XAVIER BECERRA, State Bar No. 118517
Attorney General of California
ADRIANO HRVATIN, State Bar No. 220909
Supervising Deputy Attorney General
ELISE OWENS THORN, State Bar No. 145931
TYLER V. HEATH, State Bar No. 271478
KYLE A. LEWIS, State Bar No. 201041
LUCAS HENNES, State Bar No. 278361
Deputy Attorneys General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7318
Fax: (916) 324-5205
E-mail: Elise.Thorn@doj.ca.gov
Attorneys for Defendants

ROMAN M. SILBERFELD, State Bar No. 62783
GLENN A. DANAS, State Bar No. 270317
ROBINS KAPLAN LLP
2049 Century Park East, Suite 3400
Los Angeles, CA 90067-3208
Telephone: (310) 552-0130
Fax: (310) 229-5800
E-mail: RSilberfeld@RobinsKaplan.com
Special Counsel for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	Case No. 2:90-cv-00520 KJM-DB (PC) **DEFENDANTS' PLAN ADDRESSING COVID-19 PANDEMIC** Judge: The Hon. Kimberly J. Mueller

During the March 27, 2020 status conference, the Court ordered Defendants to file the California Department of Corrections and Rehabilitation's (CDCR) Statewide Mental Health Program's March 25, 2020 plan addressing the impacts of the COVID-19 pandemic.

Attached is a letter from CDCR's Office of Legal Affairs providing the March 25, 2020 Memorandum and plan for the COVID-19 Mental Health Delivery of Care Guidance.

Dated: March 27, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ADRIANO HRVATIN
Supervising Deputy Attorney General

/S/ *ELISE OWENS THORN*
Elise Owens Thorn
Deputy Attorney General
Attorneys for Defendants

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 27, 2020

Elise Thorn
Office of the Attorney General
1300 I Street
Sacramento, CA 95814

VIA EMAIL

Dear Elise,

At a status conference on March 27, 2020, the court requested Defendants file its COVID-19 Emergency Plan, which was previously provided to the Special Master and Plaintiffs on March 25, 2020. That plan, and its cover memo entitled COVID-l9 – Mental Health Delivery of Care Guidance, is attached.

Sincerely,

/s/ Nick Weber

NICK WEBER
Attorney
Office of Legal Affairs

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: March 25, 2020

To: Chief Executive Officers
Chief Psychiatrists
Chief of Mental Health
Senior Psychiatrist, Supervisors

From:
EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Services

Subject: **COVID-19 – MENTAL HEALTH DELIVERY OF CARE GUIDANCE**

In response to the current coronavirus disease 2019 (COVID-19) pandemic and out of an abundance of caution the California Department Corrections and Rehabilitation (CDCR) Statewide Mental Health Program (SMHP) is taking necessary precautions to reduce exposure to Coleman patients and mental health staff by addressing exceptional allowances provided. This memorandum provides guidance for the delivery of mental health care with the understanding that new challenges and impacts of COVID-19 may permit more restrictions at some institutions than others as we move through this difficult time and may likewise lead to interim changes in practice and/or policy exceptions not otherwise allowed by the *Mental Health Services Delivery System Program Guide 2009 Revision.*

Clinical leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc.. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

To ensure patients continue to receive the most appropriate and effective interventions necessary to meet their needs, each clinical provider shall assess the patient's needs and continue to deliver services as appropriate in person, or via tele-health technology such as WebEx, Citrix, and other solutions.

The attached chart serves as a guide and provides a tiered approach on the delivery of care dependent upon each institution's staffing and operational circumstances. The CEOs, in consultation with the Wardens, will determine which tier shall be applied each day. Tier One

represents operating close to Program Guide requirements, while Tier Four represents dramatically decreased resources. The following factors shall be taken into consideration when determining the tier an institution will operate within:

- Clinical and custodial staffing levels
- Space availability
- Social distancing requirements
- Local and statewide restrictions on movement
- Quarantines and Isolations

Mental Health Patients

Mental health patients are at increased risk for escalation in depression, anxiety, panic attacks, psychomotor agitation, psychotic symptoms, delirium, and suicidality during this COVID-19 pandemic. Sources of stress include social isolation, decreased sensory stimulation, lack of access to standard clinical programing, diminished coping strategies, and limited outdoors or out-of-cell exercise and activities. We are focused on three critical areas during this COVID-19 pandemic: 1) Preserving life; 2) Stabilizing of acute mental health deterioration; 3) Helping the mental health population cope.

