equipment and materials.
    - Privacy Screens
- RCCC- All medical and psychiatric offices are confidential and free of recording. There are no cameras in medical offices to ensure privacy for inmates. All medical offices have equipment determined to be necessary by ACH. RCCC MHU Cells are recorded, but there is no audio.
- All exam rooms at Main Jail are visually and auditorily confidential.
- ACH has implemented a daily healthcare service schedule that will assign exam rooms and times for RNs to provide NSC, as well as all service functions.
- During this reporting period there were two major developments in clinic space:

- First, the nurse intake area was modified to have four confidential rooms that allow for privacy for all arrestees.
- Second, every floor and every wing at the Main Jail had two "confidential booths" or "privacy pods" installed with significant coordination and effort between ACH, SSO and DGS. This has greatly increased the ability to have confidential clinical contacts with patients. When clinic rooms are not available, nurses use these pods to conduct nurse sick call. They bring their carts, equipped with the supplies they need. During this upcoming reporting period, the pods will have curtains installed to allow greater privacy when needed.
- All projects were developed in consultation with class counsel and the SME's who were satisfied that this will meet clinic space and privacy requirements.

Long term, privacy would be further improved through additional construction. DGS is leading an effort to build an annex that includes a new booking loop with the required amount of space for inmate privacy adjacent and connected to the current Main Jail. The project is currently undergoing a third-party peer review.

Due to the improvements during this monitoring period, the compliance rating is being raised from Partial Compliance to Substantial Compliance.

VI.G.2 - Non-Compliance

"The County shall ensure that any negative pressure isolation rooms meet community standards, including an antechamber to ensure that the room remains airtight, appropriate pressure gauges, and regular documented checks of the pressure gauges."

At Main Jail, negative pressure rooms are checked daily by DGS to ensure the requested standards are met. Further consultation with DGS will be required to better assess the compliance rating of negative pressure isolation rooms.

VI.G.3 - Substantial Compliance ↑

"The County shall ensure that absent individualized, documented safety and security concerns, patients in acute medical or quarantine placements shall be allowed property and privileges equivalent to what they would receive in general population based upon their classification levels."

All inmates in medical or quarantine placements are allowed to keep personal property with them as well as participate in programs that do not interfere with safety and security concerns. Based on a review of this provision, the compliance rating is being raised from Partial Compliance to Substantial Compliance.

VI.G.4 - Substantial Compliance ↑

"The County shall ensure that patients in medical placements are not forced to sleep on the floor, including providing beds with rails or other features appropriate for patients' clinical needs and any risk of falling."

At RCCC and the Main Jail, no inmate is forced to sleep on the floor. Beds with rails are available in the Medical Housing Unit.

All cells in medical housing are required to have medical beds. If a bed is out for repair, a temporary replacement is provided or the cell is deemed to be out of commission.

Outdated and broken medical beds have been replaced at both facilities. Based on a re-evaluation of this provision, the compliance rating is being raised from Partial Compliance to Substantial Compliance.

VI.G.5 - Substantial Compliance ↑

"The County shall not discriminate against patients in medical placements solely because of their need for C-Pap machines, but instead shall provide access to programs and services in accordance with their classification level, as set forth in the ADA remedial plan."

Housing units in RCCC currently do not have outlets near any sleeping areas, except the Medical Housing Unit. Inmates housed in the Medical Housing Unit are able to participate in programs and services consistent with others in their classification.

ACH has widely expanded the use of battery-operated CPAPs. Those who do not need the additional nursing care and were solely in 2East for CPAPs have been moved to general population or protective custody housing. As a result of this improvement, the compliance rating is being increased from Partial Compliance to Substantial Compliance.

H. Patient Privacy

VI.H.1 - Substantial Compliance ↑

"The County shall develop and implement policies and procedures to ensure that appropriate confidentiality is maintained for health care services. The policies shall ensure confidentiality for clinical encounters, including health care intake screening, pill call, nursing and provider sick call, specialty appointments, and mental health treatment. The policies shall also ensure confidentiality for written health care documents, such as health care needs requests and grievances raising medical care or mental health concerns, which shall not be collected by custody staff."

Exam rooms and attorney booths provide confidentiality for some health encounters.

ACH has changed the ITI form/process to no longer include PHI that is visible to SSO. The form now instructs the nurse to place all medical information in an attached envelope to send to the provider. The form now instructs the outside provider to protect PHI by returning documentation in a sealed envelope.

Clinical encounters are offered in a private and confidential setting. Deputies stand near when necessary for safety, while still offering privacy. All written health care correspondence is handled directly by medical staff, including medical grievances.

During this reporting period, there were two major developments in patient privacy that have allowed this provision to increase from Partial Compliance to Substantial Compliance. First, the nurse intake area was modified to have four confidential rooms that allow for privacy for all arrestees.

Second, every floor and every wing at the Main Jail had two "confidential booths" or "privacy pods" installed with significant coordination and effort between ACH, SSO and DGS. This has greatly increased the ability to have confidential clinical contacts with patients. When clinic rooms are not available, nurses use these pods to conduct nurse sick call. They bring their carts, equipped with the supplies they need. During this upcoming reporting period, the pods will have curtains installed to allow greater privacy when needed.

MH staff can use one booth in each wing for their confidential MH encounters.

VI.H.2 - Partial Compliance

"The County shall provide adequate clinical space in each jail to support clinical operations while also securing appropriate privacy for patients, including visual and auditory privacy from prisoners and auditory privacy from staff."

The nurse intake renovation took place in December 2022 to create more confidential space, however that did not satisfy the privacy requirements.
To meet Substantial Compliance, the County developed a comprehensive plan to restructure the arrest report room/medical intake area. The plan involves DGS repurposing the current room where the breathalyzer is stored, a bathroom, an exam room, and an office into four confidential medical intake spaces. This plan was shared in detail with the SME's and class counsel and the response was favorable in that it would meet requirements to achieve compliance. This work was completed during the current monitoring period.

ACH worked with SSO to identify additional exam room stationing areas to provide additional, confidential space to complete services on each floor in each wing – including NSC. These pop-up stations are currently being used for NSC.

Transparent interviewing cubicles were constructed with four pods on each floor, two in each wing during this reporting period. MH staff will use one in each wing for confidential interviews and small multi-disciplinary meetings and nursing staff will use the other for NSC, lab draws and other medical contacts. ACH worked with DGS and SSO to choose a privacy curtain on rails to ensure visual privacy during specific exams. Class counsel and the SMEs have seen the plans and are satisfied that this will meet clinic space and privacy requirements. Privacy curtains will be installed in the next reporting period.

At RCCC, the intake medical trailer is equipped with video recording for staff safety, but does not have any audio. All medical and psychiatric offices are confidential and free of recording. There are no cameras in medical offices to ensure privacy for inmates. Medical offices on floors have video, but no audio, for nurse's safety.

The Main Jail medical offices, floors 3-8, are located in the elevator salle port away from the general floor area to provide privacy. Medical offices on floors have video, but no audio, for nurse's safety.

Pending the next review by subject matter expert , this rating may be raised to Substantial Compliance once the level of adequacy of private clinical spaces is assessed.

VI.H.3 - Substantial Compliance ↑

"All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such a determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be made based on housing placement or custodial classification. The issuance of pills does not constitute a clinical interaction.

a) For any determination that a clinical interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.
b) If the presence of a correctional officer is determined to be necessary to ensure the safety of staff for any clinical encounter, steps shall be taken to ensure auditory privacy of the encounter.
c) The County's patient privacy policies, as described in this section, shall apply to contacts between patients and all staff who provide health-related services on site at the jail."

For VI.H.3.a, this is the current process. There is a confidential encounter indicator in each health encounter form where staff indicates if the visit was confidential or non-confidential and the rationale.

For VI.H.3.b, maintaining auditory privacy is difficult due to space configuration. County has a project approved by the BOS to build the IHSF and other space modifications to

resolve the privacy issues. The current practice mandates deputies stand at a distance that offers their ability to intervene, if necessary, while offering auditory privacy. This distance offers deputies an ability to intervene, if necessary for safety, while offering auditory privacy.

For VI.H.3.c, the County's patient privacy policies apply to all health-related contacts. The policy was published on May 15, 2024 in consultation with the SMEs. Efforts are made to ensure medical and psychiatric visits are done in a private and confidential setting. Officers standby when necessary for safety, while still offering privacy to the inmate. Due to the developments identified in VI.H.1, the compliance rating for this provision is being increased from Partial Compliance to Substantial Compliance.

VI.H.4 - Substantial Compliance

"Jail policies that mandate custody staff to be present for any medical treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and medical staff shall be trained accordingly."

No Jail policy mandates custody staff to be present for any medical treatment.

I. Health Care Records

VI.I.1 - Substantial Compliance

"The County shall develop and implement a fully integrated electronic health care record system that includes medical, psychiatric, and dental records and allows mental health and medical staff to view the medical and mental health information about each patient in a single record. This shall be accomplished within 12 months of the date the Remedial plan is issued by the Court."

ACH has developed and implemented a fully integrated electronic health care record system that includes medical, psychiatric, and dental records and allows mental health and medical staff to view the medical and mental health information about each patient in a single record.

The athenaPractice EHR provides all these components to medical and mental health staff via end user access to patient charts containing medical, dental and mental health data/records. The EHR is also integrated with several web applications for eMAR, mental health groups, managing orders and labs as well as with several medical reference and resource websites.

Medical EHR Updates:

- Public Health Lab Requisitions/Test Results: The remaining compendium of lab types identified for submittal via the Public Health Lab requisition process have been deployed as of July 2023. Also, specimen label printers have been installed and configured at several workstations in both facilities so labels will automatically

print for each lab requisition entered. This will improve data accuracy and completeness for all specimens submitted for analysis. A public health lab orders report is in production and available to staff for tracking lab order status by date and by facility. The report also provides totals by facility, order status, and order type/description.

- Voice recognition device and software (VRS) – ACH providers have continued to use the VRS system for dictation in patient charts. Microphone devices have been deployed to all work stations accessed by providers at both facilities. VRS admins can create new accounts and run usage reports as required. ACH will be renewing the licenses for the VRS software. The laptops being used for pill call and related tasks will be used for a telehealth pilot project using Microsoft Teams. Clinical staff will be able to schedule appointments between the patient and a remote provider/healthcare worker. The patient can be seen virtually with audio and video functionality built into the laptop.

VI.I.2 - Substantial Compliance

"Until such a system is implemented, the County shall develop and implement policies and procedures to ensure that medical staff have access to mental health information and mental health staff have access to medical information, as needed to perform their clinical duties. This information shall include all intake records. Medical and mental health staff shall be trained in these policies and procedures within one month of the date the Remedial plan is issued by the Court."

The EHR provides access and contains information regarding medical, mental health and intake records.

VI.I.3 - Substantial Compliance

"The County shall develop and implement policies and procedures to monitor the deployment of the CHS Electronic Health Record (EHR) to ensure the records system is modified, maintained, and improved as needed on an ongoing basis, including ongoing information technology support for the network infrastructure and end users."

ACH has developed and implemented policies and procedures to monitor the deployment of the ACH Electronic Health Record (EHR) to ensure the records system is modified, maintained and improved as needed on an ongoing basis, including ongoing information technology support for the network infrastructure and end users.
Several systems are in place to achieve maintenance and enhancements for the EHR:

- Sac County IT Help Desk (JIRA)
    - The County's IT department (DTech) has an IT Service Desk application (JIRA) for tracking/assigning help desk calls for EHR support. Details regarding nature of the call, user info, resolution description, IT staff assigned, etc. Reports are available for tracking call volume, type, frequency, etc. ACH EHR support staff have been given the permissions/ability to create and assign

their own help desk tickets for EHR-related issues/problems. This greatly increases the efficiency with which outages, errors, glitches, etc. can be addressed and a resolution provided.

- Fusion Help Desk
  - ACH EHR Support staff have access to the EHR Vendor's (Fusion) help desk for more complicated troubleshooting problems and enhancement requests. Issues can be tracked by type of subject – Interfaces/Forms/Reports/App Issues. Reports can be requested via the Sac County Account manager regarding call volume/type/frequency, etc. ACH is working closely with Fusion, the EHR Vendor on continual upgrades to Athena Practice. These upgrades include CPOE, real-time data dashboards, upgraded eMAR and 24-hour Fusion support.
- ASAP System
  - There is an application to request new EHR accounts, access to particular EHR functionality, etc. for new ACH staff and/or modify access for ACH staff. Report requests are also sent through this system. Additionally, internal ACH EHR support staff have taken over creation of EHR accounts for new employees/users upon receiving notification that a network account has been created. This enables a more complete account setup with correct system security permissions for staff based on job classification and business need. It also ensures staff are able to complete assigned tasks within the EHR without getting permission/access errors necessitating additional help desk requests.

J. Utilization Management

VI.J.1 - Partial Compliance

"The County shall revise its utilization management (UM) system to ensure that critical health decisions about patients' access to care are made with sufficient input from providers and a thorough review of health care records."

ACH has implemented policies regarding the utilization management (UM) system in collaboration and agreement with court-appointed Experts. A utilization management (UM) subcommittee was formed and began meeting in October 2021. Subcommittee members include service line directors, QI, MH, and case management. The UM subcommittee continued reviewing selected cases of high utilizers, high risk, complex, and/or high cost to ensure that resources are applied appropriately and timely during the monitoring period.

Case management staff began using InterQual as the utilization management platform for specialty referrals in March 2021. However, after using InterQual criteria to make decisions regarding specialty services approval and denial, ACH found that using InterQual criteria resulted in denials of most specialty services requests. Therefore, ACH has discontinued the use of InterQual. Instead, there are weekly meetings with the Medical Director and CM to review all referrals over 30 days. There is an initial review of all new referrals to

determine if they can move forward by ensuring they have the proper work up completed to process the referral. The provider will decide what work up is needed, decide the appropriateness of the triage level, or if it should be denied. However due to the increase in providers, specialty referrals have increased significantly. CM is now receiving between 400-500 specialty referrals per month. Many of which are incomplete and need further workup before an appointment can be requested. CM was unable to keep up with the workload with the current practice of communicating back and forth with the provider to get the workup needed. The executive team met multiple times to discuss internal process changes needed. Following these workgroups, the following was implemented in June 2024:

- Providers were instructed to consult with Rubicon MD first before generating certain specialty referrals.
- CM spoke with each specialty provider to determine what was specifically needed (labs, imaging, etc) for each type of referral. Order sets were created so the workup is automatically ordered urgently. Providers follow up in three weeks via chart review to ensure workup is complete, then submit the order so an appointment may be scheduled. Urgent referrals are automatically processed with no provider follow up.
- ACH management is meeting regularly to discuss the changes and get updates on progress. This is a major step forward in tracking compliance in this area.
- Specialty care referral provider guidelines were developed, and training is continually provided to assist providers in submitting sufficient documentation when making referrals.

CM is coordinating both on-site and off-site specialty services. A tracking report is under construction, dependent upon documentation in the EHR. The EHR CM SCR form has been updated and in production effective 12/5/24 and meetings with DTech resumed 12/18/24 to update the tracking report with all the changes and additions. The plan to have the tracking report in production effective early February 2025, if not sooner, and a PowerBI dashboard report to follow.

Providers have recently been granted access to view the CM Specialty Care Referral (SCR) encounter in the EHR to view the status of patient appointments. Per SSO, due to security concerns, staff are not to share appointment dates unless there is an emergent need to know the date, in which Providers will contact CM directly. The CM SCR encounter includes the date that the appointment was secured. This will also be on the Specialty Care Tracker.

Patient education on the importance of the appointment is done by providers at the time of ordering. Provider will notify the patient that a specialty care referral is ordered for the future, necessary prep, not to refuse an appointment as it may delay their care along with not refusing prep and or work-up as that may delay their care as well (as the specialty clinics will not see the patients if they refuse prep) and gain patient's agreeance to comply.

During this reporting period, UM meetings have increased to review referrals; however, ACH is in process of recruiting a provider from registry with Utilization Management (UM) experience to assist with UM reviews until a position can be added. After much internal discussion, it has been decided that having a single provider conduct UM reviews on every referral that comes through is more cost-effective and timely than having a nurse run every referral through Interqual and then having both a nurse and a provider conduct UM reviews on all denials. ACH anticipates this process being in place by the next reporting period.

VI.J.2 - Partial Compliance

"The County shall ensure that decisions about a patient's access to, timing of or need for health care are made by a physician, with documented reference to the patient's medical record. Nurses may gather information and coordinate the UM process, so long as it does not interfere with that requirement. All decisions by the UM committee shall be documented, including the clinical justification for the decision."

All specialty referrals are ordered by physicians who determine the priority level based on their clinical assessment. The orders are routed to CM to review for completeness of workup and/or information to schedule the appointment. This provision will be in Substantial Compliance once a dedicated provider conducts a UM review on all referrals.

VI.J.3 - Partial Compliance

"The UM system shall ensure that providers and patients are promptly informed about decisions made by the UM committee, including denial of a specialist referral request."

The Medical Director meets weekly with CM to discuss and review specialty referrals for priority-level appropriateness. All decisions for approval and denial are documented, including the clinical justification for the decision.

A lead physician and CM meet weekly to review new referrals. Priority levels may change because of the review and the provider is notified immediately.

Once process changes have been fully implemented and all referrals are being reviewed by the UM provider and staff have been trained, this provision will be in Substantial Compliance.

CM SRN plans to perform studies to determine the effectiveness of changes and identify gaps in the process and opportunities for improvement.

VI.J.4 - Partial Compliance

"The UM system shall include an appeal process to enable patients and providers to appeal a decision denying a referral request."

If the specialty service is denied, CM will schedule a provider sick call so the ordering provider can discuss the decision with the patient. The patient is then informed of the appeal process. This provision will move into Substantial Compliance when ACH can monitor this process with evidence to support.

Referrals are typically denied when there is a specialty service that must occur prior to the service the patient was referred to. The ordering provider is given the information so the correct service can happen first. For example, providers have referred patients to surgery prior to receiving a surgery consultation by a specialist first. The surgery referral will be denied and the provider will be informed that a consultation will need to occur first.

K. Sanitation

VI.K.1 - Substantial Compliance ↑

"The County shall consult with an Environment of Care expert to evaluate facilities where patients are housed and/or receive clinical treatment, and to make written recommendations to address issues of cleanliness and sanitation that may adversely impact health."

The County consulted with an environment of care expert to evaluate facilities where patients are housed in medical and mental health units and in medical clinic areas to address consistent with environmental cleaning and sanitation standards.

An action item tool was developed to follow up on the recommendations from the Environment of Care Report and was sent to the SMEs.

ACH/DGS contracted with Bissel Brothers now called Olympic Cleaning Service for environmental cleaning services requested in the Environment of Care Report. The contract was executed February 2024. There have been no major complaints about the execution of their work.

The County has updated the Infection Prevention and Control Manual to include policies and procedures with guidelines on proper cleaning and disinfecting approved by the California Department of Public Health for the medical and mental health areas.

The compliance rating for this provision is being increased from Partial Compliance to Substantial Compliance. Sanitation has greatly increased during this reporting period due to the use of a contracted cleaning vendor. They are onsite daily and ensure cells and other areas that need deep cleaning are conducted promptly.

L. Reproductive and Pregnancy Related Care

VI.L.1 - Partial Compliance

"The County shall ensure that pregnant patients receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care (including mental health services)."

ACH maintains a weekly OB/GYN clinic at the Main Jail. Pregnant patients are identified and followed by UCD OB onsite consistent with policy and federal and state regulations. Previously, there was an issue with women from RCCC being identified and transported to their appointments. The problem was in the interface between Athena and ATIMS where OB/GYN appointments were not showing on the medical transport list.

When acute issues arise, on-site providers evaluate the patient and consult with UCD OBGYNs via phone as needed. ACH QI developed audit indicators to review reproductive and pregnancy-related care and expect the audit will be in production in 2025.

VI.L.2 - Substantial Compliance

"The County will provide pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or have an abortion."

ACH provides pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or terminate the pregnancy. If patients elect for termination, coordination with UCD occurs immediately and their team prioritizes patients to be scheduled based on their gestational age, as is done in the community.

VI.L.3 - Substantial Compliance

"The County will provide non-directive counseling about contraception to female prisoners, shall allow female prisoners to continue an appropriate method of birth control while incarcerated (with consideration given to the patient's preference and/or current method of birth control), and shall provide access to emergency or other contraception when appropriate."

ACH provides non-directive counseling about contraception to female prisoners, allows female patients to continue an appropriate method of birth control, provides access to emergency or other contraception when appropriate. All forms of contraception including Depo-Provera, COCs, Progesterone only pill, and IUDs are offered.

M. Transgender and Gender Non-Conforming Health Care

VI.M.1 - Partial Compliance

"The County shall implement policies and procedures to provide transgender and intersex prisoners with care based upon an individualized assessment of the patient's medical

needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate:

a) *Hormone Therapy*
b) *Surgical Care*
c) *Access to gender-affirming clothing*
d) *Access to gender affirming commissary items, make-up, and other property items"*

ACH has implemented policies and procedures to provide transgender and intersex patients with care based upon an individualized assessment of the patient's medical needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate:

- Hormone Therapy
- Surgical Care
- Access to gender-affirming clothing
- Access to gender affirming commissary items, make-up, and other property items

For continuity of care, patients who are identified as receiving hormone treatment from a community licensed provider continue the medication while incarcerated. A provider will assess the patient and include the medication as part of the patient's treatment plan. This provision will be in substantial compliance when all patients who qualify are referred and seen in a timely manner at the gender-affirming clinic.

V1.M.2 - Substantial Compliance

"The County shall ensure that medical and mental health staff have specific knowledge of and training on the WPATH Standards of Care."

Mental Health staff worked with a consultant to develop training on the WPATH Standards of Care, LGBTQIA, and Health Equity. Feedback from medical, mental health and suicide prevention experts has been incorporated. In consideration of the medical expert recommendation, ACH has created additional slides regarding the WPATH standards in relation to ACH policy to be included in the training. The training was approved, and training began in March 2023. Newly hired staff are expected to complete it within three months of hire and trainings are offered about every four to six months.

As of December 2024, 95% of MH staff have completed LGBTQ+ WPATH Training.

As of December 2024, 69% of Permanent ACH staff and 3% of registry staff have completed LGBTQ+ WPATH Training.

ACH has hired a nurse educator and he began late December. He is in charge of maintaining required staff training and ensuring compliance moving forward. He has also retrained intake nurses on referring patients to the transgender affirming clinic during his most recent intake training.

N. Detoxification Protocols
V1.N.1 - Partial Compliance

"Within three months of the date the Remedial plan is issued by the Court, the County shall develop and implement protocols for assessment, treatment, and medication interventions for alcohol, opiate, and benzodiazepine withdrawal that are consistent with community standards."

ACH developed and implemented policies and protocols for assessment, treatment, and medication interventions for alcohol, opiate and benzodiazepine withdrawal that are consistent with community standards and in agreement/approval from court-appointed medical experts. ACH will continue to train RNs on withdrawal management ACH policies and SNPs, emphasizing monitoring timeframe based on acuity.

Electronic health record templates were revised to capture the latest changes.

A withdrawal monitoring unit was created in 6 East. It is an entire pod of patients identified at intake that will need withdrawal monitoring services. This allows the nurses easier access to patients in order to conduct their monitoring.

Withdrawal monitoring is being tracked daily by two MAT/withdrawal monitoring supervising registered nurses to ensure seven-day coverage and monitoring.

Two MAT nurses are assigned to withdrawal monitoring per shift.

Electrolytes have been placed in these units to assist patients with hydration, which may prevent emergency department send outs.

Staff developed an audit tool to evaluate withdrawal monitoring in the Main Jail booking loop in March 2022. Audits are completed monthly and a corrective action plan was issued due to delays in timely monitoring for the purpose of identifying and correcting issues with monitoring patients at risk of withdrawal.