Provisions of Treatment

To the extent possible, institutions shall follow current Program Guide policies and procedures including, but not limited to: clinical contacts, group and treatment requirements, emergent and urgent referral processes, crisis intervention, suicide prevention, and inpatient referrals. However, to ensure patients receive the essential care and support services during this time of fewer onsite staff and various restrictions on patient movement the below and attached guidelines provide direction on ways to provide services and minimize the risk to both patients and staff:

- Individual clinical contacts shall continue while maintaining social distancing. As institutions move toward less patient movement measures and staffing levels decrease, individual contacts should be triaged by emergent referrals, patient acuity and levels of care.
- Interdisciplinary Treatment Teams (IDTT) shall continue while maintaining social distancing. In lieu of the tradition setting, the use of technology should be optimized to ensure attendance by all IDTT members. The best solution is to turn team meetings into teleconference meetings, with staff calling in from their individual offices.
- Groups shall continue but may be reduced in size in order to adhere to social distancing requirements. In addition, alternative locations should be explored. Larger classrooms or vocational space, temporarily closed during this time, could be used to allow for social distancing for groups. Develop in-cell Recreational Therapy and other group activities that can be conducted and distributed.
- Patients in isolation and/or quarantine will not attend groups but shall be provided with therapeutic treatment packets, workbooks, and other in cell activities and shall receive

daily rounding by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers.

- Psychiatry and primary care clinicians should be consulted urgently on patients expressing suicidal ideation or intent, psychosis, medication side effects, incomplete symptom control, or acute agitation.
- Psychiatry should also be consulted for other non-urgent significant psychiatric symptoms as usual.
- In the event of severe staffing shortages, frequent mental health wellness and surveillance rounding is required with liaison between psychiatrists, psychologists, suicide prevention coordinators and recreational therapists to identify significant concern for a patient's mental health sequelae. These rounds are to identify any urgent/emergent clinical issues including but not limited to acute suicidality.
- Issues identified through these rounds are to be promptly brought to the attention of the assigned psychiatrist.
- Staff performing rounds shall use appropriate personal protective equipment (PPE) as determined by public health.
- Psychiatry encounters may be via tele-psychiatry during the COVID-19 pandemic as approved by the hiring authority (See section on tele-psychiatry below for details).

Suicide Prevention

As much as possible, all Suicide Risk Assessments shall continue per policy and patients identified as a suicide risk will receive an in-person mental health evaluation. As operational abilities are impacted due to staff reductions, the clinician assessing the patient for suicidality will conduct the Columbia screener and a full mental health status exam and do the following:

1. If the patient screens positive, he/she shall be placed in alternative housing and be referred to a Mental Health Crisis Bed (MHCB). Within 24 hours of placement in the MHCB or if the patient remains in alternative housing longer than 24 hours, a full Suicide-Risk and Self-Harm Evaluation shall be completed.
2. If the patient screens negative, the clinician shall establish a safety plan with the patient and he/she can be returned to housing with a consult order for the primary clinician to see the patient with an urgent or routine referral.
   - All (5) five-day follow-ups will be completed in person, per policy, while maintaining social distancing.
   - As the operational abilities begin to limit clinical contacts and services, Administrative Segregated Unit workbooks shall be distributed to Enhanced Out-Patient housing units and the Correctional Clinical Case Management System population for in-cell activities.
   - Suicide Prevention and Response Focus Improvement Team Coordinators shall distribute the high risk list to all primary clinicians and psychiatrists. Cell visit check-ins with these patients shall be conducted by a mental health provider, in addition to the required scheduled appointments.

Inpatient Referrals and Services

As of March 17, 2020, the Department of State Hospitals (DSH) has temporarily suspended patient transfers to and from CDCR. As a result, patients referred to a higher level of care of at least a restrictive housing of a DSH facility will remain at CDCR. The below information and reminders are critical to ensure all patients currently housed or awaiting placement to an inpatient bed receive the appropriate care and oversight during this time.

- All referrals to higher levels of care shall continue as clinically indicated and determined by the IDTT.
- Patients housed out of their least-restrictive housing due to the inability to transfer to DSH, shall be placed in the least restrictive housing available within CDCR.
- As wait times increase, every effort shall be made to provide these patients with the services commensurate with their level of care. This includes providing enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Patients housed in an MHCB awaiting transfer to a higher level of care and patients in alternative housing awaiting transfer to an MHCB will be provided enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Inpatient licensed beds shall not be closed to admissions by the institutions without going through the proper authorization and notification process.

Patient Education

Clinical focus shall be on supporting patients by encouraging questions and helping them understand the current pandemic situation. Clarify misinformation and misunderstandings about how the virus is spread and that not every respiratory disease is COVID-19. Provide comfort and extra patience. Check back with patients on a regular basis or when the situation changes. Recognize that feelings such as loneliness, boredom, fear of contracting disease, anxiety, stress, and panic are normal reactions to a stressful situation such as a disease outbreak.

Key communication messages to mental health patients:

- The importance of reporting fever and/or cough or shortness of breath along with reporting if another patient is coughing in order to protect themselves. Indicate how these reports should be made.
- Reminders about good-health habits to protect themselves, emphasizing hand hygiene.
- Plans to support communication with family members if visits are curtailed.
- Plans to keep patients safe, including social distancing.

Patient Isolation (Symptomatic Patients)

A critical infection control measure for COVID-19 is to promptly separate patients who are sick with fever or respiratory symptoms away from other patients in the general population. Precautionary signs shall be placed outside the isolation cell and PPE appropriate protocols shall be followed.

Quarantine (Asymptomatic Exposed Patients)

The purpose of quarantine is to assure that patients who are known to have been exposed to the virus are kept separated from other patients with restriction of movement to assess whether they develop viral infection symptoms.

- Exposure is defined as having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with suspected or confirmed COVID19.
- Examples of close contact include sharing eating or drinking utensils, riding in close proximity in the same transport vehicle, or any other contact between persons likely to result in exposure to respiratory droplets.
- The door to the Quarantine Unit should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Unit which lists recommended personal protective equipment (PPE).
- Medical Holds are employed for both isolation and quarantine. A temporary prohibition of the transfer of patients with the exception of legal or medical necessity is now in place.

Social Distancing

To stop the spread of COVID-19, social distancing must be employed. CDC officials recommend avoiding large gatherings of more than 10 people and maintaining a distance of 6 feet from other people. This reduces the chance of contact with those knowingly or unknowingly carrying the infection.

Patient-to-Patient; Patient-to-Staff Social Distancing

If group spaces are too small to accommodate the 6-feet rule, consider smaller group sizes in the interim. Groups can be smaller with higher frequency or this may mean needing to decrease the number of treatment offerings. Say to the patients that because of the COVID19, "We have a policy of keeping at least 6 feet of distance between patients and staff and patients and each other, which is why I'm sitting here and you're sitting there." If you don't say it, many patients may misinterpret social distancing (i.e. "my clinician is scared of me"). Maximize disinfection of all areas used for group and 1:1 treatment.

Tele-Psychiatry and Social Distancing

With the latest expansion of tele-psychiatry waivers, exceptions issued by the Center for Medicare and Medicaid Services (CMS), tele-psychiatry may be used to minimize any COVID-19 impacts that could disrupt the daily psychiatric services to patients. Psychiatrists who are unable to come into the institution because of personal risk factors (age > 65, chronic medical condition, etc.) or are under a personal quarantine who are otherwise fit to work can be authorized to use WebEx to conduct patient visits from a home computer that has a camera, speaker, and microphone. A state laptop with a VPN or any home computer with Citrix can access the EHRS.