ACH has been very proactive with overdose prevention by going from only continuing MAT with a valid prescription to a full MAT induction program at the jail. The following efforts have taken place:

- All providers are required to provide MAT services.
- MAT providers are assigned to take calls from nurses to continue MAT medications during weekdays. After hours, standby providers order bridge treatment.
- ACH has been participating in a MAT expansion grant through Health Management Associates (HMA). It was decided that the funding would be used to purchase suboxone and pilot MAT inductions at the Main Jail. The pilot

population was for those testing positive for fentanyl or admitting to using fentanyl at intake. In addition to the funding, HMA has been an incredible resource for ACH in providing technical assistance and training to staff.

ACH worked with County Behavioral Health Leadership and obtained $1 Million dollars in opioid settlement funds to roll out a full MAT induction program. This funding has extended into the current fiscal year.

All patients who have disclosed recent opiate use are offered a MAT assessment and provided MAT services as medically indicated. All patients who were previously incarcerated before the induction rollout have received the same assessment and have been inducted if appropriate.

On October 15, 2023, MAT induction housing was established at the Main Jail. ACH has been successful in hiring addiction medicine specialists to staff the induction unit daily and to provide ongoing training and assistance to other providers.

ACH staff continue to work with SSO to procure and download SUD education groups onto patient tablets. ACH plans to purchase a full video curriculum of relapse prevention/education groups. This will be available to all patients, which will assist the limited number of SUD counselors to focus on discharge planning efforts.

ACH and SSO meet weekly to discuss MAT induction housing to identify and resolve any issues that arise.

Providers and nursing staff are required to watch an initial Sublocade administration training video before administering the medication.

Due to the diversion that exists with this medication, ACH has created a medication diversion note that informs the providers of the details of the incident so they can speak with the patient to determine how to prevent future diversion. If diversion continues, patients are offered Sublocade as a preferred alternative to discontinuing the medication.

HMA has featured Sacramento County’s MAT program several times at learning collaboratives and national trainings.

Narcan has been placed in housing units directly available to inmates, and in control rooms.

Withdrawal and detox policies and procedures, SNPs as well as MAT induction guidelines, are being revised with the input of addiction medicine trained physicians as well as nursing staff. Fixed dose treatment regimens for alcohol withdrawal as well as benzodiazepine withdrawal have been in place and part of the protocol. For opioid withdrawal, all

medications are fixed dose, with the exception of Loperamide, which is currently used as needed for diarrhea.

Intake forms are being modified to enhance clarity regarding substance use history, withdrawal history, and time of last use, and nurses will be trained on which patients need to urgently be evaluated by the addiction provider within 24 hours.

Early in the upcoming monitoring period, addiction medicine trained physicians will hold trainings for intake nursing staff as well as withdrawal monitoring nursing staff once the new policies and SNPs are finalized. Trainings will include clear guidance regarding CIWA and COWS assessments.

VI.N.2 - Partial Compliance

"The protocols shall include the requirements that:

- *i. nursing assessments of people experiencing detoxification shall be done at least twice a day for five days and reviewed by a physician.*
- *ii. nursing assessments shall include both physical findings, including a full set of vital signs, as well as psychiatric findings.*
- *iii. medication interventions to treat withdrawal syndromes shall be updated to provide evidenced-based medication in sufficient doses to be efficacious.*
- *iv. the County shall provide specific guidelines to the nurses for intervention and escalation of care when patients do not respond to initial therapy; and*
- *v. patients experiencing severe-life threatening intoxication (an overdose), or withdrawal shall be immediately transferred under appropriate security conditions to a facility where specialized care is available."*

For VI.N.2.i, ACH worked in collaboration with custody at the Main Jail to designate a specific housing pod for a detox unit to support consistent withdrawal monitoring because of a decreased need for quarantine pods. Two RNs are designated for MAT services and designated nurses are assigned to administer medications daily. Due to the implementation of the detox units, twice-daily checks are improving and being closely monitored.

For VI.N.2.ii, nursing assessments include both physical findings, including a full set of vital signs, as well as psychiatric findings. If patients refuse their withdrawal monitoring checks, the RN goes to the cell and has SSO open the door. The nurse will attempt to engage the patient and get as much information on their status as they can.

For VI.N.2.iii, medication interventions have been updated to treat withdrawal syndromes and in sufficient doses to be efficacious. ACH medical leadership will develop a protocol for starting patients on opiate withdrawal medications at intake based on history and self-reporting– rather than solely dependent upon assessment scoring. ACH will continue to discuss initiating medications at intake for patients not yet in alcohol and benzodiazepine

withdrawal with experts, custody, and County Counsel due to patient safety concerns related to compounding depressants as well as risks associated with quick releases from custody.

For VI.N.2.iv, detoxification protocols are in place to instruct nurses on intervention and escalation when needed.

For VI.N.2.v., nurse intake screening will declare patients experiencing life-threatening intoxication unfit and send them to the ER for appropriate treatment. For those experiencing life-threatening withdrawal post intake – the nurse conducting monitoring will alert SSO and providers of the need to transport to the ER when identified. The unfit criteria was recently updated and the Medical Director trained all nursing staff.

The MAT policy was revised in December 2023. The minimum requirement for Withdrawal (WD) monitoring is twice per day for the prescribed number of days for the designated medication.

During this reporting period, a second SRN was assigned to WD monitoring. This area now has seven day per week coverage and oversight. A major emphasis has been placed on the WD monitoring nurses to conduct their assessments timely and according to the order. ACH now tracks and reports weekly on the number of twice daily monitoring and six- hour monitoring that occurs with WD. ACH monitoring percentages have greatly increased. The provider stationed on the WD monitoring floor (6th) has been assigned to making daily rounds five days per week. On the weekends, an onsite MAT provider sees the patients who are most critical.

There have also been significant changes made to the "sobering cell", now called "medical observation cell" (MOC). This assessment will ensure that there is a face-to-face encounter between the medical staff and the patient which allows ACH to ensure patient safety during this potentially high-risk time. ACH and SSO meet weekly to problem-solve and discuss any issues that arise.

O. Nursing Protocols

The Remedial Plan states that SNPs shall include assessment protocols that are sorted based on symptoms into low, medium, and high-risk categories. As of right now, each SNP notes symptoms RNs may manage, those requiring a provider consult, and those that require emergency stabilization. ACH will continue to work on categorizing SNPs this way as required.

A total of 52 SNPs have been created and are available on the Intranet site. They include SNPs in the functional areas listed below.

- General (1)
- Abdominal (1) – Medical Expert feedback received 08/05/22
- Allergies (1)
- Cardiovascular & Lung (7)

- Dental (1)
- Endocrine (1)
- Eyes, Ears, Nose & Throat (5)
- Infection Control (1)
- Musculoskeletal (2)
- Neurological (4)
- Pregnancy (1)
- Skin (13)
- Substance Use Disorders (4) – Medical Expert feedback received 04/20/22
- Urological (5)
- Sexually Transmitted Infections (5) – Medical Expert feedback received 11/18/22

Nurse managers are reviewing other areas that may require SNPs. Registered nurses have completed SNP testing for all SNPs which are current. Nursing is currently updating all SNPs into a new format, which will also serve as a contingency form. The new format is currently awaiting the medical expert's feedback and approval.

After receiving the medical expert's feedback and approval, the template will be uploaded and available in the EHR.

VI.O.1 - Partial Compliance

"Nurses shall not act outside their scope of practice."

The nursing director oversees two senior health program coordinators (nurse managers) responsible for overseeing nursing staff at each respective jail facility for continuity to overall nursing services. Nursing has 14 supervising registered nurses (SRNs) directly supervising nursing staff and daily operations.

Regularly scheduled meetings with nurse managers (senior health program coordinators and SRNs) and meetings with direct nursing staff include trainings on policies and procedures, review of QI audits and corrective action plans to strategize problem solving around areas of concern, announcements, etc.

Nursing position standards were created or revised for the senior health program coordinators (Sr HPCs), supervising registered nurses, infection prevention coordinator, registered nurses, licensed vocational nurses, medical assistants, and certified nursing assistants.

Supervisory oversight and training help ensure that nurses do not act outside their scope of practice. Nurses shall demonstrate proficient knowledge, experience, and training in nursing principles and practices. They must maintain competency in performing nursing standardized procedure functions.

Nursing Services has designated a supervising RN as staff development coordinator to ensure hiring, onboarding, and retention of nurses.

The new nurse educator will be revamping the onboarding process to include a comprehensive initial new-hire orientation, competency and skills check, and preceptorship.

The nursing director conducts concurrent medical chart reviews for nursing documentation and application of nursing practice. Staff who are not in compliance with policies and procedures receive additional training and mentorship as needed.
The training coordinator (QI SRN) has begun implementing trainings for nursing and will be able to increase training to nursing staff during the next monitoring period.
SRNs make daily rounds to ensure efficiencies and competencies of nursing staff.
SRNs and Sr HPCs review encounter from the EHR to ensure productivity.

The nursing director created and implemented daily staff assignments for both facilities, ensuring all the positions/assignments are covered.

VI.O.2 - Partial Compliance

"To that end, the County shall revise its nursing standardized protocols to include assessment protocols that are sorted, based on symptoms, into low, medium, and high-risk categories.

a) Low-risk protocols would allow RNs to manage straightforward symptoms with over-the-counter medications;
b) Medium-risk protocols would require a consultation with a provider prior to treatment; and
c) High-risk protocols would facilitate emergency stabilization while awaiting transfer to a higher level of care."

A total of 52 SNPs have been completed consistent with this requirement; however, four Standardized Nursing Procedures have been finalized, six are in process of revision and development and 42 continue to be pending medical Expert review. The nursing director and medical director will continue to revise and reformat SNPs. Staff will be trained accordingly.

During this reporting period, at the recommendation of the SMEs, ACH hired a nursing consultant to assist with the revision of the nursing policies and nurse protocols. This consultant has already begun these revisions and the nurse educator will be training all nursing staff once changes have been approved.

During the next reporting period, the nurse educator will be creating a nursing onboarding curricula that will incorporate policies and SNPs in a user-friendly method. Documentation of all trainings and appropriate tracking will occur.

P. Review of In-Custody Deaths

VI.P.1 - Partial Compliance ↓

"Preliminary reviews of in-custody deaths shall take place within 30 days of the death and shall include a written report of the circumstances of the events leading to the death, with the goal to identify and remedy preventable causes of death and any other potentially systemic problems."

Preliminary reviews of in-custody deaths take place within 30 days of the death and include a written Clinical Mortality Review Report of the circumstances of the events leading to the death, with the goal to identify and remedy preventable causes of death and any other potentially systemic problems.

Leadership staff are notified when there is an in-custody death and review of the medical chart is initiated by key service line directors.

SSO in-custody death reviews shall happen as soon as possible, within 30 days. SSO Lexipol Policy on reporting in-custody deaths was published on 02/20/2024.

Due to the changes in how mortality reviews are being conducted and the depth of the review process, there have been several mortality reviews this reporting period that were slightly past the 30-day mark. As a result, the compliance rating for this provision has been decreased from Substantial Compliance to Partial Compliance. ACH expects that this will not be an issue moving forward and it will return to Substantial Compliance.

VI.P.2 - Partial Compliance

"Mortality reviews shall include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which might have contributed to the death, and the identification of problems for which corrective action should be undertaken."

Mortality reviews include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which may have contributed to the death, and the identification of problems for which corrective action should be undertaken.

ACH and SSO leadership and SSO began collaborating more closely on investigations surrounding the event. As a result, more comprehensive corrective action plans are being developed. ACH will continue to develop this provision.

During this reporting period, ACH has continued to refine and improve the depth of the mortality review process. This includes input from the nursing director to include nursing findings and corrective actions.

The framework for the review moving forward is to identify critical lapses in care and system issues that may have contributed to the patient's death.

Corrective action plans are more comprehensive and include responsible persons, timeframes for completion and the specifics of the plan. SSO has implemented its own corrective action plan that gets incorporated the documents produced by ACH.
ACH developed and implemented a tracking log and process that went into effect in February 2022.

ACH continues to schedule a joint administrative review meeting with custody leadership within ten days of a patient death to determine if any immediate actions are required. Monthly multidisciplinary meetings are scheduled recurring to review the episode of care and develop corrective action plans when indicated to address systemic or training issues. ACH has implemented a monthly mortality CAP meeting to monitor active corrective action plans until completed. This is an interdisciplinary approach that involves all parties. ACH reviewed and revised the "in custody death" policy. It is currently under reviewed by class counsel and the SMEs. They received it on 05/13/2024.

Key ACH staff are on the distribution list for coroner's reports. Death certificates are obtained from public health staff when available. ACH designee initiates request for death certificates if not received timely.

SSO has homicide detectives respond to all in-custody deaths.

Q. Reentry Services
VI.Q.1 - Substantial Compliance

"The County shall provide a 30-day supply of current medications to patients who have been sentenced and have a scheduled release date, immediately upon release."

Sentenced and court-ordered patients are provided a 30-day supply of prescribed medications when released. ACH staff are coordinating with SSO custody for more accurate lists of potential release candidates in order to increase medications delivered at release. An alert is entered into Athena(eHr) to indicate to custody that a patient must get medication prior to release.

Discharge medications continue to be provided to approximately 80% of eligible sentenced and 95% court-ordered patients upon release. Staff continue to work on the discharge medication release process with medical leadership and custody staff.

Planning discussions to support a 24-hour pharmacy at Main Jail during next fiscal year continue, which will increase medication distribution. ACH was approved for an additional

pharmacist and a pharmacy technician for the 24/25 fiscal year. Also, running reports in Athena that lists all sentenced patients on medication improves the notification process.

VI.Q.2 - Non-Compliance

"Within 24 hours of release of any patient who receives prescription medications while in custody and is classified as pre-sentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the patient's current prescription medications."

ACH was sending prescriptions to the Primary Care Clinic; however, this is no longer occurring. An evaluation of this practice revealed that less than 5% of patients picked up their medications from Primary Care Pharmacy. Due to the significance of the workload and the low rate of patients picking up prescriptions from Primary Care, Medical Directors discontinued this practice. Presentenced patients may request a prescription for a 30-day supply of medication and ACH will fill the prescription at the County's Primary Care Pharmacy. Upon patients arriving at Primary Care, pharmacy communicates with ACH pharmacy and/or 2nd floor MD office to acquire prescriptions. ACH is participating in joint efforts working with SSO regarding the upcoming CalAIM 90-day prerelease benefit, which will include filling of prescriptions for those indicated upon release.

Notification from SSO custody prior to release is pertinent for preparation of medication upon release.

ACH has established an email box for county public defenders, conflict attorneys and district attorneys to communicate releases and patient medication needs. This has been a useful tool to learn quickly about same day releases. This email is monitored daily.

Filling prescriptions prior to release will increase the continuity of care as compared to sending the script to an offsite pharmacy.

Sacramento County developed and submitted a CalAIM implementation plan in March 2024 that focuses on reentery services for the justice involved population. ACH is currently working on a readiness assessment that is required by CalAIM before they greenlight the county to implement the CalAIM 90 day Prerelease program. The program is expected to go live in 2025.

With the requirements of the 1115 waiver mandating all patients leaving the jail have a 30-day supply in hand, ACH intends to fully utilize the 24-hour pharmacy to meet this demand. ACH is currently hiring a NOC shift pharmacist and pharm tech who will consistently monitor releases real-time in coordination with SSO for them to have release meds.

VI.Q.3 - Partial Compliance

"The County, in consultation with Plaintiffs, shall develop and implement a reentry services policy governing the provision of assistance to chronic care patients, including outpatient referrals and appointments, public benefits, inpatient treatment, and other appropriate reentry services."

ACH developed and implemented a discharge planning for reentry services policy governing the provision of assistance to chronic care patients, including outpatient referrals and appointments, public benefits, inpatient treatment, and other appropriate reentry services. The discharge planning policy was revised to become a joint policy with mental health and incorporates expert feedback.

ACH meets internally and participates in county-wide meetings to address obstacles to improve discharge planning and successful linkage to ongoing care. Collaboration between ACH medical and mental health, SSO custody, the courts, community partners such as Community Health Works (formerly known as Sacramento Covered) for ongoing medical needs and County Behavioral Health for individuals with serious mental illness (SMI) is necessary for successful discharge planning.

A designated discharge planning nurse and MA work with patients with complex conditions to ensure there is continuity of care post-release.

SUD counselors work with patients in need of continuity of SUD treatment and MAT. However, with the increase in MAT inductions, it became clear that ACH needed dedicated MAT discharge planners to connect patients to MAT programs upon release. The HSA, QI director, and budget analyst applied for a grant through the Board of State and Community Corrections (BSCC) to fund two of these positions (one for each jail). Sacramento County was awarded this grant, but funds were not approved in the California State budget. The onsite contracted SUD counselors are incorporating these connections in their scope.

Mental health staff are required to provide linkage of patients with SMI to county mental health – a workflow was created and MH staff were trained on the referral process. County behavioral health established the Community Justice Support Program – a full-service partnership to serve justice-involved patients with serious mental illness. ACH mental health meets regularly with the program leadership to address barriers and collaborate on the referral process. A report was developed to capture the projected release date and level of care to identify patients with SMI and release dates within six weeks.

Medi-Cal managed care plans rolled out a new benefit under the initiative California Advancing and Innovating Medi-Cal (CalAIM). CalAIM provides enhanced care management (ECM) and coordination for patients with intensive health/mental health

needs. The CalAIM program in Sacramento County was expected to roll out in January 2025 but is now extended to June 2025. This is a major initiative that will require many additional staff. ACH is working on a request and hopes to advance this during the next reporting period.

Sacramento County was awarded the Reentry Opportunities and Access to Resources (ROAR) program through a Proposition 47 grant. The primary focus will be on the population leaving jail within the first three days; it is expected to be implemented in the next reporting period and will offer expanded access to mental health and substance use prevention and treatment services as well as housing linkages.

This provision remains in Partial Compliance due to the need for more discharge planners.

R. Training
VI.R.1 - Partial Compliance

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:

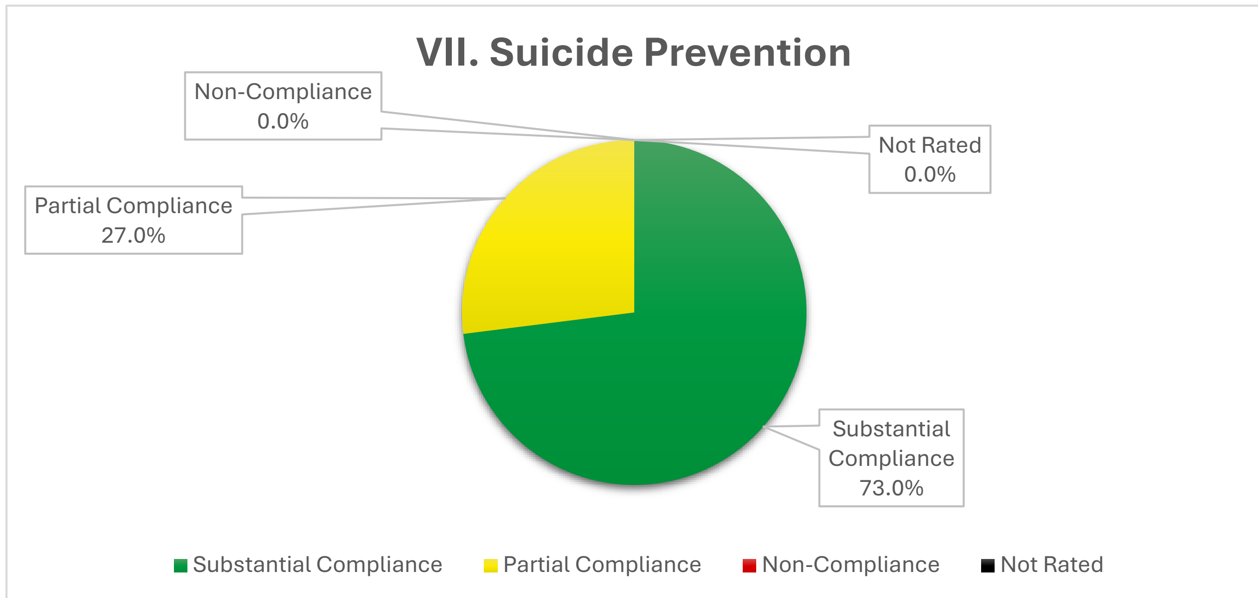
a) All jail custody staff shall receive formal training in medical needs, which shall encompass medical treatment, critical incident response, crisis intervention techniques, recognizing different types of medical emergencies, and acute medical needs, appropriate referral practices, relevant bias and cultural competency issues, and confidentiality standards. Training shall be received every two years, at minimum."

ACH collaborates with SSO on training as requested. The ACH Medical Director has created a didactic training for staff on critical incident response. All SSO staff at MJ were trained in June 2024. RCCC SSO staff were trained in July 2024. During the next reporting period, the medical director or delegate and the new nurse educator will work together to develop and implement the required curricula.

No one class encompasses all requirements of this provision every two years. All sheriff deputies attend a 6-month academy with specific learning domains covering bias and discrimination (LD 42) and First Aid and CPR (LD 34). Updated nine hours of medical emergency and CPR training is done every two years.

All custody staff receive eight hours crisis intervention. Specialized units, especially those assigned to designated mental health units, receive additional training relevant to their assignment. SSO and ACMH plan to hold more formal, joint training in 2025 encompassing these topics. SSO will work to address corrections-specific medical issues, referral practices, and bias in a two-year training cycle.

VII. Suicide Prevention



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	46 (73%)	46 (73%)
Partial Compliance	15 (23.8%)	17 (27%)
Non-Compliance	1 (1.6%)	0 (0%)
Not Rated	1 (1.6%)	0 (0%)
Total Provisions	**63**	**63**

Attachment 11, Suicide Prevention Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

A. Substantive Provisions

VII.A.1 - Substantial Compliance

"The County recognizes that comprehensive review and restructuring of it suicide assessment, monitoring, and prevention practices are necessary to address the risk of suicide and self-harm attendant to detention in a jail setting."

A Custody Instructions form was created to provide MH staff directions regarding housing, observation level, property, privileges, and clothing restrictions. MH developed a training module called Suicide Precautions and LCSW Role and provided training to MH staff and custody leadership on the form and workflow. Morbidity and Mortality (M&M) reviews were implemented during Suicide Prevention Subcommittee meetings in December 2021.

ACMH updated MH PP 04-07 Acute Psychiatric Unit Precautions and Observations to include relevant sections from the Suicide Prevention Program policy; this was finalized in June 2022.

ACMH completes weekly audits on MH compliance on determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to the Suicide Prevention Subcommittee on monthly basis. ACMH implemented the Constant Observation Program and have filled all vacancies. Staff are available 24/7 to provide 1:1 constant observation.

ACMH developed workflow and implemented procedures for posting suicide precaution forms outside of patient cells in APU. ACMH developed a process to restrict OTC and KOP medications in MH housing units (IOP, APU, SITHU) as a suicide prevention measure.

ACMH is working with ACH to embed the Suicide Risk Assessment into the MH Clinical SOAP note. This will improve consistency of documentation, ease of locating SRA, and eliminate duplication/redundancy of documentation.

Audit findings indicate MH is meeting substantial compliance when determining and documenting housing, observation level, property, privileges and clothing restrictions for patients place on suicide precautions. Due to meeting substantial compliance, SP SME determined audit could be completed on quarterly vs monthly cycle.

ACMH implemented monthly Suicide Prevention Multidisciplinary meetings to discuss patients with complex mental health needs who engage in self-injurious behaviors (July 2022). MH staff received updated training on the new process of developing safety plans at the time of a Suicide Risk Assessment (SRA) evaluation starting in January 2023. All MH staff have been trained and a compliance audit was completed to identify areas for process improvement.

Audit results of Suicide Risk Assessment and Safety Planning from Mar-May 2025 are as follows:

- MH completed a suicide risk assessment for 100% (60/60) of patients referred for being a danger to self.
- 83% (10/12) of patients placed on suicide precautions had a safety plan completed at the time of initial SRA. Of the two patients with no safety plan, one had a completed safety plan once they were cleared from suicide precautions.
- 100% (19/19) of charts had a completed suicide risk assessment for patients discharged from suicide precautions.
- 89% (17/19) of charts had completed safety plans for patients discharged from suicide precautions. This is an 18% increase from the last report period.

The SSO Suicide Prevention and Intervention Policy and Procedure 713 were updated on 09/12/2023 and 2/14/24 respectively.