- Each clinician who is providing tele-services will require a tele-presenter within the institution.
- Tele-presenters can include Medical Assistant, Certified Nursing Assistant, Licensed Vocational Nurse, Registered Nurse, or any other healthy employee who is available to assist. This could include support staff who are on Administrative Time Off.
- Presenters shall be provided PPE as needed based upon public health recommendations. Successful use of tele-psychiatry will require clinic space, tele-health equipment, IT assistance, scheduling organization, escort support, frequently updated telephone and email contact lists, and local executive leadership support.

cc: Diana Toche, DDS, Undersecretary
Joseph Bick, MD, CCHP, Director
Connie Gipson, Director
Regional Health Care Executives
Deputy Directors

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier One: Delivery of care continues with minor modifications up to and including: • Patient movement permitted between and within CDCR facilities. • Minor movement restrictions within specific housing units or yards. • Temporary suspension of transfers to DSH. • Adequate clinical staff are on site and available to provide services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social Distancing Required	Referrals continue per policy. Patients out of LRH, due to bed unavailability (DSH unlocked dorm) will be placed in the least restrictive housing available within CDCR.	**Suicide Risk Assessments:** Continue to complete per policy. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Continue to respond to referrals in accordance with MHPG timelines.	**IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. **Individual contacts:** Continue, with social distancing. **Patients on isolation:** Provide with treatment packets/therapeutic activities to complete in cell. Treatment team members visit cell daily. **Personal Protective Equipment:** Those rounding in quarantined and isolated areas must be provided appropriate personal protective equipment (PPE) based upon the most recent public health recommendations. All staff shall receive training in the appropriate use of PPE.	**Pre-Release Planning:** All required activities to occur when social distancing can be followed. **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Two: Minor movement restrictions and staff limitations impacting daily operations. • Patient movement permitted between and within CDCR facilities • Minor movement restrictions within specific housing units and/or yards • Temporary suspension of transfers to DSH. • Minor clinical staffing shortages requires triage for services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social distancing required	Referrals continue per policy. As wait times increase, patients shall be provided enhanced care, which may include, but not limited to, daily rounds, out of cell time, and therapeutic activities as operations allow, while awaiting transfer. Patients awaiting MHCB will be placed in alternative housing on 1:1 status per current policy. Treatment frequency should be that of MHCB patients, when operations allow, while awaiting transfer.	**Suicide Risk Assessments:** Columbia Screener may be used with a mental status examination for suicide screening when staffing shortages prevent use of SRASHE. Patients identified as suicide risk will receive in person evaluation. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Triage referrals responding to emergent and urgent first, and triage routine referrals for urgency. **Prevention:** Distribute ASU Workbooks to outpatient housing units (EOP) for in-cell activities. SPRFIT Coordinators distribute the high risk list to all primary clinicians. PCs to conduct cell visits for check-ins with individuals on this list. These visits should be in addition to required scheduled appointments. If decompensation is noted, patients should be brought out for assessment.	**Treatment may be triaged as follows as staffing shortages and space access are decreased:** **Triage Guidelines:** Individual contacts as follows: - Emergent referrals - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient LOC - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. May be triaged. - CCCMS groups may be reduced or cancelled to redirect resources to EOP and inpatient programs. -Consider altering work schedules to stagger groups and offer into late evenings and weekends.	**Pre-Release Planning:** Prioritize the ROIs to those releasing only to L.A. county and San Diego county Prioritize completion of the PRPA for those releasing to L.A. and San Diego counties first. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. Evaluators will bundle evaluations for a single visit to reduce the number of trips to a facility. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			-Develop in cell RT and other group activities and distribute when group offerings decrease. **Patients on isolation:** Provide with treatment packets to complete in cell. Treatment team members visit cell daily. **Psychiatry:** Psychiatrists check in & check out daily with Chief Psychiatrist to track availability and coverage. Updated contact lists and workflows will be determined and provided by each institution up to and including contact list for: - Nursing - MHCB/TTA/CTC - Institutional leadership (Chief Psychiatrist, CMH, CEO) - Medical providers - Pharmacists - Custody command chain - Telepsychiatry Seniors - Medication lines Begin to Triage as follows: Admissions and discharges and related inpatient processes Suicide watch assessments and orders - Suicide precaution assessments and orders - Emergency Medication orders during patient crisis, PC 2602s - Seclusion and Restraints "Face to Face" assessments or renewals - Stat Labs for patients with suspected toxicity e.g. Lithium)	facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Renewing expiring psychiatric medications - Medication changes as necessary - Confirming lack of psychiatric medication-related medical issues - IDTT participation - Routine psychiatric follow up **Telepsychiatry:** Psychiatrists who are assigned to work on-site who are no longer able to come into the institution (for example >65 years old, high risk medical condition, quarantine but still able to work) can use WebEx to conduct patient visits from any home computer with a camera/ speaker/ microphone. A state laptop with a VPN (or any home computer with Citrix) can access EHRS. - Staff that could be used as telepresenters is decided by each institution to include: • MA or CNA • Any staff unable to perform their assigned duties during the crisis (with training), e.g. - Dental - ATO - support staff - any healthy state personnel - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD) - LVN, RN	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Any medical provider (PA, NP, MD) All telepresenters require personal protective equipment as in Tier 1 This will also require: office space, tele-health equipment, IT assistance, OT organization, Custody escort support, contact lists as in tier 2, and local leadership support	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Three Movement restrictions within facilities and staffing shortages requires substantial change in standard practice • Patient movement permitted between most CDCR facilities. • Movement restrictions are in effect within the institutions. • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires increased triage for services • There may be insufficient beds and/or staff for alternative housing and 1:1 watch.	Referrals continue per policy. **If staffing and space become unavailable:** **Alt Housing Location:** Patients who can be safely watched in their existing cell will be placed on 1:1 watch (must be single cell status, items removed per watch policy). These patients will be treated as MHCB patients for all clinical contacts as operations allow. **1:1 Watch:** When there are not enough staff for 1:1 watch, patients in alternative housing may be placed on 2:1 watch if the location allows for good line of sight and patients are next door to one another, allowing continuous watch of each. CEO to determine when this can be applied and will provide the direction above with oversight for safety.	**Suicide Risk Assessments:** *See Tier two* **Five day follow ups:** *See Tier Two* **Referrals:** *See Tier Two* **Prevention:** *See Tier Two and Provision of Treatment Column*	**Rounding:** Every day, every patient in the Mental Health Services Delivery System (CCCMS, EOP, MHCB, ICF, ACUTE) shall be rounded on by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers, by building and yard. The review includes questions of immediate, acute suicidality and/or medical concerns. Patients who answer in the affirmative must be brought to the attention of the assigned psychiatrist at least once a day (preferably twice) at fixed times for treatment. When patients respond in the affirmative: - A consult order shall be placed per current policy. - MH clinicians will address emergent issues per current policy. - Patients will be placed on a list for discussion with the psychiatrist. Rounds shall be documented in the healthcare record as follows: Nursing: Iview psych tech daily rounds. MH Clinicians: MH PC Progress note. Personal protective equipment required as in tier 1.	**Pre-Release Planning:** ROIs to those releasing only to L.A. county and San Diego county ONLY. Complete the PRPA for those releasing to L.A. and San Diego counties. For releases to other counties, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community stakeholders via email. Document efforts in a pre-release planning progress note. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document. Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			As ability to provide out of cell groups decreases: - RTs play music and conduct other activities on the unit - Continue to replenish supply of in cell treatment materials. Direct Staff and Care as follows: - Emergent referrals - Five Day Follow Ups - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient facility - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **Telepsychiatry: As per tier 2 above**	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Four Patient movement restrictions between and within facilities is suspended and significant staffing shortages require substantial change in standard practice • Patient movement is not permitted between most CDCR facilities. • Patient movement restrictions in most units and/or yards within facilities • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires further triage for services • Insufficient beds and/or staff available for 1:1 watch and alternative housing.	*See Tier Three*	*See Tier Three*	*See Tier Three* **Psychiatry Services** Any physician, NP, or PA serves as psychiatrists for the plans in Tier 2 and 3 above. Laptops with VPN (or home computers with Citrix) provide for chart access from home, for the equivalent of basic on-call coverage. Local triage (by Chief Psychiatrist and CMH) to establish referral priority for tele-health.	**Pre-Release Planning:** - ROIs will not be completed - The PRPA will not be completed For releases, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community via email. The assigned psychiatrist will continue to be notified of the release date. - Complete 5150 requests per standard process - Complete transportation Chrono's per standard process - Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*