VII.A.2 - Substantial Compliance

"The County shall establish, in consultation with Plaintiffs' counsel, a new Suicide Prevention Policy that shall be in accordance with the following: [see section B. Training]."

County ACH Mental Health established a Suicide Prevention Policy in agreement/approval with Class Counsel and the court-appointed Experts. SSO Suicide Prevention and Intervention Policy and Procedure 713 was updated on 09/12/2023.

B. Training

VII.B.1 - Partial Compliance

"The County shall develop, in consultation with Plaintiffs' counsel, a four-to-eight-hour pre-service suicide prevention curriculum for new Jail employees (including custody, medical, and mental health staff), to be conducted in person in a classroom or virtual classroom setting, that includes the following topics:

a) avoiding obstacles (negative attitudes) to suicide prevention;
b) prisoner suicide research;
c) why facility environments are conducive to suicidal behavior;
d) identifying suicide risk despite the denial of risk;
e) potential predisposing factors to suicide;
f) high-risk suicide periods;
g) warning signs and symptoms;
h) components of the jail suicide prevention program
i) liability issues associated with prisoner suicide;
j) crisis intervention."

County ACH MH developed and implemented a four-hour Suicide Prevention training for new Jail employees (including SSO Custody, medical, and mental health staff) in agreement and approval from Class Counsel and court-appointed Experts.

The four-hour Suicide Prevention Training for new employees was approved by Class Counsel and Suicide Prevention Expert in February 2022. MH staff worked with custody and medical staff to prepare for the training. The first training was conducted on June 2, 2022, and is ongoing. Staff are required to attend training within three months of hire.

As of December 2024, 94% of MH staff are compliant with the four-hour training requirement.

As of December 2024, 90% of Permanent ACH staff are compliant with the four-hour training requirement. However, 90% of registry staff are out of compliance with this requirement.

Since ACH relies heavily on registry staff, many who work minimal hours per month – compliance numbers are not sufficient for compliance. To improve this, ACH is working on changing registry contract language to include this as a requirement prior to starting. During this reporting period, ACH and ACMH met with the Suicide Prevention SME and agreed that ACH can move forward with a virtual option for the 4-hour training. This is an impactful change and ACH anticipates it will help medical compliance numbers significantly.

As part of pre-service training, the Adult Corrections Officer Supplemental Core Course has been revised where Module 19.0 addresses suicide prevention. This section has been approved by the Board of State & Community Corrections (BSCC) as well as the Standards and Training for Corrections (STC).

All current employees have received the 2-hour suicide prevention training developed in collaboration with the mental health SMEs. New employees have received the 4-hour suicide prevention training since May 22, 2022.

SSO Lexipol Procedure on Suicide Prevention and Intervention was updated on 02/24/2024.

VII.B.2 - Partial Compliance

"The County shall develop, in consultation with Plaintiffs' counsel, a two-hour annual suicide prevention curriculum for all custody, medical, and mental health staff, to be conducted in person in a classroom or virtual classroom setting, that includes:

a) *review of topics (a)-(j) above*
b) *review of any changes to the jail suicide prevention program*
c) *discussion of recent jail suicides or attempts"*

County developed a two-hour annual Suicide Prevention Training for all staff (SSO Custody, medical, and mental health staff) in agreement and approval from Class Counsel and court-appointed Experts.

MH began offering a two-hour Suicide Prevention training to medical and custody staff in December 2021 and is ongoing. Staff attend on an annual basis.

As of December 2024, 94% of MH staff are compliant with the 2-hour training requirement.

As of December 2024, 63% of Permanent ACH staff and 97% of registry staff are compliant with the 2-hour training requirement. This provision remains in Partial Compliance as Permanent ACH staff have not reached the 90% threshold.

SSO's Suicide Prevention and Intervention Policy was updated on 09/12/2023. Lexipol Procedure on Suicide Prevention and Intervention was published on 02/14/2024.

The Morbidity and Mortality (M&M) workgroup meets regularly to review serious suicide attempts. Once reviews are completed, the results, findings and recommendations are reported to the Suicide Prevention Subcommittee. There is also a Suicide Precautions Multidisciplinary Team Meeting to discuss management of inmates on suicide precautions which are particularly challenging.

VII.B.3 - Substantial Compliance

"Custody officers assigned to Designated Mental Health Units shall receive additional specialized training on suicide prevention and working with prisoners with serious mental illness."

All custody staff are required to take four hours of suicide prevention training, and SSO plans to require four hours combined of Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports. This training is in addition to mental health training received in the POST Basic Academy, Corrections Supplemental Core Course, and SSO mandated 24-hour Crisis Intervention Training.

Custody officers assigned to Designated Mental Health Units receive additional specialized training on suicide prevention and working with prisoners with serious mental illness. IOP and JBCT Deputies receive 24 hours of advanced CIT training. Several IOP/JBCT Deputies also attended negotiation training specific to custody.

VII.B.4 - Substantial Compliance

"All mental health staff, including nurses, clinicians, and psychiatrists, shall receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation."

All mental health staff, including clinicians, and psychiatrists, receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.

The Suicide Risk Assessment Training was approved by SME. Staff complete the training within three months of hire and again every two years.

As of December 2024, 90% of MH staff are compliant with required Suicide Risk Assessment training.

VII.B.5 - Substantial Compliance

“All mental health staff and custody officers shall be trained on the appropriate use of safety suits—i.e., not to be utilized as a default, not to be used as a tool in behavior management, not to be utilized for patients being observed at 30-minute observations.”

All mental health staff and custody officers are trained on the appropriate use of safety suits—i.e., not to be utilized as a default, not to be used as a tool in behavior management, not to be utilized for patients being observed at 30- minute observations. This element has been incorporated into the Suicide Prevention Training.

Safety Suits are used at the discretion of ACMH based on collaboration with custody staff and not as a behavior management tool. MH monitors the use of safety suits through the Suicide Precautions Weekly Audit-Quarterly Report.

Results of audit findings from Aug-Oct 2024:

- Suicide precautions form is being completed 100% (152/152) of the time for each patient encounter.
- Clinical justification for removal of privileges and property is completed 100% (152/152) of patient encounters.
- MH is making recommendations regarding removal of clothing/safety smock in 100% (152/152) of patient encounters.

During the four hour and two hour Suicide Prevention Class, there is training and discussion about proper safety suit use consistent with this remedial plan.

SSO Lexipol Procedure on Suicide Prevention and Intervention was updated on 02/14/2024.

VII.B.6 - Substantial Compliance

“The County shall ensure that all staff are trained in the new Suicide Prevention Policy.”

For ACH, the Suicide Prevention Policy is incorporated in the Annual Suicide Prevention Training that is required for all staff.

For SSO, Suicide Prevention and Intervention Policy and Procedure 713 was updated on 09/12/2023. Staff are prompted to review and acknowledge the policy which is electronically recorded in Lexipol.

C. Nursing Intake Screening

VII.C.1 - Substantial Compliance

“Intake screening for suicide risk will take place at the booking screening and prior to a housing assignment. If clinically indicated, JPS will then perform an additional clinical assessment after the inmate is placed in a housing assignment.”

Intake screening for suicide risk takes place at the booking Receiving Screening and prior to a housing assignment. If clinically indicated, a referral is made to ACH MH, who will then perform an additional clinical assessment after the patient is placed in a housing assignment.

VII.C.2 - Substantial Compliance ↑

"All nursing intake screening shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

To resolve compliance issues, the County developed a comprehensive plan to restructure the arrest report room/medical intake area. DGS repurposed the current room where the breathalyzer is stored, a bathroom, an exam room and an office into four confidential medical intake spaces. This plan was shared in detail with the SME's and Class Counsel and the response was favorable in that it would meet requirements to achieve compliance. This project was completed during this monitoring period.

This provision is being increased from Non-Compliance to Substantial Compliance due to the redesigned intake area and new confidential intake rooms.

VII.C.3 - Substantial Compliance

"The County shall revise its nursing intake assessment procedures and screening forms to ensure timely identification of acute and high-risk mental health conditions, consistent with the recommendations made by Lindsey Hayes. Intake screening, as documented on screening forms, shall include:

- *a) Review of suicide risk notifications in relevant medical, mental health, and custody records, including as to prior suicide attempts, self-harm, and/or mental health needs;*
- *b) Any prior suicidal ideation or attempts, self-harm, mental health treatment, or hospitalization;*
- *c) Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness;*
- *d) Other relevant suicide risk factors, such as:*
    - *i. Recent significant loss (job, relationship, death of family member/close friend);*
    - *ii. History of suicidal behavior by family member/close friend;*
    - *iii. Upcoming court appearances;*
- *e) Transporting officer's impressions about risk."*

County ACH revised the nursing Intake assessment procedures and screening forms to ensure timely identification of acute and high-risk mental health conditions, consistent

with the recommendations made by the court-appointed Suicide Prevention Expert (Lindsey Hayes) to be consistent with this requirement.

Training has been developed for intake nurses on screening for mental health issues, suicide risk assessment screening, danger-to-self or others and grave disability and referral process for emergent MH evaluations. Formal Intake training by the Training Coordinator began December 2022.

During this reporting period, the nurse intake was revised to be conducted in two phases. The suicide risk questions were also revised in coordination with the SME. The questions are clearer and less redundant. They have automatic orders associated with them to be referred to MH staff depending on the answer from the patient.

VII.C.4 - Substantial Compliance

"Regardless of the prisoner's behavior or answers given during intake screening, a mental health referral shall always be initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration."

Regardless of a patient's behavior or answers given during intake screening, an automatic mental health referral is initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration.

VII.C.5 - Substantial Compliance

"The County shall develop and implement a written policy and procedure for referrals to mental health by intake staff. The policy shall correspond with the triage system and timeframes set forth in the Mental Health Remedial Plan."

County ACH updated and implemented the Nurse Intake policy and procedure that includes referrals to mental health by Intake staff. The policy corresponds with the triage system and timeframes set forth in the Mental Health Remedial Plan.

VII.C.6 - Substantial Compliance

"Any prisoner expressing current suicidal ideation and/or current suicidal/self-injurious behavior shall be designated as an emergent referral and immediately referred to mental health staff."

Any patient expressing current suicidal ideation and/or current suicidal/self-injurious behavior shall be designated as an emergent referral and immediately referred to mental health staff. There has been a significant increase in emergent referrals since nurse intake questions and orders were changed due to this provision.

Due to ongoing challenges with Intake nursing asking all suicide risk screening questions, QI Nursing began onsite monitoring of the nurse intake process, including suicide risk

assessment questions to ensure compliance with screening requirements. Nursing updated the intake form to auto generate referrals for patients expressing suicidal ideation or at risk.

D. Post-Intake Mental Health Assessment Procedures

VII.D.1 - Partial Compliance

"All mental health assessments shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

MH clinicians document whether assessments are confidential or non-confidential including rationale.

During this reporting period, confidential booths comprised of plexiglass enclosures with doors were installed in the indoor area of each housing unit. Privacy curtains will be added in the upcoming reporting period to increase privacy in some booths. With the installation of interview booths completed in October 2024, MH has seen an increase in the number of confidential contacts at the Main Jail. In September 2024, an average of 66% of contacts were confidential. Following installation of the booths, in November 2024, an average of 81% of contacts were confidential. On many floors, confidential contacts were in the 90% range.

VII.D.2 - Partial Compliance

"Mental health staff shall conduct assessments within the timeframes defined in the mental health referral triage system."

Auditing of MH compliance meeting four (4) and six (6)-hour timelines to care is being completed and presented to MH QI Subcommittee and Suicide Prevention Subcommittee. MH continues to work towards meeting timelines to care. The high number of referrals for both emergent and urgent assessments has increased significantly. In May 2024, supervisors started assigning caseloads to staff to prioritize patients being seen in a timely manner.

During the period of Jun-Aug 2024:

- 35% of patients were seen within the four-hour timeline to care for Emergent referrals for safety cell placement
- 45% of patients were seen within the six-hour timeline to care for Emergent referrals for sobering/segregation cell placements

A comparison between the last report, Mar-May 2024, and this current period indicated that MH experienced increased referrals for:

- Emergent 24-hours, referrals increased by 46% (from 1,631 to 2,388).

- Urgent 36-hours, referrals increased 5% (from 1,981 to 2,081).

VII.D.3 - Substantial Compliance

"The County shall revise its mental health assessment procedures and related forms to ensure identification of historical and current patient mental health and suicide risk information, consistent with the recommendations of the subject matter expert."

MH has revised its mental health assessment procedures and related forms to ensure identification of historical and current patient mental health and suicide risk information, consistent with the recommendations of the subject matter expert.

Nursing Intake and SRA forms have been updated and approved by SME.

MH worked with ACH and embedded the Suicide Risk Assessment into the MH Clinical SOAP note. This will improve consistency of documentation, ease of locating SRA, and eliminate duplication/redundancy of documentation.

E. Response to Identification of Suicide Risk or Need for Higher Level of Care

VII.E.1 - Partial Compliance

"When a prisoner is identified as at risk for suicide and placed by custody staff in a safety cell, on suicide precautions, and/or in a safety suit, mental health staff shall be contacted immediately. A qualified mental health professional, or other appropriately trained medical staff in consultation with mental health staff, shall complete a confidential in-person suicide risk assessment as soon as possible, consistent with the "must-see" referral timeline."

Regular auditing of MHs compliance meeting four (4) and six (6)-hour timelines to care are being completed and presented to MH QI Subcommittee and Suicide Prevention Subcommittee. Findings indicated that low staffing levels and high levels of emergent referrals are impacting compliance.

When ACMH assessments are conducted, the maximum level of privacy is afforded given the case-by-case safety risk. At Main Jail, a private booking attorney booth has been converted to be utilized as a confidential interview room for Mental health assessments. Structural space issues exist at both facilities. Neither has enough confidential treatment space to become fully compliant.

On MJ housing floors, booths consist of plexiglass enclosures with doors are now situated in the indoor rec area of each housing unit. Some booths have a partition for safety as well as a security desk/chair.

SSO has purchased a specialty security desk/chair, which allows leg shackles to be secured. This allows clinicians to safely speak to higher security inmates in privacy without custody staff standing nearby.

Custody staff place the inmate/patient in the least restrictive setting as possible contingent on available space. Staff constantly attempts to move inmate/patients out of safety cells to segregation cells (toilet and sink) or a 3-West suicide resistant SITHU cell. 16 cells on the lower tier of 3-West 200 pod have been modified to provide additional suicide resistant cells.

RCCC has offices designated for mental health evaluations.

VII.E.2 - Substantial Compliance

"Consistent with current RCCC policy, if there is no mental health staff on site at RCCC at the time that an emergent mental health need is identified, the prisoner shall be transported to the Main Jail for emergency evaluation within two hours of the initial report."

MH provides a televisit option for after-hours emergent referrals. If a Main Jail MH clinician is not available to complete the televisit assessment, SSO transports the patient to the Main Jail for an evaluation.

VII.E.3 - Substantial Compliance

"The County shall revise its JPS suicide risk assessment procedures and forms in consultation with Plaintiffs. The County shall ensure that its JPS suicide risk assessment process, policies, and procedures consider and document the following:

- *a) Review of suicide risk notifications and records from any previous incarcerations at the Jail, including records pertaining to suicide attempts, self-harm, and/or mental health needs;*
- *b) Other prior suicide ideation or attempts, self-harm, mental health treatment or hospitalization;*
- *c) Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness;*
- *d) Suicide risk factors and protective factors, such as:*
    - *i. Recent significant loss (job, relationship, death of family member/close friend);*
    - *ii. History of suicidal behavior by family member/close friend;*
    - *iii. Upcoming court appearances;*
- *e) Transporting officer's impressions about risk;*
- *f) Suicide precautions, including level of observation."*

The Suicide Risk Assessment captures the information listed in this provision.
Suicide Risk Assessment and Suicide Prevention Program policy developed and revised in conjunction with SME and Class Counsel.

MH staff complete a review of the patients EHR, including previous and current records pertaining to suicide attempts, self-harm and/or mental health needs.

See Post-Intake Mental Health Assessment Procedures (Provision D.) for work accomplished in this area.

VII.E.4 – Substantial Compliance ↑

"The County shall ensure that the meal service schedule or other custody-related activities cause no delay in the completion of suicide risk assessments for prisoners."

A recent Court-Appointed Monitor report found this provision to be in Substantial Compliance. Per ACH, SRAs take priority and MH staff are able to see patients without custody related delays. Prior to this reporting period, no compliance rating had been assigned for this provision.

F. Housing of Inmates on Suicide Precautions

VII.F.1 - Substantial Compliance

"The County's policy and procedures shall direct that prisoners, including those identified as being at risk for suicide, be treated in the least restrictive setting appropriate to their individual clinical and safety needs. "

ACMH policies state all patients, including those identified as being at risk for suicide, are treated in the least restrictive setting appropriate to their clinical needs.

In October 2024, ACMH, in consultation with SMEs, implemented the Critical Needs Assessment Program (CNAP). The CNAP provides intensive services to patients who have reported suicidal ideation and/or engaged in chronic self-injurious behaviors but do not meet criteria for inpatient treatment on the Acute Psychiatric Unit (APU) for danger to self pursuant to W&I Code 5150. The goal of the program is patient stabilization and return to assigned housing/program or higher level of care if clinically indicated. The CNAP program is located in the SITHU.

G. Inpatient Placements

VII.G.1 - Partial Compliance

"The County shall ensure that prisoners who require psychiatric inpatient care as clinically indicated are placed in the 2P unit within 24 hours of identification, absent exceptional circumstances. In all cases, the provision of clinically indicated treatment to any prisoner requiring inpatient level of care shall be initiated within 24 hours."

MH staff ensures that patients are assessed for the APU and placed in the unit as soon as possible and within 24 hours when there is bed availability. Patients who are on the pre-

admission list beyond 24 hours are assessed daily for continuous need of placement or clearance. MH meets daily to discuss patients pending APU admission and triage level of care.

In October 2024, ACMH, in consultation with SMEs, implemented the Critical Needs Assessment Program (CNAP). The CNAP provides intensive services to patients who have reported suicidal ideation and/or engaged in chronic self-injurious behaviors but do not meet criteria for inpatient treatment on the Acute Psychiatric Unit (APU) for danger to self pursuant to W&I Code 5150. The goal of the program is patient stabilization and return to assigned housing/program or higher level of care if clinically indicated. The CNAP program is located in the SITHU.

ACH has regular meetings with SSO Custody leadership to discuss space needs and options for increasing APU beds.

Facility deficiencies result in this area remaining non-compliant due to insufficient space for APU beds. On December 8, 2022, the Sacramento Board of Supervisors approved to build a Jail Intake and health Services Facility as well as make ADA facility improvements to the current Jail. The project is currently undergoing a peer review; the results of the peer review are expected in the next reporting period. The inpatient unit will be designed to comply with this 24-hour requirement. An interim solution of converting an existing Main Jail housing pod to an expanded psychiatric inpatient unit will assist with moving toward compliance with the 24-hour requirement. IOP level of care has been expanded which can help reduce inpatient care requirements.

H. Temporary Suicide Precautions
VII.H.1 - Partial Compliance

“No prisoner shall be housed in a safety cell, segregation holding cell, or other Temporary Suicide Precautions Housing for more than six (6) hours. If mental health or medical staff determine it to be clinically appropriate based on detoxification-related needs, this time limit may be extended to no more than eight (8) hours. If exceptional circumstances prevent transfer within these timelines, those circumstances shall be documented, and transfer shall occur as soon as possible. This does not preclude the housing of a prisoner in the IOP unit if clinically indicated.”

The County currently follows these timeframes as much as possible with the limited number of cells in the APU. Custody staff places the inmate/patient in the least restrictive setting as possible contingent on available space. Staff constantly attempts to move inmate/patients out of safety cells to segregation cells (toilet and sink) or a 3-West suicide resistant SITHU cell. The Main Jail has a total of 26 SITHU cells available.

The addition of 23 female and 20 male IOP beds at the Main Jail and 48 IOP beds at RCCC has improved compliance. There is a planned expansion for an additional 24 male IOP beds at RCCC and 10 female beds at MJ. This is projected to be completed in May 2025. Other large construction, such as the proposed Intake and Health Services Facility, will assist in achieving compliance in this area.

VII.H.2 – Substantial Compliance ↑

"The County shall ensure, including by revising written policies and procedures where necessary, the timely and adequate completion of medical assessments for prisoners in need of suicide precautions, as required under Operations Order 4/05 (i.e., within 12 hours of placement of the next daily sick call, whichever is earliest, and then every 24 hours thereafter)."

Custody staff shall notify medical staff within fifteen (15) minutes that a prisoner is temporarily housed in a safety or segregation cell and medical staff shall complete an assessment within 12 hours of placement or the next sick call, whichever is earliest.
ACH revised the Mental Health policy 04-09 Acute Psychiatric Unit Admission, Program and Discharge (revision 11/30/22) to include procedures to ensure the timely and adequate completion of medical assessments for patients in need of suicide precautions. The ACH suicide prevention policy exceeds the requirements of this provision by stating that medical assessments are conducted "within one hour of placement and every four hours thereafter."

Patients are receiving a medical assessment within 12 hours of placement and every 24 hours after; these assessments are documented in Nurse Sick Call encounters.
If the patient is not transferred to the APU, the nurse continues to evaluate the patient. The APU Certified Nursing Assistant will monitor the patient once they move to the APU.
Due to the language used in written policies and procedures as well as the recent Court-Appointed Monitor assessment, the compliance rating for this provision is being increased from Partial Compliance to Substantial Compliance.

VII.H.3 - Substantial Compliance

"The County shall ensure that any cell used for holding prisoners on suicide precautions is clean prior to the placement of a new prisoner, as well as cleaned on a normal cleaning schedule."

SSO Lexipol Policy on Safety, Separation, and Sobering Cells was published on 05/21/2024.

VII.H.4 - Substantial Compliance

"The County shall create and implement a written policy ensuring adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting when a prisoner is in cell used for holding prisoners on suicide precautions."

SSO added the required language to its Suicide Prevention policy.

VII.H.5 - Substantial Compliance

"Inmates on suicide precautions shall not automatically be on lockdown and should be allowed dayroom or out-of-cell access consistent with security and clinical judgments."

This language has been included in the updated Suicide Prevention policy. Monthly audits are conducted by the Main Jail IOP supervisor for those inmates housed in the SITHU. Audits include access to showers and out of cell time and are shared with the Suicide Prevention subcommittee.

VII.H.6 - Substantial Compliance

"The classrooms or multipurpose rooms adjacent to the housing units in the Main Jail are designed for, and should be made available for, prisoner programs and treatment. Absent an emergency, the County shall not use the classrooms and multipurpose rooms to hold prisoners pending a mental health evaluation or on suicide precautions. Where such emergency occurs, the County shall document the reasons for retention and move the prisoner, within six (6) hours, to the inpatient unit or other appropriate housing location for continued observation, evaluation, and treatment."

Classrooms are only being used for programs and treatment and no longer used to hold patients pending an evaluation or on suicide precautions.

I. Suicide Hazards in High-Risk Housing Locations

VII.I.1 - Substantial Compliance

"The County shall not place prisoners identified as being at risk for suicide or self-harm, or for prisoners requiring IOP level of care, in settings that are not suicide-resistant as consistent with Lindsay Hayes's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities.""

Inmates at risk for suicide, self-harm, or IOP level of care are housed in suicide resistant cells.

VII.I.2 - Substantial Compliance

"Cells with structural blind spots shall not be used for suicide precaution."

This has been incorporated into SSO's Suicide Prevention policy. The Main Jail has a total of 26 SITHU level cells available. The IOP deputies that work in this area do not use the corner cells, those with a partially obstructed view, for those inmates who are suicidal. The safety cells used in booking have an unobstructed view.

J. Supervision/Monitoring of Suicidal Inmates

VII.J.1 - Partial Compliance

"The County shall ensure adequate visibility and supervision of prisoners on suicide precautions."

SSO expanded the number of suicide resistant observation cells in the Suicidal Temporary Housing Unit (SITHU) at the Main Jail. This provision remains in Partial Compliance due to inadequate space and staff to provide Constant Observation. This will be addressed with the installation of the Security Corridor on the 3W 200 pod.

VII.J.2 - Substantial Compliance

"The County shall not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a prisoner on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need."

Lexipol Procedure on Suicide Prevention and Intervention was published on 02/14/2024. Through continuous supervision provided by the on-duty Sheriff's Sergeant, SSO ensures that custody staff does not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a prisoner on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need.

The Sergeant conducts a direct observation check of those inmates on suicide precautions every two hours to ensure compliance with this section as well as a Watch Commander every eight hours when available.

VII.J.3 - Partial Compliance

"The County shall revise its policies regarding the monitoring of prisoners on suicide precautions to provide for at least the following two defined levels of observation:

a) Close observation shall be used for prisoners who are not actively suicidal but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or have a recent prior history of self-destructive behavior. Close observation shall also be used for prisoners who deny suicidal ideation or do not threaten suicide but are engaging in other concerning behaviors indicating the potential for self-injury. Staff shall observe the prisoner at staggered intervals not to exceed every 15 minutes and shall document the observation as it occurs.

b) *Constant observation shall be used for prisoners who are actively suicidal, either threatening or engaging in self-injury, and considered a high risk for suicide. An assigned staff member shall observe the prisoner on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals. Staff should be physically stationed outside of the prisoner's cell to permit continuous, uninterrupted observation."*

MH has revised its policies regarding the monitoring of patients on suicide precautions to provide for at least the following two defined levels of observation:

Close Observation: Staff shall observe the patient at staggered intervals not to exceed every 15 minutes and shall document the observation as it occurs. Lexipol Procedure on Suicide Prevention and Intervention was published on 02/14/2024. The revised policy addresses this issue. The SSO Suicide Prevention policy language has been agreed upon by Class Counsel and SSO. The policy was updated in September of 2023, and each Sheriff's Office staff member must read and acknowledge the policy.

Constant Observation: An assigned staff member shall observe the patient on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals. Staff should be physically stationed outside of the patient's cell to permit continuous, uninterrupted observation. This is included in the ACH PP 02-05 Suicide Prevention Program policy. Constant Observation began in March 2023 with the addition of Mental Health Worker positions. The County implemented the Constant Observation Program and has filled all vacancies. Staff are available 24/7 to provide 1:1 constant observation. However, this area remains in Partial Compliance due to a limited number of MHWs available to provide Constant Observation.

VII.J.4 - Substantial Compliance

"For any prisoner requiring suicide precautions, a qualified mental health professional shall assess, determine, and document the clinically appropriate level of monitoring based on the prisoner's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically-determined level of monitoring."

For any patient requiring suicide precautions, a qualified mental health professional assesses, determines, and documents the clinically appropriate level of monitoring based on the patient's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically determined level of monitoring.

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS.
SSO expanded the number of suicide resistant observation cells in the Suicidal Temporary Housing Unit (SITHU) at the Main Jail.

MH hired staff and implemented constant observation level of monitoring in March 2023.

MH completes weekly audits on compliance determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to Suicide Prevention Subcommittee on quarterly basis.

Once ACMH staff has completed the inmate's evaluation, the ACMH staff member shall consult with custody staff to determine the appropriate housing location for the inmate.

VII.J.5 - Substantial Compliance

"Video monitoring of prisoners on suicide precaution shall not serve as a substitute for Close or Constant observation."

Video monitoring of suicidal inmates ended in November 2021. Direct monitoring occurs every 15 minutes for deputies, two hours for Sergeants, and eight hours for Watch Commanders.

K. Treatment of Inmates Identified as at Risk of Suicide

VII.K.1 - Partial Compliance

"Qualified mental health professionals shall develop an individualized treatment plan and/or behavior management plan for every prisoner that mental health staff assesses as being a suicide risk."

All MH staff received updated training on the new process for developing safety plans at the time of an SRA evaluation. MH has been auditing staff compliance with the practice and findings from Dec 2023-Feb 2024 indicate:

- MH completed a suicide risk assessment for 100% (66/66) of patients referred for being a danger to self.
- 86% (32/37) of patients placed on suicide precautions had a safety plan completed at the time of initial SRA. This is a 14% increase from the last report period.
- 100% (21/21) of charts had a completed suicide risk assessment for patients discharged from suicide precautions.
- 76% (16/21) of charts had completed safety plans for patients discharged from suicide precautions.

Study results were shared with staff and supervisors. Supervisors are monitoring staff compliance and providing training as needed. MH will continue to audit the new process.

VII.K.2 - Partial Compliance

"Treatment plans shall be designed to reduce suicide risk and shall contain individualized goals and interventions. Treatment plans shall be reviewed following discharge from suicide precautions and updated as clinically indicated."

MH staff have received training on this requirement in both SRA and Treatment Planning training. MH has been auditing staff compliance with the practice.

VII.K.3 - Partial Compliance

"All assessments, treatment, and other clinical encounters shall occur in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

Staff utilize the confidential interview office in booking, classrooms, newly installed plexiglass "pods", and attorney booths for confidential interviews when available. Facility deficiencies that result in a lack of confidential space in the Booking Area and 2E keep the status at Partial Compliance.

When necessary, custody staff will standby for security while offering auditory privacy. Proximity is dependent on the inmate's behavior safety risk. This can be accomplished at RCCC due to the design of the three offices where these contacts take place. All of the doors can be closed. They have windows where the officers can stand outside and see what is taking place in the room.

At Main Jail, a private attorney booth has been converted to be utilized as a confidential interview room for Mental Health assessments in booking.

On MJ housing floors, classrooms, newly installed plexiglass enclosures, and confidential attorney booths are available for clinical encounters.

SSO has purchased security desk/chairs which allows leg shackles to be secured. This allows clinicians to safely speak to higher security inmates in privacy without custody staff standing nearby.

L. Conditions for Individual Inmates on Suicide Precautions

VII.L.1 - Substantial Compliance

"The County's Suicide Prevention Policy shall set forth clear and internally consistent procedures regarding decisional authority for determining the conditions for individual inmates on suicide precautions. Mental health staff shall have primary authority, consistent with individualized classification and security needs, with respect to the following: [see M. Property and Privileges]."

The Suicide Prevention Policy addresses MH's role as the primary authority to make decisions on property and privileges, use of safety suits, and discharge from suicide precaution based on clinical assessment. Per SSO, Mental Health staff's recommendations are taken into consideration when making housing decisions for inmates with mental health concerns.

M. Property and Privileges

VII.M.1 - Substantial Compliance

"Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, depending on suicide risk, the removal and/or return of routine privileges (e.g., visits, telephone calls, recreation) that are otherwise within the limitations of a prisoner's classification security level. Any removal of privileges shall be documented with clinical justification in the prisoner's medical/mental health record and reviewed on a regular basis."

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS.

The Suicide Precautions and/or Grave Disability Observations – Custody Instructions Form was developed to document MH staff's directions regarding housing, observation level, property, privileges, and clothing restrictions.

MH provided training and created a workflow for staff on responsibilities related to suicide precautions and clinical decisions regarding housing, observation levels, privileges, clothing, and property in August 2021.

MH completes weekly audits on compliance determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to Suicide Prevention Subcommittee on quarterly basis.

Suicide Precautions Audit findings indicate MH is meeting substantial compliance when determining and documenting housing, observation level, property, privileges and clothing restrictions for patients place on suicide precautions.

Audit findings from Aug-Oct 2024 are as follows:

- The suicide precautions form is being completed 100% (152/152) of the time for each patient encounter.
- Clinical justification for removal of privileges and property is completed 100% (152/152) of patient encounters.

- MH is making recommendations regarding removal of clothing/safety smock in 100% (152/152) of patient encounters.
- Daily assessments are being completed for restoration of privileges and property and restoration of clothing or documentation of continued use in 85% (106/125) of patient encounters.

SSO allows prisoners placed in a safety cell to retain enough clothing or be provided with a suitably designed “safety garment” to provide for the prisoner’s personal privacy unless specific identifiable risks to the prisoner’s safety or to the security of the facility exist and are documented. The Procedure on Suicide Prevention and Intervention was updated on 02/14/2024.

At the Main Jail, the SSO’s Intensive Outpatient Supervisor (IOP) conducts monthly audits for suicidal inmates in the SITHU and in safety cells to evaluate compliance with mental health’s recommendations. The results of these audits are shared with the Suicide Prevention Subcommittee on a monthly basis.

VII.M.2 - Substantial Compliance

“Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff depending on suicide risk, the removal and/or return of a prisoner’s clothing and possessions (e.g., books, slippers/sandals, eyeglasses) that are otherwise within the limitations of a prisoner’s classification security level. The removal of property shall be documented with clinical justification in the prisoner’s medical/mental health record and reviewed on a regular basis.”

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. ACH developed workflow and implemented procedure for posting suicide precaution forms outside of patient cells in the APU and SITHU.

If deemed necessary by ACMH staff, the inmate’s clothing shall be taken and the inmate will be given a “safety suit” to wear. Prisoners shall otherwise be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property. The SSO Procedure on Suicide Prevention and Intervention was updated on 02/14/2024.

MH staff received updated training on the new process of developing safety plans at the time of a Suicide Risk Assessment (SRA) evaluation starting in January 2023. All MH staff have been trained and a compliance audit was completed to identify areas for process improvement. See audit results in VII.M.1.

VII.M.3 - Substantial Compliance

"Cancellation of privileges should be avoided whenever possible and utilized only as a last resort."

Cancellation of privileges is done only as a last resort or if deemed necessary per ACMH. SSO's Procedure on Suicide Prevention and Intervention was updated on 02/14/2024. This section is monitored by monthly audits conducted by the Main Jail IOP Sergeant.

N. Use of Safety Suits

VII.N.1 - Substantial Compliance

"Decisions about the use of a safety suit (smock) or removal of normal clothing will be under mental health staff's authority, based on individualized clinical judgment along with input from custody staff."

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS.
This is current practice for SSO. Outlined in the current Suicide Prevention Program Operations Order. The use of the "Safety Suit" shall be at the discretion of ACMH, based on collaboration with intake or custody staff. The SSO Procedure on Suicide Prevention and Intervention was updated on 02/14/2024.

VII.N.2 - Partial Compliance ↓

"Custody staff may only temporarily place an inmate in a safety suit based on an identified risk of suicide by hanging until the qualified mental health professional's evaluation, to be completed within the "must see" referral timeline. Upon completion of the mental health evaluation, the mental health professional will determine whether to continue or discontinue use of the safety suit."

In these instances, a qualified mental health professional completes an evaluation within the "must see" referral timeline. Upon completion of the mental health evaluation, the mental health professional determines whether to continue or discontinue use of the safety suit.

Absent direction from ACMH deeming a "safety garment" necessary, a sworn supervisor must authorize custody staff to take the clothing and supply the prisoner with a "safety garment." Unless a "safety garment" is necessitated by the prisoner's behavior, prisoners shall be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property.
As timelines-to-care are not being consistently met, the compliance rating for this provision is being reduced from Substantial Compliance to Partial Compliance.

VII.N.3 - Substantial Compliance

"If an inmate's clothing is removed, the inmate shall be issued a safety suit and safety blanket."

SSO provides a safety suit and safety blanket if an inmate's clothing is removed. The SSO Procedure on Suicide Prevention and Intervention was updated on 02/14/2024.

VII.N.4 - Substantial Compliance

"As soon as clinically appropriate, the provision of regular clothing shall be restored. The goal shall be to return full clothing to the inmate prior to discharge from suicide precautions."

MH assesses the need for continued safety suit daily. Regular jail issued clothing is restored as soon as clinically indicated.

The IOP Sergeant conducts QA audits of safety smock use and timely return of clothing and property when notified by ACMH.

VII.N.5 - Substantial Compliance

"A qualified mental health professional shall conduct daily assessments of any prisoner in a safety suit and document reasons for continued use when clinically indicated."

All patients on the pre-admit list and in the APU are seen daily to assess continued use of safety suit, observation level and restriction of property and privileges. MH documents clinical justification for continued use of the safety suit and/or restriction of property and privileges.

VII.N.6 - Substantial Compliance

"If a qualified mental health professional determines that 30-minute (or less frequent) observations are warranted for a prisoner, safety suits shall not be used on that prisoner."

When MH determines that 30-minute (or less frequent) observations are warranted for a patient, safety suits are not used for that patient. Current practice by SSO, as use of safety suit and 30 minute or less frequent observations are done only if determined by ACMH.

VII.N.7 - Substantial Compliance

"Safety suits shall not be used as a tool for behavior management or punishment."
Safety suits are not used as a tool for behavior management or punishment. Safety suits are only used when necessary for the safety and security of the inmate. The Procedure on Suicide Prevention and Intervention was updated on 02/14/2024. All ACH staff are trained on this during the Annual Suicide Prevention Training.

O. Beds and Bedding

VII.O.1 - Substantial Compliance

"All prisoners housed for more than four hours on suicide precautions and/or in an inpatient placement shall be provided with an appropriate bed, mattress, and bedding unless the prisoner uses these items in ways for which they were not intended (e.g., tampering or obstructing visibility into the cell). Such a determination shall be documented and shall be reviewed on a regular basis."

Inmates housed in safety cells in the booking area are moved to appropriate suicide resistant housing as soon as a bed/cell opens up. 26 SITHU cells are available at the Main Jail. Custody distributed new suicide-resistant mattresses to the high acuity MH housing areas and safety cells in May 2022.

P. Discharge from Suicide Precautions

VII.P.1 - Substantial Compliance

"A qualified mental health professional shall complete and document a suicide risk assessment prior to discharging a prisoner from suicide precautions in order to ensure that the discharge is appropriate and that appropriate treatment and safety planning is completed."

An ACMH mental health professional completes and documents a suicide risk assessment prior to discharging a patient from suicide precautions to ensure that the discharge is appropriate, and that appropriate treatment and safety planning is completed.

VII.P.2 - Partial Compliance

"Treatment plans shall be written for all prisoners discharged from suicide precautions. The treatment plan shall describe signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur."

The treatment plan describes signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur. MH staff have received training as part of the SRA and Treatment Planning trainings to ensure treatment goals are included to reduce suicide risk. Auditing of charts will begin in February 2025.

VII.P.3 - Substantial Compliance

"Qualified mental health professionals shall provide clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the prisoner) upon discharge. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically

discharged from suicide precautions, the prisoner shall be promptly transferred to appropriate housing."

MH provides clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the prisoner) upon discharge. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically discharged from suicide precautions, the prisoner shall be promptly transferred to appropriate housing. Patients are transferred to the IOP (based upon bed availability) and/or assigned a clinically appropriate level MH care at time of discharge from the APU.

This is current custody practice, accomplished with the input of Classification staff and ACMH.

VII.P.4 - Partial Compliance

"Prisoners discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts. Unless a prisoner's individual circumstances direct otherwise, a qualified mental health professional shall provide follow-up assessment and clinical contacts within 24 hours of discharge, again within 72 hours of discharge, again within one week of discharge."

Patients who are discharged from the APU after being treated for a suicide attempt or ideation receive follow up MH appointments (24 hours, 72 hours, and seven days). Patients on the APU pre-admit list who have been discharged from suicide precautions receive follow-up MH appointments (24 hours, 72 hours and again within one week of discharge) This provision will be in Partial Compliance pending audit and confirmation that timelines-to-care are being met.

Historically, audits have indicated compliance ratings above 80%. However, there was a significant dip in compliance for the period of July – September 2024. This was due to ACH nursing not scheduling follow-ups when patients were discharged from APU and the high number of emergent referrals received. The QI Supervisor reviewed MH policy regarding follow-up timeframes with APU nursing staff. During the period reviewed, there were 28 patients discharged from APU with none or only one MH follow-up scheduled. QI provided study results for these patients to ACH SRN for follow-up and to reinforce policy with ACH nurses.

Patients Seen After Discharge from Suicide Precautions By Timeframe

Time Frame	Discharges Reviewed	Patients Seen Within 24 Hours of Discharge	Patients Seen Within 72 Hours of Discharge	Patients Seen Within 5 Days of Discharge
2024 Q3 (July – Sept.)	32	19/32 (60%)	8/32 (25%)	14/32 (44%)
2024 Q2 (April – June)	17	12/13 (92%)	10/12 (83%)	11/12 (92%)
2024 Q1 (Jan. - March)	25	15/18 (83%)	13/14 (93%)	11/13 (85%)
2023 Q4 (Oct. - Dec.)	21	16/19 (84%)	15/16 (94%)	15/16 (94%)
2023 Q3 (July – Sept.)	19	13/15 (87%)	14/14 (100%)	11/14 (79%)
2023 Q1 & 2 (Jan – June)	28	18/21 (86%)	19/20 (94%)	16/18 (89%)

Note: The number of discharges may differ in each assessment period. Discharges will not be counted when patients are temporarily out, released, or placed back on the preadmit list.

Q. Emergency Response

VII.Q.1 - Substantial Compliance

"The County shall keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff be trained on the location of this emergency response bag and shall receive regular training on emergency response procedures, including how to use appropriate equipment."

ACH health staff maintains emergency equipment and supplies to ensure availability and operability in the event of an emergency. A monthly inventory check is performed to ensure that supplies are not expired. Emergency response training is reviewed at each nurse staff meeting where man-down drill results are discussed and procedures are reiterated.

VII.Q.2 - Partial Compliance ↓

"All custody and medical staff shall be trained in first aid and CPR."

All Medical staff are required to be trained in first aid and CPR. QI tracks this area for compliance and reporting. Sworn staff receives CPR training every two years. It is part of the Advanced Officer Training (AOT) program.

All staff shall receive regular training on emergency procedures including how to use emergency equipment. Man down drills are practiced once a year on each shift at each jail facility. These drills are debriefed, and results are shared with all health staff, and recommendations for health staff are acted upon.

Based on the recent Court-Appointed Monitor report, the compliance rating for this provision is being reduced to Partial Compliance. The Court-Appointed Monitor has

requested CPR and First Aid training data be provided each January and June to better assess compliance.

VII.Q.3 - Substantial Compliance

"It shall be the policy of the County that any staff who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, and alert other staff to call for medical personnel. Trained staff shall begin to administer standard first aid and/or CPR, as appropriate."

It is the policy of the County that any staff who discovers an inmate attempting suicide shall immediately respond, and trained staff begin to administer standard first aid and/or CPR. This is reinforced in staff meetings and man-down drills.

R. Quality Assurance and Quality Improvement

VII.R.1 - Substantial Compliance

"The County shall establish regularly scheduled multidisciplinary meetings related to treatment, and plan of care issues, on a monthly basis, between medical, and mental health personnel."

MH implemented monthly Suicide Prevention Multidisciplinary meetings to discuss patients with complex mental health needs who engage in self-injurious behaviors (July 2022).

VII.R.2 - Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, revise its in-custody death review policy and procedures. Reviews shall be conducted with the active participation of custody, medical, and mental health staff. Reviews shall include analysis of policy or systemic issues and the development of corrective action plans when warranted."

ACH has, in consultation with Class Counsel, revised its in-custody death review policy and procedures. Reviews are conducted with the active participation of custody, medical, and mental health staff. Reviews include analysis of policy or systemic issues and the development of corrective action plans when warranted.

VII.R.3 - Substantial Compliance

"For each suicide and serious suicide attempt (e.g., requiring hospitalization), the County's Suicide Prevention Task Force shall review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate

recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures."

The Suicide Prevention Subcommittee established a Morbidity and Mortality (M&M) Review for cases meeting provision criteria in December 2021. The M&M Workgroup reviews cases and reports findings back to Suicide Prevention Subcommittee.

VII.R.4 - Substantial Compliance

"The County will track all critical incidents which include prisoner suicides, attempted suicides, and incidents involving serious self-harm. The County shall review critical incidents and related data through its quality assurance and improvement processes."

MH tracks incidents of suicide, attempted suicide and serious self-harm. MH completes incident reports and reviews on deaths by suicide, attempted suicide and serious self-harm and submits incident reports to ACH QI for review and tracking.

VII.R.5 - Substantial Compliance

"The County shall implement a continuous quality assurance/quality improvement plan to periodically audit suicide prevention procedures that include, but are not limited to: intake screening (to include audits to ensure that staff ask and record all suicide screening questions), mental health assessments, suicide risk assessments, crisis response, and treatment plans/behavior management plans for prisoners identified as being at risk of suicide or self-harm."

MH convened a multidisciplinary Suicide Prevention Subcommittee to review, track, and audit the requirements. Suicide Prevention Subcommittee moved meetings from a quarterly to monthly schedule to improve communication, implement Suicide Prevention training, and complete morbidity and mortality reports in a timely manner.

MH completes Suicide Precaution Weekly Audits and reports results to Suicide Prevention Subcommittee on a quarterly basis. MH completes audits of four and six-hour timelines to care and reports findings and recommendations to MH QI and Suicide Prevention Subcommittees. MH audits the number of confidential versus non-confidential contacts and presents findings and recommendations to MH QI Subcommittee.

ACMH completed quarterly baseline studies of MH Rules Violation Reviews and presented findings and recommendations to MH QI Subcommittee. ACMH Completed QI study of MHs timeliness to medication verification and initiation following intake referral and presented findings and recommendations to MH QI Subcommittee. As a result of study findings, ACMH worked with nursing leadership to message intake nurses on importance of identifying community pharmacy and created a hard-stop in intake form that requires response if patient indicates they receive medication in the community.

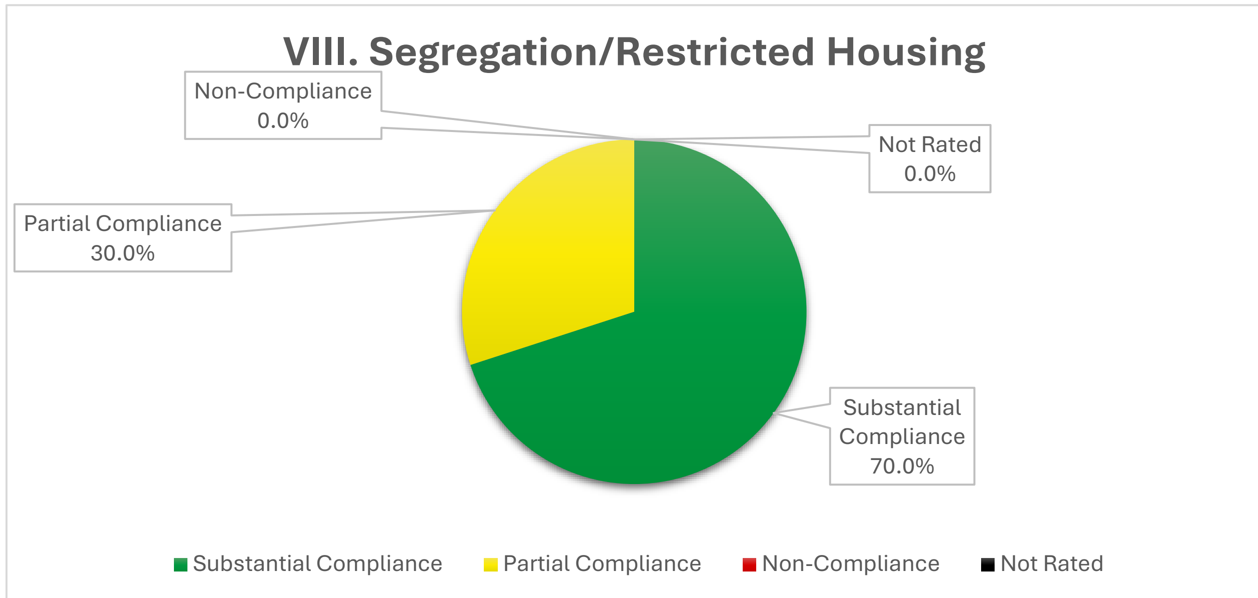
ACMH completed a Multidisciplinary Intervention Plan (MDIP) Audit to determine the number of completed MDIPs. This data was used to meet with staff and discuss importance of considering MDIPs for patients who meet criteria.

ACMH completed a QI study utilizing the APU Daily Patient Activity Report which staff use to track custody support on the APU. As a result of the study, staff identified a need for additional deputies and worked with SSO to increase deputy coverage on the APU.

ACMH utilized new reporting feature in Athena that tracks number of groups offered and cancelled and developed QI study that highlighted reasons for cancelled groups. The results and recommendations were shared with the MH QI Subcommittee.

ACMH developed baseline MDT and Treatment Planning study to identify compliance with treatment planning and MDTs in IOP and APU. Findings and recommendations were presented to the MH QI Subcommittee.
ACMH completed a study on the number of MH referrals and completed encounters by clinicians and prescribers and presented findings to MH QI Subcommittee. ACMH completed APU Discharge Follow-ups and Timelines to Care report and presented findings and recommendations to MH QI and Suicide Prevention Subcommittees. ACMH completed an APU Involuntary Detention Audit and presented findings to MH QI and Suicide Prevention Subcommittees.

VIII. Segregation/Restricted Housing



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	29 (72.5%)	28 (70%)
Partial Compliance	11 (27.5%)	12 (30%)
Non-Compliance	0 (0%)	0 (0%)
Not Rated	0 (0%)	0 (0%)
Total Provisions	**40**	**40**

Attachment 12, Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

There was a change in terminology for this section and those inmates classified as Administrative Segregation (ADSEG) are now known as Administrative Separation (ADSP). Some forms and partners continue to use the ADSEG terminology. Both terms may be used throughout this section.

A. General Provisions
VIII.A.1 - Partial Compliance ↓

"Prisoners will be housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff, other prisoners, and the public.

a) *The County shall not place prisoners in more restrictive settings, including Segregation, based solely on a mental illness or any other disability. Prisoners will be housed in the most integrated setting appropriate to their individual needs.*
b) *The County shall not place prisoners into Segregation units based solely on classification score.*
c) *The County shall review the housing and restrictions of female prisoners classified as high security to ensure that this population is not subject to Segregation conditions of confinement.*
d) *Specialized medical units (e.g., Main Jail 2 West Med/Psych, Main Jail 2 East) and mental health units (e.g., OPP, IOP, MHU, 2P) are not Segregation housing units. The County shall ensure that prisoners housed in these units receive daily access to out-of-cell time, telephones, showers, and other programs, services, and activities consistent with their classification and treatment plan."*

At the Main Jail, SSO implemented Administrative Separation (ADSP) classification review utilizing objective criteria and forms created with the assistance of Class Counsel. ADSP placement is reviewed based on objective factors for separation and not mental health status. At the Main Jail, the female IOP program was expanded 23 beds to better service the SMI population. RCCC has implemented several SMI program pods, where inmates housed in a single cell are assigned based on ACMH recommendation and allowed program/recreation time with other inmates for a minimum of 17 hours per week. A high security IOP program was implemented at RCCC with 48 male beds. Expanding dedicated mental health units and programming for inmates with significant mental health needs reduces the use of restrictive housing placements in this population

Sub-provision VIII.A.1.a is in Substantial Compliance. Several objective indicators, vetted through Class Counsel, are used to determine the appropriateness of separation, including written documentation supporting the rationale for separation. SSO has established a periodic review of these justifications. Inmates solely classified as "high" security are not routinely separated.

Sub-provision VIII.A.1.b is in Partial Compliance. The County continues to expand the programming available for those housed on 7 West and Ramona at RCCC.

Sub-provision VIII.A.1.c is in Partial Compliance. To support mental health programming, custody staff on APU is now 12hr day/seven days a week for better availability as requested by ACMH; further, an additional two Deputy positions have been added to evening coverage. 3-West IOP deputies provide staffing for daily access to IOP programing. The IOP staffing schedule has been changed to increase staffing during peak daytime hours to better facilitate the need for dedicated escorts during mental health programs.

The MJ implemented a male OPP single celled housing unit with 30 beds on 3-East 100 Pod. The female IOP program was expanded to 23 beds to better service the SMI population. A high security IOP program has been implemented at RCCC for 48 male beds.

Both SSO and ACMH have added staffing to provide better services to the population needing mental health services. RCCC has an open floor plan setting for medical housing with access to phones, showers, and yard. IOP housing units at both facilities have constant programming which allows them to exceed the minimum out of cell time of 17 hours.

While improvements continue, facilities have not yet reached a level of Substantial Compliance.

VIII.A.2 - Substantial Compliance

"The County shall not place a prisoner in Segregation units without first determining that such confinement is necessary for the safety of the staff, other prisoners, or the public. The County shall clearly document in writing the specific reason(s) for a prisoner's placement and retention in Segregation housing. The reason(s) shall be supported by clear, objective evidence. Prisoners will remain in Segregation housing for no longer than necessary to address the reason(s) for placement.

a) A qualified mental health or medical professional shall conduct check-ins at least once a week, to assess and document the health status of all prisoners in Segregation, and shall make referrals as necessary. The check-in shall include a brief conversation with each prisoner, a visual observation of the cell, and an inquiry into whether the prisoner would like to request a confidential meeting with a mental health or medical provider. Steps shall be taken to ensure effective communication, as well as auditory privacy consistent with security needs. When a prisoner in Segregation requests a confidential meeting with a mental health or medical provider, or the medical or mental health professional identifies a mental health or medical need, staff shall make appropriate arrangements to include triage, examination and treatment in an appropriate clinical setting. In such cases, staff shall give the prisoner the opportunity to complete a health care request but will otherwise initiate a referral without requiring the prisoner to complete a request form."

With the assistance of Class Counsel, ADSEG forms were created and are currently being utilized by SSO staff to comply with this requirement. Staff uses objective factors when determining segregation status of individual inmates. The Classification Sergeant reviews each case for an inmate placed on administrative separation with Compliance Commander approval. The criteria is based on Policy authored in conjunction with Class Counsel (Policy/Procedure 505) published 7/24/2024.

ACH Policy 05-22 Patients in Segregation requires ACH staff to regularly observe and evaluate patients placed in segregation to ensure health and mental health needs are being addressed in a timely, confidential, and appropriate manner. The weekly or more frequent check-in requires a nurse to visually observe the cell and patient, have a brief conversation with the patient, and inquire whether the patient would like a confidential

meeting with a mental health or medical provider. If such a meeting is requested, nursing staff make appropriate arrangements. Nursing staff document each assessment in the patient's record.

VIII.A.3 - Substantial Compliance

"The County shall not place the following prisoners in a Segregation setting unless necessary to address a serious risk of physical harm, and in such cases only for the minimum time necessary to identify an alternative appropriate placement:

a) Prisoners with acute medical needs that require an inpatient level of care and/or daily nursing care;

b) Prisoners who are pregnant, post-partum, who recently had a miscarriage, or who recently had a terminated pregnancy."

This is current practice and an inmate's medical concern will take priority over their need for separation. In a single-cell medical cell, if needed, both the treatment of the medical need as well as the separation can be accomplished. There is regular collaboration with both ACMH and ACH for proper housing for those who need to be separated from others.

B. Conditions of Confinement

VIII.B.1 - Partial Compliance

"The County will provide at least 17 hours of out-of-cell time per week for all prisoners, with the exception of prisoners subject to Administrative Segregation Phase I and Disciplinary Segregation in accordance with this remedial plan. The County will monitor out-of-cell time, and if minimum out-of-cell time requirements are routinely not being met at a particular facility or in a particular housing unit, the Sheriff's Department division commander or designee will review the situation and take appropriate steps to resolve the issue.

a) The County shall implement a policy to document out-of-cell time provided to each prisoner. The County shall conduct monthly audits to ensure that prisoners have been provided the required treatment and recreation time out of cell. This data will be regularly reviewed as part of the County's Quality Assurance procedures."

Out-of-cell time is monitored and recorded in the current ATIMS system. Reports are generated on a weekly basis and checked for compliance. This standard has been codified in updated policy (1003 on 5/24/2024). At the MJ, weekly out-of-cell time reports are distributed to supervisors and managers to promote compliance. The compliance units continue to refine these reports to make them a valuable tool for shift leadership.

The Main Jail is compliant with out-of-cell time requirements on most floors other than the 8th floor, due to its varying classifications of inmates including those who need to be separated from others. During this reporting period, the Main Jail and RCCC have worked

together to reallocate classifications across the two facilities (including those in administrative separation) to help with out-of-cell time goals.

In 2025, this collaboration will continue with a review of the correctional system's housing plan and a targeted focus on out of cell time at both facilities.

VIII.B.2 – Partial Compliance ↓

"Out-of-cell time with the opportunity to exercise shall be provided to each prisoner seven (7) days per week, including outdoors/recreation time when feasible. The County shall offer out-of-cell time at appropriate times of day."

Schedules have been created to promote fair distribution of outdoor recreation. Additional measures, outlined in the above section, are forthcoming. As the County is not yet meeting weekly out-of-cell time hours for at least 90% of inmates, this provision is being reduced to Partial Compliance.

VIII.B.3 - Substantial Compliance

"The County shall modify its non-disciplinary Segregation policies and procedures to allow reasonable access to the following: (1) Personal phone calls for all prisoners, including at least five hours or three weekdays per week of phone access during normal business hours; (2) Education, rehabilitation, and other materials (e.g. writing implements, art supplies, tablets), for in-cell activities; (3) Personal and legal visiting; (4) Religious services; and (5) Commissary.

a) The conditions and privileges described above shall be provided unless there is a specific safety or security issue preventing provision of such materials or the prisoner is subjected to disciplinary action."

At both facilities, phones are available during any out-of-cell time. The SSO Policy on Exercise and Out of Cell Time (1003) was published on 05/15/2024. The SSO Procedure for Special Management of Incarcerated Persons (505) was updated 07/23/2024.
Both facilities enabled the function on the inmate assigned tablets allowing the use of the telephone feature. The tablets are distributed to inmates in the morning and collected before 11PM.

The tablets also provide another opportunity for inmates to access educational material, digital books, health and mental health educational material, as well as order commissary directly from the device.

VIII.B.4 - Substantial Compliance

"Cell windows shall not be covered with magnetic flaps, towels, sheets, or any other visual barrier preventing visibility into and out of the cell, unless there is a specific security or

privacy need that is documented, and then for only a period of time necessary to address such security or privacy need. This provision shall apply to all cells housing prisoners."

This has been codified in the new Suicide Prevention and Intervention Policy and Procedure (713). Supervising SSO staff monitor the appropriate use of magnetic flaps during emergency/tactical situations. Staff must acknowledge review and receipt of the policy as part of their training.

VIII.B.5 - Substantial Compliance

"The County shall establish procedures so that all housing unit cells are searched and cleaned prior to a prisoner's placement in the cell."

SSO Procedure 802 was published and outlines the housing officer's responsibility to ensure cells are searched and cleaned prior to placement of new incarcerated persons.

VIII.B.6 - Substantial Compliance

"The County shall establish procedures to ensure that no prisoner is placed in a Segregation housing cell without a mattress and appropriate bedding."

SSO's Incarcerated Person Hygiene Policy and Procedure (804) was published 11/24. The procedure outlines the clothing and bedding requirements for inmates. Policy 804 requires blankets and mattresses be issued to all inmates.

C. Mental Health Functions in Segregation Units

VIII.C.1 - Partial Compliance

"Segregation Placement Mental Health Review

a) *All prisoners placed in a non-disciplinary Segregation housing unit and all prisoners housed in a Disciplinary Detention unit shall be assessed by a qualified mental health professional within 24 hours of placement to determine whether such placement is contraindicated. All prisoners subjected to Disciplinary Segregation conditions for 72 hours in their general population housing unit (i.e., confined to cell 23 hours per day) shall also be assessed by a qualified mental health professional no later than the fourth day of such placement.*
b) *Any decision to place prisoners with Serious Mental Illness in Segregation shall include the input of a qualified mental health professional who has conducted a clinical evaluation of the prisoner in a private and confidential setting (absent a specific current risk that necessitates the presence of custody staff), is familiar with the details of the available clinical history, and has considered the prisoner's mental health needs and history.*
c) *Mental Health Staff shall consider each prisoner's age and cognitive functioning as part of the Segregation Placement review. Staff shall receive training regarding the*

features of youth and brain development of young adults (i.e., 24 years old and younger) and the needs of individuals with intellectual disabilities.

d) *If mental health or medical staff find that a prisoner has a Serious Mental Illness or has other contraindications to Segregation, that prisoner shall be removed from Segregation absent exceptional and exigent circumstances.*

e) *The County shall document and retain records of all Segregation Placement mental health evaluations, as described above. The County shall consult with Plaintiffs regarding such documentation, including the development of new forms where necessary."*

MH RVR/ADSEG supervisor and clinicians access ATIMS to ensure that all patients placed on Administrative Segregation and/or full discipline are identified and assessed by MH. Custody staff notifies ACMH immediately after an inmate is moved to disciplinary housing. To ensure that referrals are received promptly, MH has a new process in place where the ADSEG team can view ATIMS and identify when patients are placed in ADSEG.

Objective ADSEG Forms reduce unnecessary segregation. The MJ female IOP program was expanded with 23 beds to better service the SMI population. A similar high security IOP program has been implemented at RCCC with a total of 48 male beds. SSO and ACMH have added staffing to provide better services to this population. MJ SSO and ACMH meets regularly to discuss confidential MH visits and troubleshoot issues. Disciplinary housing is issued only with clearance from ACMH staff assigned to these programs. Consultation with SMI inmates and ACMH in these programs are confidential.

MH staff provide case management to patients with serious mental illness who are in segregated housing. Collaboration between ACMH and Custody on the development of the RVR and Administrative Segregation referral form occurred in December 2021; ACMH trained custody on referral process. MH provided updated training on MH RVR and Administrative Segregation Reviews following SME recommendations related to Administrative Segregation assessment in April 2023. Staff have updated MH RVR and Administrative Segregation Assessment referral forms to improve communication between MH and Custody and ensure timely response to referral requests.

MH has staff available seven days a week to complete RVR and Administrative Segregation Reviews. MH continues to actively recruit for MH RVR/Ad Seg positions. A supervisor and three clinicians have been hired. MH assigned a MH RVR/Ad Seg clinician to complete assessments at RCCC.

MH established a Positive Behavioral Support Team that provides specific DBT interventions and staff consultation to address patient behaviors that interfere with patients participating in programming or being housed in the least restrictive setting.

Sub-provisions VIII.C.1.a, VIII.C.1.d, and VIII.C.1.e are addressed in SSO Policy and Procedure 505-Special Management Incarcerated Persons (published 5/24). Proof of practice occurs via tracking by each facility's Classification Sergeant.

VIII.C.2 - Partial Compliance

"Segregation Rounds and Clinical Contacts

a) *Cell checks (to ensure that prisoners are safe and breathing) shall be conducted for all prisoners in Segregation at least every 30 minutes, at staggered intervals. Completion of cell checks will be timely documented.*
b) *A qualified mental health or medical professional shall conduct check-ins at least once a week, to assess and document the health status of all prisoners in Segregation, and shall make referrals as necessary. The check-in shall include a brief conversation with each prisoner, a visual observation of the cell, and an inquiry into whether the prisoner would like to request a confidential meeting with a mental health or medical provider. Steps shall be taken to ensure effective communication, as well as auditory privacy consistent with security needs. When a prisoner in Segregation requests a confidential meeting with a mental health or medical provider, or the medical or mental health professional identifies a mental health or medical need, staff shall make appropriate arrangements to include triage, examination and treatment in an appropriate clinical setting. In such cases, staff shall give the prisoner the opportunity to complete a health care request but will otherwise initiate a referral without requiring the prisoner to complete a request form."*

The SSO Lexipol Policy on Special Management of Incarcerated Persons (505) was published on 05/14/2024. The policy outlines the need for safety checks every 30 minutes. Checks are documented in ATIMS. Sergeants review these electronic logs twice a shift, and a Watch Commander reviews once per shift.

The County began Administrative Segregation MH assessments in December 2021. MH staff provide case management to patients with serious mental illness who are in segregated housing. MH continues to collaborate with custody on efficient use of attorney booths for patients in administrative segregation for confidential contacts. Additional booths consisting of plexiglass enclosures with doors are situated in the indoor area of each housing unit. Some booths are planned to have a partition for safety as well as a security desk/chair. SSO has purchased specialized security desk/chairs which allow leg shackles to be secured. This allows clinicians to safely speak to higher security inmates in privacy without custody staff standing nearby.

Custody staff facilitate inmate access to medical and mental health staff. No inmate is denied a request for access to medical or mental health care regardless of housing or classification. If an inmate requests to see medical staff, they submit an HSR if it is not an

emergency. If it is an emergency, officers notify ACH or ACMH. SSO and ACMH meet regularly to discuss confidential MH visits and troubleshoot non-compliance.

Please see section VIII.A.2 for ACH weekly health status check-ins for inmates placed in Administrative Segregation.

VIII.C.3 - Partial Compliance

"Response to Decompensation in Segregation

a) If a prisoner in Segregation develops signs or symptoms of mental illness where such signs or symptoms had not previously been identified, suffers deterioration in his or her mental health, engages in self-harm, or develops a heightened risk of suicide, the prisoner shall immediately be referred for appropriate assessment and treatment from a qualified mental health professional who will recommend appropriate housing and/or programming.

b) Jail staff shall follow a mental health recommendation to remove a prisoner from Segregation unless such removal poses a current safety risk that is documented. In such a case, the Commander or management-level designee shall be notified and staff shall work to remove the prisoner from Segregation and secure a placement in an appropriate treatment setting at the earliest possible time."

SSO's Policy and Procedure 505 outline's SSO's response to decompensation in separation (Section 505.3). The procedure mandates housing officers to immediately notify ACMH for each of these elements. Patients developing signs/symptoms of decompensation are referred to ACMH for assessment. MH staff provide case management to patients with serious mental illness who are in segregated housing and monitor for decompensation.

The Classification Sergeant maintains a detailed log of all inmates placed on administrative separation. In addition to the specialized forms, this log serves to track placement and removal from separation status.

D. Placement of Prisoners with Serious Mental Illness in Segregation

VIII.D.1 - Partial Compliance

"Prisoners with a mental health condition meeting criteria for placement in a Designated Mental Health Unit (2P, IOP, OPP) will not be placed in Segregation, but rather will be placed in an appropriate treatment setting – specifically, the inpatient unit or other Designated Mental Health Unit providing programming as described in Exhibit A-2."

Numerous former inmates who were housed in segregated units have been distributed to the following mental health housing units in collaboration with ACMH:

- The MJ implemented a male OPP single celled housing unit with 30 beds on 3-East 100 Pod reduced those on ADSEG. The female IOP program was expanded to 23 beds to better service the SMI population.

- A high security male IOP program has been implemented at RCCC. SSO and ACMH have added staffing to provide better services to this population.

There sometimes is an objective reason or need to keep individuals separated from other inmates for safety or security reasons. Individuals are integrated into small groups for treatment whenever feasible to prevent segregation. Segregation is never based on SMI. This provision remains in Partial Compliance due to insufficient APU and IOP beds.

VIII.D.2 - Substantial Compliance

"In rare cases where a prisoner with a mental health condition meeting criteria for placement in a Designated Mental Health Unit presents an immediate danger or significant disruption to the therapeutic milieu, and there is no reasonable alternative, such a prisoner may be housed separately for the briefest period of time necessary to address the issue, subject to the following:

a) The prisoner shall receive commensurate out-of-cell time and programming as described in Exhibit A-2 (including for IOP and OPP, 10 hours/week of group treatment/structured activities, 7 hours/week unstructured out-of-cell time, weekly individual clinical contact) with graduated programming subject to an individualized Alternative Treatment Program.

b) The prisoner shall receive the following:

i. As part of the weekly confidential clinical contact, the clinician shall assess and document the prisoner's mental health status and the effect of the current placement on his or her mental health, and determine whether the prisoner has decompensated or is at risk of decompensation.

ii. The weekly check-ins described in Section VIII.C.2.b shall supplement, and not be a substitute for, the weekly treatment session described herein.

iii. Treatment provided in the least restrictive setting that is appropriate based on the prisoner's circumstances.

iv. Privileges commensurate with the Designated Mental Health Unit program, unless modified in an Alternative Treatment Program based on individual case factors that are regularly reviewed.

v. Daily opportunity to shower."

This is SSO's current practice and relies on strong collaboration with ACMH. Often because of the Designated Mental Health Units, segregation is not needed. Alternative Treatment Plans are utilized in IOP and Multidisciplinary Intervention Plans are utilized in Outpatient Services and EOP to address significant or dangerous behaviors or significant disruptions to the therapeutic milieu.

MH established a Positive Behavioral Support Team that provides specific DBT interventions and staff consultation to address patient behaviors that interfere with patients participating in programming or being housed in the least restrictive setting.

SSO is working to further compliance with feedback from Class Counsel. At both facilities, IOP no longer removes patients that are disruptive without clinical assessment and agreement by ACMH. When patients are moved, they are monitored by ACMH through case management. Custody and ACMH staff now have more housing options with the MJ single celled OPP pod, expanded female IOP program, and RCCC's 48 bed male high security IOP unit.

Inmates in DMHUs housed without a cellmate receive program and recreation time with other inmates. Incentives programs are utilized as advised by ACMH staff. Out-of-cell time generally exceeds the 17-hour minimum per weekly reports. ACMH determines when an inmate in these housing facilities must be housed in a solitary cell. Custody has deferred all decisions related to property and privileges to ACMH unless deemed a safety or security risk which is documented with articulable facts. Four (4) dedicated deputies are assigned to the Acute Psychiatric Unit (2P) to facilitate programing during the day. Their schedule allows for coverage 12 hours day/7 days a week for better availability requested by ACMH. An additional two deputies were added to the evening shift allowing for additional programing and treatment.

Hygiene opportunities are available during any recreation time and incentivized in some programs.

VIII.D.3 - Substantial Compliance ↑

"A prisoner with Serious Mental Illness requiring restraints (e.g., handcuffs, belly chains, etc.) shall not be denied clinically indicated group or individual treatment due to security factors, absent exceptional circumstances that are documented. Prisoners with Serious Mental Illness housed in Segregation who require restraints when out of cell shall have the opportunity to work their way out of restraints through graduated programming subject to an individualized Alternative Treatment Program."

Patients with Serious Mental Illness housed in Segregation who require restraints when out of cell can graduate out of restraints through programming subject to an individualized Alternative Treatment Program (ATP). IOP patients who are subject to restrictions of property, privileges, or out-of-cell time are placed on an ATP.

ACMH currently utilizes ATPs for patients in DMHU. Patients who require restraints when out-of-cell would be placed on an ATP with plan to graduate them to regular programming as soon as clinically possible. The multidisciplinary team meets daily to discuss the patient's progress and the transition of the patient from ATP to general programming. While there are security chairs, they are not routinely utilized for groups.

E. Administrative Segregation

VIII.E.1 - Substantial Compliance

"Use of Administrative Segregation

a) Only the Classification Unit can assign a prisoner to Administrative Segregation.
b) The County may use Administrative Segregation in the following circumstances:
   i. Objective evidence indicates that a prisoner participated in a recent assault and the assaultive behavior involved an assault on staff or visitors, serious injury, use of a weapon, gang removals, or multiple prisoner assaults. Mutual combat situations that do not otherwise qualify for Administrative Segregation are excluded.
   ii. During a brief investigative period not to exceed ten days while Classification staff attempts to verify the need for Protective Custody or while the prisoner is awaiting transfer to another facility.
c) The Compliance Commander shall have the authority to place prisoners in Administrative Segregation under the following circumstances:
   i. The prisoner poses an extraordinary safety risk and no other housing unit is sufficient to protect the prisoner from harm;
   ii. The prisoner has failed to integrate into a lesser restrictive housing setting because of repeated and recent history of assaultive behavior or current threats of violence associated with being in a lesser restrictive setting; or
   iii. Objective evidence indicates that the prisoner attempted to escape or presents an escape risk."

The SSO Policy and Procedure on Special Management of Incarcerated Persons (505) was updated on 07/03/2024. The procedure is published with this language outlining the process. Administrative Separation is not used outside these parameters.
SSO continues to move towards compliance with input from Plaintiff's Counsel. While many inmates on floor 8-West have been stepped down to general population and are no longer classified as in ADSEG or Disciplinary housing, the complexity of classifications on that specific housing unit wing make programming and out of cell time difficult within the current facility constraints.

SSO investigations into the need for Protective Custody generally conclude within 10 days which lead to a decision for long-term housing assignment. More serious investigations, such as sexual assault, may take longer causing segregation to go beyond 10 days.

VIII.E.2 - Substantial Compliance

"Notice, Documentation, and Review of Administrative Segregation Designations
a) The Classification Unit shall document the rationale for designating a prisoner for Administrative Segregation in the classification file using objective evidence. For prisoners younger than 24, the Classification Unit shall consider the prisoner's age as a mitigating factor when assigning the prisoner to Administrative Segregation.
b) Classification shall attempt to down-class prisoners to a lesser restrictive housing setting at the earliest possible opportunity, consistent with safety and security.
c) County shall provide prisoners in Administrative Segregation with a written notice within 72 hours of the prisoner's initial placement in Administrative Segregation,

explaining the reasons for the prisoner's Administrative Segregation designation and how the prisoner may progress to a lesser restrictive housing setting.

d) *Prisoners housed in Segregation units will, at least every thirty (30) days, receive face-to-face interviews in a private out-of-cell setting, consistent with individual security needs, to discuss progress and compliance with their individual case plan as part of a classification review. Consideration will be given to their mental health and to their appropriateness for transfer to a less restrictive setting.*

e) *The Compliance Commander or higher-ranked officer will review and approve the decision to designate a prisoner for Administrative Segregation for longer than 15 days.*

f) *The County shall document the reason the prisoner is retained in the same Administrative Segregation Phase. The prisoner will be given written notice of the reasons the prisoner is being retained in the same Phase of Administrative Segregation and what conduct the prisoner is required to exhibit to progress to a lesser restrictive housing setting.*

g) *The Compliance Commander or higher-ranked officer must approve the continued retention of a prisoner in Administrative Segregation for longer than 90 days, and the Compliance Commander or higher-ranked officers must reauthorize such placement at least every 90 days thereafter."*

The SSO Policy and Procedure on Special Management of Incarcerated Persons (505) was updated on 07/03/2024. The procedure is published with this language outlining the process. Administrative Separation is not used outside these parameters.

Each stage of the Administrative Separation (ADSP) process is tracked by the Classification Sergeant in the Administrative Separation tracking log. The log includes the dates placed into ADSP, the reason for placement and/or retention, document face to face interviews with the inmate and Sergeant. The tracking log also alerts the Classification Sergeant to the next deadline in the review process.

VIII.E.3 - Partial Compliance

"Administrative Segregation Phases

a) *The County shall develop and implement a phased system for prisoners designated as Administrative Segregation to achieve a lesser restrictive housing setting.*

b) *Administrative Segregation Phase I:*

    i. *This is the most restrictive designation for prisoners in Administrative Segregation.*

    ii. *Prisoners shall be offered a minimum of one hour per day out of cell time for a total of seven hours per week.*

    iii. *Prisoners shall be offered an opportunity for Out-of-Cell Activities for at least five of the seven hours per week.*

iv. *Prisoners shall not remain in Phase I for longer than 15 days unless the prisoner engages in new conduct warranting retention in Administrative Segregation as specified in Section VIII.E.1.b.*

c) *Administrative Segregation Phase II:*

a. *Prisoners shall be offered a minimum of 17 hours of out of cell time per week.*
b. *Prisoners shall be offered an opportunity for Out-of-Cell Activities for at least 10 of the 17 hours per week.*
c. *Prisoners shall be offered the opportunity to program in groups of two to four prisoners, unless pairing with another prisoner is not possible for safety or security reasons, and those reasons are documented by the County.*
d. *The County shall develop a program of incentives for good behavior.*
e. *Prisoners shall not remain in Phase II for longer than 30 days unless the prisoner commits a serious behavioral violation while in Administrative Segregation: fighting; threatening staff or other prisoners; resisting or delaying an order from staff that impedes Jail operations (e.g., failure to lock down); refusing to submit to a search of person or property; destroying or damaging Jail property (excluding property issued to a prisoner and/or minor defacing of property or destruction of low-value property) or facilities"*

Out-of-cell time is monitored weekly, but not all individuals on Phase II regularly receive 17 hours of out-of-cell time. When possible, those on Phase II are grouped with other individuals either on ADSP status or not. This also helps to increase the out-of-cell time as inmates can recreate with others instead of by themselves. ACMH utilizes an incentive program consisting of commissary items as clinically indicated and to increase compliance with treatment goals and custody directive.

Steps have been taken with Classification to create more defined groups of inmates who are able to recreate together. Additionally, the daily schedule (including dayroom and outdoor recreation) has been updated as a guide for shifts to follow to increase out of cell time.

F. Protective Custody

VIII.F.1 - Substantial Compliance

"When a prisoner faces a legitimate threat from other prisoners, the County will seek alternative housing, by transferring the threatened prisoner to the general population of another facility or unit, or to a special-purpose housing (Protective Custody) unit for prisoners who face similar threats."

Inmates who face threats from other inmates are transferred to other housing units of the same classification and not automatically classed to a higher security level. This has been codified in the Special Management Incarcerated Persons Policy (505)

VIII.F.2 - Substantial Compliance

"The County will not operate Protective Custody units with Segregation-type conditions of confinement. Prisoners placed in Protective Custody shall have the same programs and privileges as general population prisoners, absent exceptional circumstances that are documented."

This has been codified in the Special Management Incarcerated Persons Policy (505). SSO is working to meet compliance with feedback from Class Counsel. RCCC currently has re-entry programs for PC classifications and dorm style housing units with open dayroom. At the Main Jail, protective custody inmates are generally housed with access to privileges consistent with general population. As SSO strives to meet compliance, adjustments can be made to individual needs, housing location, and program availability to better serve this population.

VIII.F.3 - Substantial Compliance

"The County shall create a policy that describes the process and criteria for placement of prisoners into Protective Custody. The County shall consult with Plaintiffs to develop such a policy."

SSO Lexipol Policy on Special Management of Incarcerated Persons was published on 05/14/2024.

VIII.F.4 - Partial Compliance

"Prisoners who are lesbian, gay, bisexual, transgender, or intersex (LGBTI) or whose appearance or manner does not conform to traditional gender expectations should not be placed in Segregation or Protective Custody solely on the basis of such identification or status, or because they are receiving gender dysphoria treatment.

a) When a prisoner who is LGBTI or gender nonconforming faces a legitimate threat, the County shall identify alternative housing, with conditions comparable to those of general population. Privileges and out-of-cell time for this population will be documented and regularly reviewed by supervisory level staff to ensure appropriate housing, out-of-cell-time, and related conditions for this group of prisoners.

b) In deciding whether to assign a transgender or intersex prisoner to a facility or program for male or female prisoners, the County shall consider on a case-by-case basis whether a placement would ensure the prisoner's health and safety, and the health and safety of other prisoners, giving serious consideration to the prisoner's own views.

c) Jail staff will receive training on the unique issues of managing transgender prisoners, with refresher training at least bi-annually."

SSO's Classification Policy and Procedure were updated in May 2024 to include the language outline in sub-provision VII.F.4.b.

A lesson plan and PowerPoint has been implemented for the topic of Cultural Awareness, which covers managing transgender prisoners. This training has been provided in the Adult Corrections Officer Supplemental Core Course starting 2021 with all new hires after the completion of a six-month POST Basic Academy in which Learning Domain 42 covers Sexual Orientation and Gender Identify SSO will work toward developing a bi-annual training.

VIII.F.5 - Substantial Compliance

"For prisoners who are LGBTI or whose appearance or manner does not conform to traditional gender expectations, the County shall identify the prisoner's preferred gender of jail staff who will perform searches of the prisoner. The County shall honor the request except in exigent circumstances when doing so is not possible."

Statement of preference forms completed by TGD prisoners allow them to request the gender of searching officer(s). The preference form and pronouns are also included in ATIMS on the inmate profile.

SSO's Search Policy and Procedure (512) were last updated 10/24 to include the following language: "As standard practice and absent exigent circumstances, searches of incarcerated persons shall be conducted by deputies of the same gender as the incarcerated person. For incarcerated persons who are LGBTI or whose appearance or manner does not conform to traditional gender expectations, members shall inquire and attempt to identify the person's preferred gender of the searching deputy to perform the search. Staff shall honor the incarcerated person's request except in exigent circumstances when doing so is not possible."

G. Disciplinary Segregation

VIII.G.1 - Substantial Compliance

"The County will not place a prisoner in disciplinary housing pending investigation of, and due process procedures for, an alleged disciplinary offense unless the prisoner's presence in general population would pose a danger to the prisoner, staff, other prisoners or the public."

SSO Policy and Procedure on Discipline (600) was published on 05/14/2024. SSO will work to develop a process to monitor this provision and provide proof of practice.

VIII.G.2 - Substantial Compliance

"The County will adhere to a discipline matrix, developed in consultation with Plaintiffs, that clearly defines when disciplinary housing may be imposed."

Both facilities utilize a discipline matrix approved in 2023.

VIII.G.3 - Substantial Compliance

"Prisoners who are found to have violated disciplinary rules following due process procedures will be placed in Segregation only after the County has determined that other available disciplinary options are insufficient, with reasons documented in writing."

The due process is outlined in SSO's Policy which includes the following steps:
"The process for an incarcerated person accused of a major rule violation includes:

a. A fair hearing in which the Jail Commander or the authorized designee presents factual evidence supporting the rule violation and the disciplinary action.
b. Advance notice to the incarcerated person of the disciplinary hearing, to allow the incarcerated person time to prepare a defense.
c. An impartial hearing officer.
d. The limited right to call witnesses and/or present evidence on the person's behalf.
e. The appointment of an assistant or representative in cases where the incarcerated person may be incapable of self-representation.
f. A formal written decision that shows the evidence used by the hearing officer, the reasons for any actions, and an explanation of the appeal process.
g. Reasonable actions for violating rules that relate to the severity of the violation.
b. The opportunity to appeal the finding."

The level of discipline will be in line with the discipline matrix and in coordination with ACMH if the incarcerated person meets the requirement for an RVR. The facility's CDHO will review imposed discipline to ensure consistency with the matrix and fairness."

VIII.G.4 - Substantial Compliance

"The denial of out-of-cell time for more than four (4) hours will not be imposed as a sanction absent a formal disciplinary write-up and due process hearing."

SSO's Policy and Procedure on Disciplinary Separation was published on 05/14/2024. This includes the following language: "No incarcerated person shall be denied more than four hours out-of-cell time, as a disciplinary sanction, without a disciplinary write-up and hearing."

VIII.G.5 - Substantial Compliance

"Prisoners serving a Disciplinary Segregation term shall receive at least seven (7) hours per week of out-of-cell time. Out-of-cell time with the opportunity to exercise shall be provided to each prisoner one (1) hour a day, seven (7) days per week."

SSO has been continuously messaging out-of-cell time requirements, including to include Disciplinary Segregation. This is monitored weekly by the Compliance Units.

VIII.G.6 - Substantial Compliance

"Prisoners in Disciplinary Segregation shall, absent an individualized assessment of security risk that is documented be provided at least one book (which prisoners may regularly exchange), legal documents, hygiene materials, legal phone calls, and legal visits."

SSO's Policy and Procedure on Disciplinary Separation (601) has been updated and published (7/24) to include reading material, legal documents, legal visits, and telephone privileges for legal phone calls as well as family emergencies.

VIII.G.7 - Substantial Compliance

"No Disciplinary Segregation term for non-violent rules violations will exceed 15 days."

SSO's Policy and Procedure for Disciplinary Separation (601) outline this 15-day limit on non-violent rule violations. This is also included in the discipline matrix.

VIII.G.8 - Substantial Compliance

"The County will, in consultation with Plaintiffs' counsel, modify its inmate discipline policy and practice to limit placements in Disciplinary Segregation conditions to no more than 15 days, absent cases of serious violations stemming from distinct incidents and with Watch Commander-level approval."

SSO's Procedure on Disciplinary Separation (601) was published on 05/14/2024 and outlines the following: "A disciplinary separation term shall not exceed 15 days for any non-violent rule violations.

a. Multiple non-violent rule violations shall not be combined to exceed 15 days.
b. Multiple non-violent rule violations may be combined to reach a maximum of 15 days.
c. Non-violent rule violations committed while serving discipline shall not extend the discipline beyond the initial 15-day period."

VIII.G.9 - Substantial Compliance

"No prisoner shall be placed in Disciplinary Segregation for more than 30 consecutive days."

SSO's Procedure on Disciplinary Separation (601) was published on 05/14/2024 and outlines the following: "No incarcerated person shall be placed in disciplinary separation for more than 30 consecutive days.

a. Multiple violent major rule violations may be combined to reach a maximum of 30 consecutive days.

b. Violent major rules violations committed while serving discipline shall not extend the discipline beyond the initial 30-day period."

VIII.G.10 - Substantial Compliance

"If after a Disciplinary Segregation term, Jail staff, with the input of a mental health clinician, determine that the prisoner cannot safely be removed from Segregation, placement on Administrative Segregation status may occur only subject to the process set forth in Section VIII.E."

Once an inmate is at the end of a disciplinary term, evaluation for placement to ADSP status would follow the procedure as outlined in that order.

VIII.G.11 - Substantial Compliance

"Once a prisoner has been moved out of Disciplinary Segregation, that prisoner shall not be placed back into Disciplinary Segregation absent (a) a new incident warranting discipline, and (b) completion of all mental health review procedures required for new Segregation placements."

The SSO Procedure on Disciplinary Separation was published on 05/14/2024 and outlines this process. This process is monitored by the designed CDHO at each facility.

H. Avoiding Release from Jail Directly from Segregation

VIII.H.1 - Substantial Compliance

"The County will avoid the release of prisoners from custody directly from Segregation-type housing, to the maximum extent possible."

The SSO Procedure on Special Management of Incarcerated Persons was published on 07/03/2024 and describes this limit. Those placed on ADSP are tracked by the Classification Sergeant.

VIII.H.2 - Partial Compliance

"If a sentenced prisoner housed in Segregation has an upcoming expected release date (i.e. less than 120 days), the County will take and document steps to move the prisoner to a less restrictive setting, consistent with safety and security needs. If Segregation becomes necessary during this time, the County will provide individualized discharge planning to prepare the sentenced prisoner for release to the community."

The SSO Procedure on Special Management of Incarcerated Persons was published on 07/03/2024 and describes this process. SSO will work with ACMH to develop a process for monitoring compliance of this provision and establish proof of practice.

I. No Food-Related Punishment

VIII.I.1 - Substantial Compliance

"The County shall modify its policy and take steps to ensure that the denial or modification of food is never used as punishment. The County shall eliminate use of "the loaf" as a disciplinary diet. Nothing in this paragraph shall be read to preclude the County from denying a prisoner use of the commissary."

The SSO Policy on Disciplinary Separation (601) was published on 05/15/2024 and outlines this provision with the following language: "Under no circumstances will an incarcerated person be denied food as a means of punishment (15 CCR 1083(e))." The disciplinary diet (loaf) is no longer used.

J. Restraint Chairs

VIII.J.1 - Substantial Compliance

"Restraint chairs shall be utilized for no more than six hours."

This is consistent with current SSO practice. The SSO Policy on Use of Restraints Policy was updated 05/15/2024. The Sheriff's Office no longer uses the restraint chair and has transferred to the utilization of the WRAP restraint device.
SSO has created a report flag within ATIMS allowing a review of all WRAP related incidents. SSO and ACMH meet regularly to monitor the use of the WRAP device as well as both agencies' coordination with an application.

VIII.J.2 - Partial Compliance

"The placement of a prisoner in a restraint chair shall trigger an "emergent" mental health referral, and a qualified mental health professional shall evaluate the prisoner to assess immediate and/or long-term mental health treatment needs."

MH assesses patients referred by SSO in a WRAP within emergent timelines to care requirements. MH and SSO meet regularly to discuss UOF, PUOF and WRAP incidents and to refine the referral and assessment process. The SSO Use of Restraints Policy was updated 05/15/2024. After SME review, changes to the policy will outline the emergent referral.

A WRAP Restraint Audit dated October 29, 2024 evaluating September 2024 data indicates improved communication and referral submission from SSO for incarcerated individuals placed in the WRAP. The audit utilized SSO's WRAP log. ATIMS and a chart review were completed for each WRAP encounter. For September 2024, nine patients were placed in the WRAP.

- 44% (4/9) SMI
- 11% (1/9) Intellectual Disability
- 89% (8/9) MH was notified after a patient was placed in a WRAP
- 63% (5/8) MH met the timelines to care for seeing patients placed in WRAP.

ACMH will continue to collaborate with SSO to gather data for WRAP audits and report findings to SSO for follow-up related to ATIMS documentation standards.

WRAP Audit Data (June - September 2024)

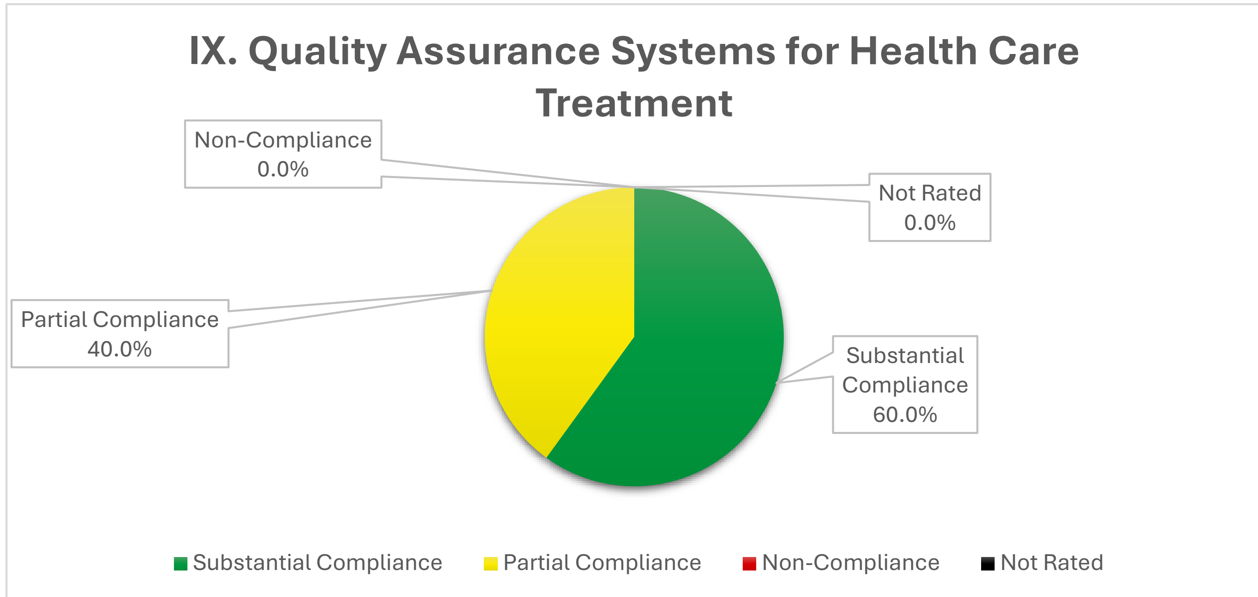
Month	WRAP Incidents	Serious Mental Illness (SMI)	Intellectual Disability (ID)	Was MH Notified?	Did MH Meet Timelines to Care?
Sept. 2024	9	4/9 (44%)	1/9 (11%)	8/9 (89%)	5/8 (63%)
August 2024	9	9/9 (100%)	0/9 (0%)	2/3 (67%)	2/2 (100%)
July 2024	6	4/6 (67%)	1/6 (17%)	2/4 (50%)	0/2 (0%)
June 2024	2	2/2 (100%)	0/2 (0%)	2/2 (100%)	2/2 (100%)
Total	**26**	**19/26 (73%)**	**2/26 (8%)**	**14/18 (78%)**	**9/14 (64%)**

VIII.J.3 - Partial Compliance

"The opinion of a qualified medical professional on placement and retention in a restraint chair will be obtained within one hour from the time of placement."

MH assesses patients referred by SSO in a WRAP within emergent timelines to care requirements.

IX. Quality Assurance Systems for Health Care Treatment



Compliance Rating	County Self-Assessment 9th Status Report (June 2024)	County Self-Assessment 10th Status Report (December 2024)
Substantial Compliance	6 (60%)	6 (60%)
Partial Compliance	4 (40%)	4 (40%)
Non-Compliance	0 (0%)	0 (0%)
Not Rated	0 (0%)	0 (0%)
Total Provisions	**10**	**10**

Attachment 13, Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation, aligns prior Court-Appointed Expert reports with the provision structure used here.

Prior to the Remedial Plan, there were limited Quality Improvement (QI) policies and practices due to lack of dedicated staff, data, and QI audits. Extensive actions have been taken to expand the QI structure.

A. Generally

IX.A.1 - Partial Compliance ↓

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, a quality assurance ("QA") plan to regularly assess and take all necessary measures to ensure compliance with the terms of this Remedial Plan."

Many data reports have been developed and will continue to be developed – including audit reports and semiannual data reports. QI audits are developed as policies are implemented and staff are trained to audit. Staff continues to audit areas of focus on a regular basis. Examples include disability identification and documentation, diabetes management, medication initiation and renewal, health service requests, ADA concerns, and referrals at intake. Additionally, ACH implemented in-person observations/audits of the medication administration process, intake, withdrawal monitoring, nurse sick call, and occupational hazards/safety. Audit data is shared with service line managers for appropriate corrective actions. New audit tools are continuously being developed.
Consent Decree training was developed and provided to medical and mental health staff in late 2021 and early 2022. The training is provided to new staff during new hire orientation.

A Utilization Review (UR) team formed in December 2022 and met to discuss UR tools and other logistics.

Monthly Continuous Quality Improvement meetings started March 2023 to review randomly selected cases pulled from patient grievances. The review team includes a provider, QI RN, QI Coordinator, QI Director, and Medical Director. Targeted reviews may result from the UR and tools will be revised as needed.

IX.A.2 - Substantial Compliance

"The QA/QI Unit shall meet regularly and include representatives from all levels of the organization and from all facilities. The meeting shall include custody representatives for topics that are relevant to custody operations."

The Quality Improvement Committee and several subcommittees (Pharmacy & Therapeutics, Mental Health QI, and Safety) meet quarterly. The meetings are multidisciplinary and all meetings include custody representatives.
The Suicide Prevention Subcommittee changed to monthly meetings, effective November 2021.

A Utilization Management Subcommittee was formed and began meeting quarterly in October 2021.

The Safety Subcommittee was refocused to include infection control in 2023 and is led by a designated QI Coordinator.

QI staff updated a list of reports and created a list of audits based on the indicators listed in the Remedial Plan. The lists clarify types of data for review in each subcommittee. These documents have been reviewed with service line managers in the Quality Improvement Committee and the MH QI Committee. QI monitors progress.

IX.A.3 - Substantial Compliance

"The County shall provide sufficient resources to the QA/QI program."

The QI team currently includes a total of nine (8) positions, including:

- QI Director
- Two (2) QI Coordinators
- Two (2) QI Nurses
- Two (2) Senior Office Assistants
- Administrative Services Officer II

The Training Coordinator position was moved under Nursing, effective December 2023. The two QI Nurse positions were filled and began employment in late May and early June 2022. One of the QI nursing positions became vacant in October 2023 and was promptly filled in December 2023.

A new Health Program Manager position (QI Director) was approved in the budget for FY 2022/23 and started in January 2023. The QI Director leads the QI team and takes point on Consent Decree planning, which had been led by the Health Services Administrator. The QI Director became vacant during this reporting period, but an offer was made to the former QI Coordinator and he began in this role late December 2024.

The Administrative Services Officer II position was filled and started March 2023.

B. Quality Assurance, Mental Health Care

IX.B.1 - Substantial Compliance

"The JPS Medical Director, the JPS Program Manager, jail administrators, and the medical psychiatric, dental, and nursing directors, or appropriate designees, will attend and participate in this process at a minimum of every quarter. Formal minutes will be taken and maintained whenever the committee convenes."

Mental health representatives participate in all QI meetings. There are three specific mental health multidisciplinary subcommittees: Mental Health (chaired by the MH Program Manager), Suicide Prevention (chaired by the MH Medical Director). The MH QI Subcommittee meets quarterly, and Suicide Prevention Subcommittee meets monthly. The chair will attend all subcommittee meetings or will assign a designee.

IX.B.2 - Substantial Compliance

"The mental health care quality assurance plan shall include, but is not limited to, the following:

a) Intake processing;
b) Medication services;
c) Screening and assessments;
d) Use of psychotropic medications;
e) Crisis response;
f) Case management;
g) Out-of-cell time;

h) Timeliness of clinical contacts;
i) Provision of mental health evaluation and treatment in confidential settings;
j) Housing of inmates with SMI, including timeliness of placements in higher levels of care and length of stay in various units;
k) Number of commitments pursuant to Welf. & Inst. Code § 5150, et seq.;
l) Use of restraint and seclusion;
m) Tracking and trending of agreed upon data on a quarterly basis;
n) Clinical and custody staffing;
o) Morbidity and mortality reviews with critical analyses of causes or contributing factors, recommendations, and corrective action plans with timelines for completion; and
p) Corrective action plans with timelines for completion to address problems that arise during the implementation of this Remedial Plan and prevent those problems from reoccurring."

Audit tools and reports have been developed related to mental health and suicide prevention Remedial Plan provisions and include:

- Emergent, Urgent and Routine Timelines to Care Report
- Health Service Requests-Timelines to Care
- Confidential Contacts-Main Jail & RCCC
- APU Involuntary Detention Audit
- APU Daily Patient Activity Report
- APU Clinical Restraint Report
- MH Referrals and Encounters
- Prescriber Audit
- Medication Refusals Audit
- MDIP Outcome Report
- APU Discharge Follow-ups-Timelines to Care
- MH Groups Scheduled & Canceled
- Suicide Precautions Quarterly Audit
- Suicide Risk Assessment & Safety Planning
- MDT & Treatment Plan Report
- MH RVR Audit-Main Jail & RCCC
- Medication Verification and Initiation
- Planned and Unplanned Use of Force Referrals & Assessments

Audit tools and reports in development:

- Administrative Segregation Referrals and Assessments
- Groups scheduled, canceled & average number of hours of treatment offered, attended and canceled per patient, per week
- Expanded Census Report that includes all data aspects as defined by Consent Decree
- APU Clinical Restraint Audit

- Adaptive Support Plan Report

Morbidity and Mortality reviews of serious suicide attempts are reviewed at each Suicide Prevention Subcommittee meeting. Staff adopted a Review Checklist suggested by the Suicide Prevention expert. Committee Chairs are responsible to ensure indicators are reviewed and tracked.

IX.B.3 - Substantial Compliance ↑

"The County will conduct peer and supervisory reviews of all mental health staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care."

All MH staff undergo performance evaluations every year.

In May 2024, MH completed an initial Psychiatric Prescriber Audit and identified the following areas of substantial compliance:

- 92% establishing target treatments and assessing progress toward goals
- 94% conducting in-person meetings, if indicated, when making medication changes
- 100% monitoring for adverse impacts/side effects
- 100% monitoring for treatment efficacy

Areas for improvement included: ordering ECG for patients on antipsychotics and ensuring completion of routine labs for patients prescribed antipsychotics, mood stabilizers and/or antidepressants.

MH also has a peer review process. During this reporting period, a system was developed to track MH staff reviews. As a result, the rating for this provision is being increased from Partial Compliance to Substantial Compliance.

C. Quality Assurance, Medical Care

IX.C.1 - Partial Compliance

"The County shall establish a Quality Assurance/Quality Improvement (QA/QI) Unit to develop accurate tracking mechanisms and monitor the timeliness and effectiveness of the following processes of health care, ensuring that all are reviewed at least annually, and shall recommend corrective action for all deficiencies:

a) intake screenings;
b) emergent, urgent, and routine requests from patients and staff referrals for health care, including Health Service Request availability;
c) clinical monitoring of patients, including the delivery of chronic care services to those patients who qualify as chronic care patients;
d) prescriptive practices by the prescribing staff;

e) *medication administration, including the initiation of verified medications, the first doses of medications, medication errors, patient refusals, and patterns of medication administration;*
f) *grievances regarding healthcare;*
g) *specialty care (including outside diagnostic tests and procedures);*
h) *clinical caseloads;*
i) *coordination between custody staff and medical staff, including escorts to medical appointments and delivery of care."*

ACH developed a Quality Assurance/ Quality Improvement (QA/AI) continuous quality improvement (CQI) program, which has implemented several tracking systems and audits to monitor to timeliness and effectiveness of health care delivery consistent with community standards. Corrective Action Plans are developed and implemented to address areas of deficiency.

Audits include, but are not limited to, the following:

- Nurse Intake Audits monitoring referrals at intake and ADA identification and documentation.
- Access to Care Audit monitoring timeliness of emergent, urgent, and routine requests from patients and staff from Health Service Requests.
- Chronic Disease Management Audit monitoring delivery of chronic care services for those with chronic conditions. A separate Chronic Disease Management- Diabetes Management, specifically assesses the quality of services related to Diabetes.
- Medication Initiation and Renewal Audit monitoring initiation of verified medication, first dose of medications, medication errors, and patient refusals.
- Grievance Report monitors all grievances by type, service area, frequency, and response timeliness.
- Specialty Care Audit, which includes monitoring service types and appointment timeliness. QI and Case Management will include onsite specialty clinics in a separate Onsite Specialty Care Audit during the next fiscal year.
- Withdrawal Monitoring Audit analyzes the frequency and timeliness of required face-to-face monitoring, medication, and referrals as appropriate.
- QI tracks SSO escort allocation for daily medical activities and delivery of care. Since the last monitoring period, QI developed a Daily Huddle template and implemented Daily Huddle meetings to ensure continuous coordination between custody and medical staff. Additionally, the ACH and SSO leadership team meets in person monthly to discuss operational needs and plans.

ACH continues to develop audits to monitor clinical caseloads, prescriptive practices by prescribing staff, and coordination between medical staff and SSO Custody, including medical appointments and delivery of care. ACH QI had adopted the medical Subject Matter Experts' recommendation to expand the timeframes of audits and avoid "point-in-time" data collection. This element will be reflected in audits moving forward. As audits are

completed, service line directors are required to submit Corrective Action Plans for deficiencies that do not improve over time.

IX.C.2 - Partial Compliance

"The studies shall be done with sufficient sample numbers to arrive at statistically valid conclusions. The studies shall include (a) a clearly articulated goals, objective, and methodology to determine if standards have been met, including a sampling strategy; (b) data collection; (c) analysis of data to identify trends and patterns; (d) analysis to identify the underlying causes of problems; (e) development of remedies to solve problems; (f) a written plan that identifies responsible staff and establishes a specific timeline for implementing remedies; (g) follow-up data collection; and (h) analysis to determine if the remedies are effective."

Studies are completed with sufficient sample numbers, include clear goals, objectives, and methodology to determine if standards are met, including sampling strategy. Studies include overall findings, recommendations, and comparative analysis. The underlying causes of the problems are reflected in the audits' findings section. As stated previously, QI has improved the sampling strategy and expanded the data collection timeframes as opposed to "point-in-time" sampling, as recommended by the medical SMEs.
QI is continuously improving efforts to implement recommendations derived from the audits via corrective action plans and monthly Continuous Quality Improvement (CQI) meetings. Corrective Action Plans and CQI identify responsible staff and specific timelines for implementing improvement strategies. QI uses Plan-Do-Study-Act (PDSA) for focused interventions.

IX.C.3 - Substantial Compliance

"The QA/QI Unit study recommendations shall be published to all staff."

QI shares recommendations in Executive team meetings, Quality Improvement Committee meetings, and subcommittee meetings as appropriate. Medical representatives participate in all QI meetings. Each forum is quarterly. QI Committee Chairs are responsible for ensuring indicators are reviewed and tracked. Recommendations and corrective actions are discussed, and follow-up is conducted as needed. Audits and recommendations are published on the ACH intranet for all staff.

IX.C.4 - Partial Compliance

"The County will conduct peer and supervisory reviews of all medical staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care."

QI staff have created and implemented a UR nurse chart review tool and began utilizing it in the monthly CQI Chart review meetings. In-person observation audits are conducted on the nurse intake, HSR, and Withdrawal Monitoring processes. QI will continue to work on

additional review tools in the next monitoring period as well as in-person audits on medication administration and mouth-check adherence.

Performance Evaluations are required annually for permanent County staff and more frequently for probationary staff (ACH PP 03-09 Performance Evaluations).

During this reporting period, the Medical Director has initiated peer review of charts by Medical Director, Asst. Medical Director and the lead physicians. A standardized form was created based on a recommendation and review of the provider consultant Dr. Radha Sadacharan and is being utilized. The policy has been drafted and in review. Feedback is being given to providers when issues are identified, including disciplinary actions when needed.

Attachments

1. Abbreviations and References

ACH	Sacramento County Adult Correctional Health
ACMH	Adult Correctional Mental Health
ADA	Americans with Disabilities Act
ADSP	Administrative Separation
ADSEG	Administrative Segregation
AHRQ	Agency for Healthcare Research and Quality
APU	Acute Psychiatric Unit
ASP	Adaptive Support Plan
ATIMS	Advanced Technology Information Management Systems (Jail Management Software)
ATP	Alternative Treatment Program
BOS	Sacramento County Board of Supervisors
BSCC	Board of State and Community Corrections
CAP	Corrective Action Plan
CBF	Christopher Boone Facility
CDHO	Chief Disciplinary Hearing Officer
CERT	Correctional Emergency Response Team
CIWA	Clinical Institute Withdrawal Assessment for Alcohol Scale
CM	Case Management
CNAP	Critical Needs Assessment Program
CO	Constant Observation
COWS	Clinical Opiate Withdrawal Scale
CPAP	Continuous Positive Airway Pressure
CPOE	Computerized Provider Order Entry
CQI	Continuous Quality Improvement
DBT	Dialectal Behavior Therapy
DC	Discharge
DGS	Sacramento County Department of General Services
DHS	Sacramento County Department of Health Services
DME	Durable Medical Equipment
DMHU	Designated Mental Health Unit
DTech	Sacramento County Department of Technology
EASS	Early Access and Stabilization Services
ED	Emergency Department
EHR	Electronic Health Record
eMAR	Electronic Medication Administration Record
EOP	Enhanced Outpatient Program
ER	Emergency Room
FTE	Full-Time Equivalent

HIPAA	Health Insurance Portability and Accountability Act
HPC	Health Program Coordinators
HS	Hours of Sleep
HSR	Health Service Request
H&P	History and Physical
ID	Intellectual Disability
IHSF	Intake and Health Services Facility
IOP	Intensive Outpatient Program
IST	Incompetent to Stand Trial
IUD	Intrauterine Device
JBCT	Jail-Based Competency Treatment
JCIAP	Jail Conditions Improvement Action Planning
JPRP	Jail Population Reduction Plans
JPS	Jail Psych Services (now ACMH)
KOP	Keep On Person
LCSW	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse
MA	Medical Assistant
MAT	Medication Assisted Treatment
MDT	Multi-Disciplinary Team
MH	Mental Health
MHD	Mental Health Diversion
MHU	Medical Health Unit
MHW	Mental Health Worker
MJ	Main Jail
MOC	Medical Observation Cell
MoCA	Montreal Cognitive Assessment
M&M	Morbidity and Mortality
NOC Shift	Night Shift
NSC	Nurse Sick Call
OB/GYN	Obstetrics and Gynecology
OPP	Outpatient Psychiatric Pod (SSO housing classification)
OTC	Over-the-counter
PC	Protective Custody
PDSA	Plan-Do-Study-Act
PHI	Protected Health Information
POST	Commission on Peace Officer Standards and Training
PREA	Prison Rape Elimination Act
PSJA	Sacramento County Public Safety and Justice Agency
PT	Physical Therapy
PUOF	Planned Use of Force
QA	Quality Assurance

QI	Quality Improvement
QMHP	Qualified Mental Health Professional
RCCC	Rio Cosumnes Correctional Center
RN	Registered Nurse
RVR	Rule Violation Review
SBF	Stuart Baird Facility
SITHU	Suicidal Temporary Housing Unit
SLI	Sign Language Interpretation/Interpreters
SME	Subject Matter Expert
SMI	Serious Mental Illness
SNP	Standardized Nursing Protocol
SOAP	Subjective, Objective, Assessment and Plan
SP	Suicide Prevention
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SSO	Sacramento County Sheriff's Office
STC	Standards and Training for Corrections
SUD	Substance Use Disorder
TBD	To Be Determined
TDD	Telecommunications Device for the Deaf
TGD	Transgender Gender Diverse
UCD	University of California, Davis
UM	Utilization Management
UOF	Use of Force
UR	Utilization Review
VHA	Veterans Health Administration
VRI	Video Remote Interpreting
VRS	Video-Relay Services
WD	Withdrawal
WPATH	World Professional Association for Transgender Health
WRAP	Wrap Restraint System

2. ACH and ACMH Policy and Procedure Developments and Revisions

Policy Status	Quantity in 9th Status Report	Current Quantity (December 2024)	Change
ACH Policies			
Finalized	44 (86%)	38 (75%)	-6
In Process	3 (6%)	3 (6%)	N/A
Pending Subject Matter Expert/Class Counsel Review	4 (8%)	10 (19%)	+6
Total	51 (100%)	51 (100%)	N/A
ACH Provider Treatment Guidelines			
Finalized	1 (25%)	1 (25%)	N/A
In Process	0 (0%)	0 (0%)	N/A
Pending Subject Matter Expert/Class Counsel Review	3 (75%)	3 (75%)	N/A
Total	4 (100%)	4 (100%)	N/A
ACH Standardized Nursing Procedures (SNP)			
Finalized	4 (8%)	4 (8%)	N/A
In Process	6 (12%)	6 (12%)	N/A
Pending Subject Matter Expert/Class Counsel Review	42 (80%)	42 (80%)	N/A
Total	52 (100%)	52 (100%)	N/A
Mental Health Policies			
Finalized	26 (96%)	28 (100%)	+2
In Process	0 (0%)	0 (0%)	N/A
Pending Subject Matter Expert/Class Counsel Review	1 (4%)	0 (0%)	N/A
Total	27 (100%)	28 (100%)	+2

ACH Policies and Procedures developed or revised during the reporting period (July 1, 2024 – December 31, 2024):

- 04-12 Emergency Medical Response - Sent to SME for Review 10/11/24
- 05-TBD Nurse Sick Call - Developed 9/30/2024 - Sent to SME for review 10/3/24
- 05-25 Intake Medical Observation Cell - Developed 9/6/2024 - Approved 11/14/24

The following Policies and Procedures were revised before this reporting period, but are still pending SME/Class Counsel review:

- 01-08 Medical Review of In-Custody Deaths - Sent to Class Counsel 9/24/24
- 01-09 Grievance Process for Health/ Disability Complaints - Sent to SME for Review 10/2/24
- 04-13 Man-down Drill - Sent to SME for review 10/9/24
- 04-14 Disaster Response - Sent to SME for review 10/5/22
- 04-22 Hospital Care - Sent to SME for review 12/29/23
- 05-05 Nurse Intake - Sent to SME for review 9/30/24
- 05-09 Health Service Requests - Sent to SME for review 10/01/24
- 05-14 Benzodiazepine Withdrawal Treatment - Under ACH Review
- 05-15 Opioid Withdrawal Monitoring and Treatment - Under ACH Review
- 05-17 Alcohol Withdrawal Treatment - Under ACH Review
- 08-01 Safeguarding Protected Health Information (Joint Policy) - Sent to SME for review 6/25/21, MH expert approved on 9/20/23, still waiting for Medical SME feedback
- 08-08 Patient Privacy (Joint policy) - Sent to SME for review on 5/21/21, MH sent feedback on 9/20/23, still waiting Medical SME feedback

3. SSO Policy and Procedure Developments and Revisions

SSO Policies and Procedures developed or revised during the reporting period (July 1, 2024 – December 31, 2024):

Procedures	**Date Completed**
400 Facility Emergencies	7/4/24
502 Reception	11/21/24
505 Special Management Incarcerated Persons	7/3/24
512 Searches	10/11/24
514 Reporting In-Custody Deaths	8/15/24
516 Transportation of Incarcerated Persons	11/20/24
521 Body Scanner	7/29/24
804 Incarcerated Person Hygiene	7/11/24
Policies	
511 Use of Restraints	11/19/24
512 Searches	10/9/24
514 Reporting In-Custody Deaths	7/3/24
516 Transportation of Incarcerated Persons	11/20/24
519 End of Term Release	11/20/24
601 Disciplinary Separation	7/10/24
601 Prison Rape Elimination Act	7/29/24
609 Service of Process on Incarcerated Persons	7/17/24
716 Incarcerated Person Health Care Communication	7/11/24
804 Incarcerated Person Hygiene	7/11/24
1003 Exercise and Out of Cell Time	7/10/24
1008 Telephone Access	8/28/24
1009 Visitation	8/28/24
1013 Religious Programs	7/9/24

4. ACH and ACMH Audits and Studies

ACH Audits and Studies Completed during this Reporting Period (July 1, 2024 – December 31, 2024):

- FY 24/25 Q1 Health Services Request Audit
- FY 24/25 Q1 ADA Audit
- FY 24/25 Q1 Diabetes Audit
- FY 24/25 Q1 Suicide Risk Inquiry (in-person) Audit
- FY 24/25 Q1 Nurse Intake Referrals Audit
- FY 24/25 Ad Hoc Waste Management Audit
- 11/20/25 NSC MJ (in-person) Audit

ACMH Audits and Studies Completed during this Reporting Period[8]:

- 07-13-2024 SRA and Safety Planning Dec 2023-Feb 2024
- 07-23-2024 PUOF Audit May 2024
- 08-12-24 Suicide Precautions Weekly Audit-Qrt Report May-Jul 2024
- 08-13-24 APU Discharge Follow-ups-Timelines to Care Apr-Jun 2024
- 08-13-24 Main Jail MH RVR Audit Apr-Jun 2024
- 08-13-2024 RCCC Confidential Contacts Report Apr-Jun 2024
- 08-13-2024 APU Deputy Support Apr-Jun 2024
- 08-13-2024 APU Involuntary Detention Audit Apr-Jun 2024
- 08-13-2024 HSR Timelines to Care Mar-May 2024
- 08-13-2024 Main Jail Confidential Contacts Report Apr-Jun 2024
- 08-13-2024 MDT Treatment Plan Oct-Dec 2023
- 08-13-2024 Medication Verification Initiation Dec 2023-Feb 2024
- 08-13-2024 MH Groups Scheduled and Cancelled Apr-Jun 2024
- 08-13-2024 MH Referrals Encounters Jan 2021-Jun 2024
- 08-13-2024 Prescriber Audit Mar-May 2024
- 08-13-2024 R3C MH RVR Audit Apr-Jun 2024
- 08-13-2024 TLC-Emergent Urgent and Routine Mar-May 2024
- MH DC Linkages Report Jul 24
- 10-29-2024 WRAP Audit Sep 2024
- 10-29-2024 PUOF Audit Sep 2024
- 11-12-2024 APU Discharge Follow-ups-Timelines to Care Jul-Sep 2024
- 11-12-2024 APU Involuntary Detention Audit Jul-Sep 2024
- 11-12-2024 APU Deputy Support Report Jul-Sep 2024
- 11-12-2024 TLC-Emergent Urgent and Routine Jun-Aug 2024
- 11-12-2024 HSR Timelines to Care Jun-Aug 2024

[8] ACMH reports, studies, and audits completed in December 2024 were not available at time of publication.

- 11-12-2024 Main Jail Confidential Contacts Report Jul-Sep 2024
- 11-12-2024 Medication Verification Mar-May 2024
- 11-12-2024 Prescriber Audit Jun-Aug 2024
- 11-12-2024 RCCC RVR Jul-Sep 2024
- 11-12-2024 SRA and Safety Planning Audit Mar-May 2024
- 11-12-2024 RCCC Confidential Contacts Report Jul-Sep 2024
- 11-12-2024 MH Groups Scheduled and Cancelled Jul-Sep 2024
- 11-12-2024 Main Jail MH RVR Audit Jul-Sep 2024
- 11-12-2024 MH Referrals Encounters Jan 2021-Sep 2024

5. Adjustments to 9th County Status Report Compliance Ratings

21 provisions were originally rated Substantial Compliance by ACH that were reduced to Partial Compliance:

- III.A.3
- III.F.1
- III.F.4
- III.I.1
- III.I.2
- III.I.3
- III.I.4
- III.I.5
- III.I.6
- III.I.7
- III.I.8
- III.I.9
- III.J.1
- III.K.2
- III.O.1
- III.P.1
- III.P.2
- III.P.3
- IV.A.1
- IV.A.2
- IV.E.1

1 provision was originally rated Substantial Compliance by SSO that was reduced to Non-Compliance:

- VI.G.2

32 provisions were originally rated Substantial Compliance by SSO that were reduced to Partial Compliance:

- III.F.2
- III.K.1
- III.K.4
- IV.A.3
- IV.C.3
- IV.E.5
- IV.E.6
- IV.F.1
- IV.F.2
- IV.F.5
- IV.F. 6
- IV.I.1
- V.A.2
- V.D.4
- V.E.3
- V.E.4
- V.E.5
- VI.C.2
- VI.G.1
- VI.G.3
- VI.G.4
- VI.P.2
- VII.B.1
- VII.B.2
- VII.H.2
- VII.J.1
- VII.K.3
- VIII.C.2
- VIII.C.3
- VIII.D.1
- VII.D.3

6. Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation

As of December 2024, one monitoring report has been completed to evaluate the American with Disabilities Act (ADA) remedial plan provisions in the Consent Decree. The first monitoring report was completed by Class Counsel (Aaron J. Fischer from the Law Office of Aaron J. Fischer, Margot Mendelson and Patrick Booth from the Prison Law Office, and Anne Handreas from Disability Rights California). The "First Monitoring Report on Americans with Disabilities Act Compliance Practices in the Sacramento County Jails" was published in March 2021. While the Court-appointed experts provided narrative comments on the various categories in the remedial plan, **no compliance ratings were assigned**.

On page 25 of the "Mental Health Expert's Fourth Round Report of Findings" by Mary Perrien, Ph.D., dated May 1, 2024, Dr. Perrien assigned a rating of Partial Compliance to provision **III.O.1**.

7. Mental Health Remedial Plan Expert Rating Reconciliation

As of December 2024, four monitoring reports have been completed to evaluate the Mental Health remedial plan provisions in the Consent Decree. The fourth monitoring report was completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

Provision	Expert Rating	Notes/Explanation
IV.A. Policies and Procedures		
IV.A.1	Partial Compliance	Pg. 27- Dr. Perrien mis-identifies IV.A.1.a-h as IV.A.1-8. Dr. Perrien rated IV.A.1.a-g as Substantial Compliance; however, since IV.A.1.h was rated with Partial Compliance, the entire provision is reduced to Partial Compliance.
IV.A.2	Partial Compliance	
IV.A.3	Not Rated	Pg. 28 - Dr. Perrien skips IV.A.3, moving from IV.A.2 to IV.A.4 instead.
IV.A.4	Partial Compliance	
IV.B. Organizational Structure		
IV.B.1	Partial Compliance	
IV.B.2	Substantial Compliance	
IV.B.3	Substantial Compliance	
IV.C. Patient Privacy		
IV.C.1	Partial Compliance	
IV.C.2	Partial Compliance	
IV.C.3	Not Rated	Pg. 30 - Dr. Perrien notes that IV.C.3 was not assessed.
IV.C.4	Partial Compliance	
IV.C.5	Partial Compliance	
IV.D. Clinical Practices		
IV.D.1	Partial Compliance	Pg. 36 - Dr. Perrien provides a rating for "IV.D." Based on context provided, it is inferred that this rating was intended to apply to IV.D.1.
IV.D.2	Partial Compliance	
IV.D.3	Partial Compliance	
IV.D.4	Partial Compliance	
IV.D.5	Partial Compliance	
IV.D.6	Partial Compliance	
IV.D.7	Partial Compliance	
IV.D.8	Partial Compliance	
IV.E. Medication Administration and Monitoring		
IV.E.1	Partial Compliance	

IV.E.2	Partial Compliance	
IV.E.3	Partial Compliance	
IV.E.4	Partial Compliance	
IV.E.5	Partial Compliance	
IV.E.6	Partial Compliance	
IV.E.7	Partial Compliance	
IV.F. Placement Conditions, Privileges, and Programming		
IV.F.1	Partial Compliance	Pg. 46 - Dr. Perrien provides a rating for "IV.F." Based on context provided, it is inferred that this rating was intended to apply to IV.F.1.
IV.F.2	Partial Compliance	Pg. 48 - Dr. Perrien rates the Non-Acute Units as being in Partial Compliance, and Acute Units as being in Non-Compliance.
IV.F.3	Partial Compliance	
IV.F.4	Partial Compliance	Pg. 51 - Dr. Perrien rates the Non-Acute Units as being in Partial Compliance, and Acute Units as being in Non-Compliance.
IV.F.5	Not Rated	Pg. 52 - Dr. Perrien skips IV.F.5, moving from IV.F.4 to IV.F.6 instead.
IV.F.6	Partial Compliance	Pgs. 52-55 - Dr. Perrien rates IV.F.6.a-d separately from IV.F.6.e; however, both portions were assigned a rating of Partial Compliance.
IV.G. Medico-Legal Practices		
IV.G.1	Partial Compliance	Pg. 55 - Dr. Perrien rated all of category IV.G as Partial Compliance. As a result, all provisions within this category have been rated with Partial Compliance.
IV.G.2	Partial Compliance	
IV.G.3	Partial Compliance	
IV.H. Clinical Restraints and Seclusion		
IV.H.1	Substantial Compliance	Pgs. 56-57 - Dr. Perrien provides an explanation along with her rating.
IV.H.2	Substantial Compliance	
IV.H.3	Partial Compliance	
IV.I. Training		
IV.I.1	Partial Compliance	

8. Disciplinary Measures and Use of Force Remedial Plan Expert Rating Reconciliation

As of December 2024, four monitoring reports have been completed to evaluate the Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the the fourth monitoring report completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

In addition to evaluating provisions within the Consent Decree, Dr. Perrien rated three additional provisions from Focus Area #4, Use of Force Policies and Practices, Class Members with Disabilities, from the June 2022 Memorandum of Agreement (MOA). Sacramento County Status Reports have not historically assigned compliance ratings to provisions in the MOA. Sacramento County intends to assign compliance ratings to the MOA provisions in the July 2025 County Status Report.

Provision	Expert Rating	Notes/Explanation
V.A. Role of Mental Health Staff in Disciplinary Process		
V.A.1	Substantial Compliance	
V.A.2	Partial Compliance	
V.A.3	Substantial Compliance	
V.B. Consideration of Mental Health Input and Other Disability Information in Disciplinary Process		
V.B.1	Non-Compliance	
V.B.2	Non-Compliance	
V.B.3	Non-Compliance	
V.B.4	Partial Compliance	
V.B.5	Partial Compliance	
V.B.6	Not Rated	Pg. 64 – Dr. Perrien identified this provision as being unable to be assessed due to a lack of adequate information.
V.B.7	Partial Compliance	
V.C. Accommodations for Prisoners with Mental Health or Intellectual Disabilities During the Disciplinary Process		
V.C.1	Not Rated	Pg. 65 – Dr. Perrien noted that she could not assess these provisions due to a lack of adequate documentation.
V.C.2	Not Rated	
V.D. Use of Force for Prisoners with Mental Health or Intellectual Disabilities		
V.D.1	Partial Compliance	
V.D.2	Partial Compliance	
V.D.3	Partial Compliance	
V.D.4	Non-Compliance	
V.D.5	Partial Compliance	

V.D.6	Partial Compliance	
V.D.7	Non-Compliance	
V.E. Training & Quality Assurance		
V.E.1	Partial Compliance	Pgs. 65-66 – Dr. Perrien refers to these provisions as V.F.1-5.
V.E.2	Partial Compliance	
V.E.3	Non-Compliance	
V.E.4	Partial Compliance	
V.E.5	Non-Compliance	
MOA Provision	**Expert Rating**	**Notes/Explanation**
MOA.3.a	Substantial Compliance	Pgs. 66-69 – Dr. Perrien refers to these provisions as V.E.1-3.
MOA.3.b	Partial Compliance	
MOA.4	Non-Compliance	

9. SSO Disciplinary Process and MH Referral Flow Chart

Sheriff's Office Disciplinary Process - Supplemental to SSO Policy and Procedure 600:
During the initial review, an inmate needs a Rule Violation Review if they meet any of the following criteria (also listed on the updated RVR form):

- RVR Criteria
  - Inmate is in a MH designated housing unit: APU, IOP, JBCT, OPP housing unit or APU preadmission list
  - Inmate has a SMI diagnosis
  - Inmate has an intellectual disability
  - Inmate has a developmental disability
  - Jail staff have reason to believe the prisoner's behavior was unusual, uncharacteristic, or a possible manifestation of mental illness
  - Prisoner is on the mental health caseload and may lose good time credit as a consequence of the disciplinary infraction with which he or she is charged
- If an RVR is submitted, do not complete the Supervisor Action during the initial review of the incident report.
- If an RVR is not submitted, complete the Supervisor Action during the initial review of the incident report.
- If the inmate is immediately sent to a discipline pod as a result of the incident and will remain in the discipline pod pending their hearing, you will need to submit a Disciplinary Placement Review at the same time you submit the RVR. A Disciplinary Placement Review is not needed at this time for inmates who are moved to a 7W/8W non-disciplinary pod.

After the hearing, an inmate needs a Disciplinary Placement Review if they meet any of the following criteria (also listed on the new DPR form):

- DPR Criteria
  - Inmate placed in a non-disciplinary Segregation housing unit
  - Inmate placed in a Disciplinary Detention unit
  - Inmate subjected to Disciplinary Segregation conditions for 72 hours in their general population housing unit (i.e., confined to cell 23 hours per day)
- If a DPR was already submitted for this incident (due to immediately being placed in a discipline pod pending the hearing), you still need to submit an additional DPR after the disciplinary hearing. You will need to credit the inmate with time served in the discipline pod by changing the discipline start date to the day the inmate was moved into the discipline pod.
- You no longer need to postdate the discipline start date, all discipline can start immediately.

Mental Health Referral Flow Chart

Does the inmate meet the following criteria:

a. Inmate is in a Mental Health housing unit: Acute Psychiatric Unit (APU)(2P), Intensive Outpatient Psych Program (IOP), Jail Based Competency Treatment (JBCT), Outpatient Psych Patient (OPP) or APU preadmission list.
b. Inmate has a SMI diagnosis
c. Inmate has an intellectual disability
d. Inmate has a developmental disability
e. Reason to believe the inmate's behavior was unusual, uncharacteristic, or a manifestation of mental illness
f. Inmate is on the Mental Health Caseload

Yes
Complete the RVR. **DO NOT** complete the Supervisor Action

→ CDHO will receive the ACMH RVR return and complete the Supervisor Action

No
RVR is not required. Complete the Supervisor Action

→ The incident will proceed to the inmate notice and the 24-72 hour disciplinary hearing window. Before you conduct the disciplinary hearing, check to see if an RVR was needed based on the above RVR criteria.

Yes
Was the ACMH RVR return uploaded to the incident report?

- **Yes**
  Review the ACMH RVR return, complete the disciplinary hearing, and add any applicable sanctions. **END**
- **No**
  Complete the disciplinary hearing and include your findings (guilty/not guilty). No sanctions can be imposed for the inmate due to the violation of the inmate's Incident Report due process. Email the CDHO with the inmate's name, x-ref, and Incident Report number so the incident can be reviewed. **END**

No
Complete the disciplinary hearing and add any applicable sanctions. **END**

Reminder: The hearing officer is required to take the ACMH findings and any other available disability information into consideration while conducting the hearing and imposing sanctions. If the hearing officer does not follow the ACMH determination regarding whether the behavior was related to symptoms of mental illness or intellectual disability, whether any mitigating factors should be considered, and whether certain sanctions should be avoided, the hearing officer shall explain in their hearing report why they were not followed.

10. Medical Care Remedial Plan Expert Rating Reconciliation

As of December 2024, five monitoring reports have been completed to evaluate the Medical Care remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fifth monitoring report completed by Madeleine L. LaMarre MN, FNP-BC, Angela Goehring RN, MSA, CCHP, and Susi Vassallo MD. The "Fifth Monitoring Report of the Medical Consent Decree" is dated July 15, 2024.

Provision	Expert Rating	Notes/Explanation
VI.A. Staffing		
VI.A.1	Partial Compliance	
VI.A.2	Non-Compliance	
VI.B. Intake		
VI.B.1	Substantial Compliance	
VI.B.2	Non-Compliance	
VI.B.3	Substantial Compliance	
VI.B.4	Partial Compliance	
VI.B.5	Partial Compliance	
VI.B.6	Partial Compliance	
VI.B.7	Substantial Compliance	
VI.C. Access to Care		
VI.C.1	Non-Compliance	
VI.C.2	Partial Compliance	
VI.C.3	Partial Compliance	Pgs. 43-44 - The Court-appointed experts assigned a rating of Non-Compliance to VI.C.3.a and a rating of Partial Compliance to VI.C.3.b-d.
VI.C.4	Non-Compliance	
VI.C.5	Non-Compliance	
VI.C.6	Substantial Compliance	
VI.C.7	Non-Compliance	Pg. 44 – Separate ratings were provided for VI.C.7.a and VI.C.7.b; however, both were assigned the same rating of Non-Compliance.
VI.D. Chronic Care		
VI.D.1	Partial Compliance	Pg. 54 - The Court-appointed experts assigned a rating of Partial Compliance to VI.D.1.a, VI.D.1.b, and VI.D.1.d. The experts assigned a rating of Non-Compliance to VI.D.1.c.
VI.D.2	Non-Compliance	
VI.D.3	Substantial Compliance	
VI.E. Specialty Services		
VI.E.1	Substantial Compliance	
VI.E.2	Partial Compliance	

VI.E.3	Non-Compliance	
VI.E.4	Partial Compliance	
VI.E.5	Partial Compliance	Pg. 66 – The Court-appointed experts noted the ratings for these provisions as "Partial Compliance (low)."
VI.E.6	Partial Compliance	
VI.E.7	Partial Compliance	
VI.E.8	Substantial Compliance	
VI.E.9	Non-Compliance	
VI.E.10	Substantial Compliance	
VI.F. Medication Administration and Monitoring		
VI.F.1	Partial Compliance	Pg. 73 – The Court-appointed experts rated IV.F.1.a as being in Substantial Compliance and IV.F.1.b as being in Partial Compliance. Because part of the rating remains in Partial Compliance, the entire provision is reduced to Partial Compliance.
VI.F.2	Non-Compliance	
VI.F.3	Partial Compliance	
VI.F.4	Partial Compliance	
VI.F.5	Substantial Compliance	Pg. 73 – The Court-appointed experts rated IV.F.5 as "Substantial Partial." Due to the table in Pg. 123 rating this provision as being in Substantial Compliance, the text on Pg. 73 is interpreted as a typo/error.
VI.F.6	Partial Compliance	
VI.G. Clinical Space and Medical Placements		
VI.G.1	Non-Compliance	
VI.G.2	Non-Compliance	
VI.G.3	Substantial Compliance	
VI.G.4	Substantial Compliance	
VI.G.5	Substantial Compliance	
VI.H. Patient Privacy		
VI.H.1	Non-Compliance	
VI.H.2	Non-Compliance	
VI.H.3	Non-Compliance	
VI.H.4	Substantial Compliance	
VI.I. Health Care Records		
VI.I.1	Substantial Compliance	
VI.I.2	Partial Compliance	
VI.I.3	Substantial Compliance	
VI.J. Utilization Management		
VI.J.1	Substantial Compliance	
VI.J.2	Partial Compliance	

VI.J.3	Non-Compliance	
VI.J.4	Substantial Compliance	
VI.K. Sanitation		
VI.K.1	Substantial Compliance	
VI.L. Reproductive and Pregnancy Related Care		
VI.L.1	Partial Compliance	
VI.L.2	Substantial Compliance	
VI.L.3	Partial Compliance	
VI.M. Transgender and Gender Non-Conforming Health Care		
VI.M.1	Partial Compliance	
VI.M.2	Substantial Compliance	
VI.N Detoxification Protocols		
VI.N.1	Partial Compliance	
VI.N.2	Partial Compliance	
VI.O. Nursing Protocols		
VI.O.1	Partial Compliance	
VI.O.2	Partial Compliance	
VI.P. Review of In-Custody Deaths		
VI.P.1	Substantial Compliance	
VI.P.2	Partial Compliance	
VI.Q. Reentry Services		
VI.Q.1	Partial Compliance	
VI.Q.2	Non-Compliance	
VI.Q.3	Substantial Compliance	
VI.R. Training		
VI.R.1	Non-Compliance	

11. Suicide Prevention Remedial Plan Expert Rating Reconciliation

As of December 2024, five monitoring reports have been completed to evaluate the Suicide Prevention remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fifth monitoring report completed by Lindsay M. Hayes. The "Fifth Monitoring Report of Suicide Prevention Practices" is dated November 11, 2024.

Provision	Expert Rating	Notes/Explanation
VII.A. Substantive Provisions		
VII.A.1	Partial Compliance	
VII.A.2	Partial Compliance	
VII.B. Training		
VII.B.1	Partial Compliance	
VII.B.2	Partial Compliance	
VII.B.3	Partial Compliance	
VII.B.4	Substantial Compliance	
VII.B.5	Substantial Compliance	
VII.B.6	Partial Compliance	
VII.C. Nursing Intake Screening		
VII.C.1	Non-Compliance	
VII.C.2	Non-Compliance	
VII.C.3	Substantial Compliance	
VII.C.4	Non-Compliance	
VII.C.5	Substantial Compliance	
VII.C.6	Substantial Compliance	
VII.D. Post-Intake Mental Health Assessment Procedures		
VII.D.1	Partial Compliance	
VII.D.2	Partial Compliance	
VII.D.3	Partial Compliance	
VII.E. Response to Identification of Suicide Risk or Need for Higher Level of Care		
VII.E.1	Partial Compliance	
VII.E.2	Substantial Compliance	
VII.E.3	Substantial Compliance	
VII.E.4	Substantial Compliance	
VII.F. Housing of Inmates on Suicide Precautions		
VII.F.1	Non-Compliance	
VII.G. Inpatient Placements		
VII.G.1	Non-Compliance	
VII.H. Temporary Suicide Precautions		
VII.H.1	Partial Compliance	
VII.H.2	Substantial Compliance	

VII.H.3	Partial Compliance	
VII.H.4	Partial Compliance	
VII.H.5	Partial Compliance	
VII.H.5	Substantial Compliance	
VII.I. Suicide Hazards in High-Risk Housing Locations		
VII.I.1	Partial Compliance	
ViI.I.2	Substantial Compliance	
VII.J. Supervision/Monitoring of Suicidal Inmates		
VII.J.1	Non-Compliance	
VII.J.2	Substantial Compliance	
VII.J.3	Partial Compliance	
VII.J.4	Substantial Compliance	
VII.J.5	Substantial Compliance	
VII.K. Treatment of Inmates Identified as at Risk of Suicide		
VII.K.1	Partial Compliance	
VII.K.2	Partial Compliance	
VII.K.3	Partial Compliance	
VII.L. Conditions for Individual Inmates on Suicide Precautions		
VII.L.1	Partial Compliance	
VII.M. Property and Privileges		
VII.M.1	Partial Compliance	
VII.M.2	Partial Compliance	
VII.M.3	Partial Compliance	
VII.N Use of Safety Suits		
VII.N.1	Substantial Compliance	
VII.N.2	Partial Compliance	
VII.N.3	Substantial Compliance	
VII.N.4	Partial Compliance	
VII.N.5	Partial Compliance	
VII.N.6	Partial Compliance	
VII.N.7	Substantial Compliance	
VII.O. Beds and Bedding		
VII.O.1	Substantial Compliance	
VII.P. Discharge from Suicide Precautions		
VII.P.1	Partial Compliance	
VII.P.2	Partial Compliance	
VII.P.3	Substantial Compliance	
VII.P.4	Partial Compliance	
VII.Q. Emergency Response		
VII.Q.1	Substantial Compliance	
VII.Q.2	Partial Compliance	

VII.Q.3	Substantial Compliance	
VII.R. Quality Assurance and Quality Improvement		
VII.R.1	Substantial Compliance	
VII.R.2	Substantial Compliance	
VII.R.3	Partial Compliance	
VII.R.4	Substantial Compliance	
VII.R.5	Partial Compliance	

12. Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation

As of December 2024, three monitoring reports have been completed to evaluate the Segregation/Restricted Housing remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the third monitoring report completed by Patrick Booth and Margot Mendelson of the Prison Law Office and Aaron J. Fischer from the Law Office of Aaron J. Fischer. The "Third Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails" is dated December 22, 2023.

Additionally, some provisions were evaluated by the Court-Appointed Mental Health Expert, Mary Perrien, Ph.D. in the "Mental Health Expert's Fourth Round Report of Findings" dated May 1, 2024. Provisions rated by the Mental Health Expert are indicated with an asterisk(*).

Provision	Expert Rating	Notes/Explanation
VIII.A. General Principles		
VIII.A.1	Partial Compliance	Pg. 1 of Attachment B – Compliance includes separate ratings for VIII.A.1 (Partial Compliance), VIII.A.1.a (Partial Compliance), VIII.A.1.b (Substantial Compliance – described as "Compliant"), VIII.A.1.c (Non-Compliance), and VIII.A.1.d (Not Rated – described as Not Evaluated).
VIII.A.2	Partial Compliance	
VIII.A.3	Non-Compliance	
VIII.B. Conditions of Confinement		
VIII.B.1	Partial Compliance	
VIII.B.2	Partial Compliance	
VIII.B.3	Partial Compliance	
VIII.B.4	Substantial Compliance	
VIII.B.5	Non-Compliance	
VIII.B.6	Not Rated	
VIII.C. Mental Health Functions in Segregation Units		
VIII.C.1*	Partial Compliance	Pg. 3 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. Pgs. 77-78 of the 4th Mental Health Expert report include a rating of Partial Compliance for this provision.
VIII.C.2*	Partial Compliance	Pgs. 3-4 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. Pgs. 78-79 of the 4th

		Mental Health Expert report include a rating of Partial Compliance for this provision.
VIII.C.3*	Partial Compliance	Pg. 4 of Attachment B – Compliance assigned a rating of Non-Compliance for Provision VIII.C.3.a. However, pgs. 78-79 of the 4th Mental Health Expert report assigned a rating of Partial Compliance for Provision VIII.C.3. As the 4th Mental Health Expert report is more recent than the 3rd Monitoring Report on Restricted Housing, the Mental Health Expert's rating stands.
VIII.D. Placement of Prisoners with Serious Mental Illness in Segregation		
VIII.D.1*	Partial Compliance	Pg. 4 of Attachment B – Compliance assigned a rating of Non-Compliance for Provision VIII.D.1. However, pgs. 79-80 of the 4th Mental Health Expert report assigned a rating of Partial Compliance for Provision VIII.D.1. As the 4th Mental Health Expert report is more recent than the 3rd Monitoring Report on Restricted Housing, the Mental Health Expert's rating stands.
VIII.D.2*	Partial Compliance	Pgs. 4-5 of Attachment B – Compliance assigned a rating of Non-Compliance for Provision VIII.D.2. However, pgs. 79-80 of the 4th Mental Health Expert report assigned a rating of Partial Compliance for Provision VIII.D.2. As the 4th Mental Health Expert report is more recent than the 3rd Monitoring Report on Restricted Housing, the Mental Health Expert's rating stands.
VIII.D.3*	Partial Compliance	Pg. 5 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. Pg. 81 of the 4th Mental Health Expert report includes a rating of Partial Compliance for this provision.
VIII.E. Administrative Segregation		
VIII.E.1	Substantial Compliance	
VIII.E.2	Partial Compliance	Pg. 6 of Attachment B – Compliance includes separate ratings for its sub-provisions. VIII.E.2.a, VIII.E.2.c, VIII.E.2.d, and VIII.E.2.f were assigned a rating of Substantial Compliance (described as Compliant). VIII.E.2.b was assigned a rating of Partial

		Compliance. VIII.E.2.e and VIII.E.2.G were Not Rated (described as Not Evaluated). Because part of the rating remains in Partial Compliance, the entire provision is reduced to Partial Compliance.
VIII.E.3	Partial Compliance	Pgs. 6-7 of Attachment B – Compliance includes separate ratings for its sub-provisions. VIII.E.3.a, VIII.E.3.b.i, VIII.E.3.b.iii, VIII.E.3.b.iv, VIII.E.3.c.b, VIII.E.3.c.c, and VIII.E.3.c.e were assigned a rating of Substantial Compliance (described as Compliant). VIII.E.3.b.ii and VIII.E.3.c.a were assigned ratings of Partial Compliance. VIII.E.3.c.d was assigned a rating of Non-Compliance.
VIII.F. Protective Custody		
VIII.F.1	Substantial Compliance	
VIII.F.2	Partial Compliance	
VIII.F.3	Not Rated	Pg. 8 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.F.4	Partial Compliance	Pg. 8 of Attachment B – Compliance includes separate ratings for each sub-provision. VIII.F.4 and VIII.F.4.a were assigned ratings of Substantial Compliance (described as Compliance). VIII.F.4.b was assigned a rating of Non-Compliance. VIII.F.4.c was described as Not Evaluated.
VIII.F.5	Not Rated	Pg. 8 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G. Disciplinary Segregation		
VIII.G.1	Not Rated	Pg. 8 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.2	Not Rated	Pg. 8 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.3	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.4	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.5	Partial Compliance	
VIII.G.6	Partial Compliance	
VIII.G.7	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.

VIII.G.8	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.9	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.10	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.G.11	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.H. Avoiding Release from Jail Directly from Segregation		
VIII.H.1	Not Rated	Pg. 9 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.H.2	Not Rated	Pgs. 9-10 of Attachment B – Compliance describes this provision as Not Evaluated.
VIII.I. No Food-Related Punishment		
VIII.I.1	Substantial Compliance	
VIII.J. Restraint Chairs		
VIII.J.1	Not Rated	Pg. 10 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. There is no reference to this provision in the 4th Mental Health Expert Report.
VIII.J.2	Not Rated	Pg. 10 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. There is no reference to this provision in the 4th Mental Health Expert Report.
VIII.J.3	Not Rated	Pg. 10 of Attachment B – Compliance describes this provision as being evaluated by the Mental Health Expert. There is no reference to this provision in the 4th Mental Health Expert Report.

13. Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation

As of December 2024, four monitoring reports have been completed to evaluate the Mental Health remedial plan provisions and five monitoring reports have been completed to evaluate the Medical Care remedial plan provisions. Both reports included ratings for provisions in Section IX. Quality Assurance Systems for Health Care Treatment.

The fourth Mental Health monitoring report was completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

The fifth Medical Care monitoring report was completed by Madeleine L. LaMarre MN, FNP-BC, Angela Goehring RN, MSA, CCHP, and Susi Vassallo MD. The "Fifth Monitoring Report of the Medical Consent Decree" is dated July 15, 2024.

<u>Rating Assignments:</u>

- IX.A was not assigned to a Court-Appointed Monitor for evaluation.
- IX.B is evaluated by the Mental Health Expert.
- IX.C is evaluated by the Medical Care Experts.

Provision	Expert Rating	Notes/Explanation
IX.A. Generally		
IX.A.1	N/A	
IX.A.2	N/A	
IX.A.3	N/A	
IX.B. Quality Assurance, Mental Health Care		
IX.B.1	Partial Compliance	Pgs. 82-83 of the 4th Mental Health Expert report includes a single rating of Partial Compliance to IX.B. Based on context provided, it is inferred that this rating was intended to apply to each provision in IX.B.
IX.B.2	Partial Compliance	
IX.B.3	Partial Compliance	
IX.C. Quality Assurance, Medical Care		
IX.C.1	Partial Compliance	
IX.C.2	Partial Compliance	
IX.C.3	Partial Compliance	
IX.C.4	Non-Compliance	