CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 4: MEDICAL SERVICES	Effective Date: 07/2015
CHAPTER 1	Revision Date:
4.1 COMPLETE CARE MODEL POLICY	Attachments: Yes ☐ No ☒

I. POLICY

California Correctional Health Care Services (CCHCS) shall manage and deliver medically necessary health care services to the patient population. The Complete Care Model (CCM) is based on the industry standard known as the Patient-Centered Health Home. The CCM shall serve as the foundation for CCHCS health care services delivery. This model improves patient outcomes, reduces the need for hospitalizations and emergency services and enhances staff satisfaction. The CCM includes the following foundational principles and requirements:

A. Continuous Care. Health care systems and processes shall be structured to ensure that patients have a consistent relationship with a team of interdisciplinary staff accountable for their care, which allows care team members to know a patient's history from experience, integrate new information and decisions from a whole-patient perspective, gain the confidence of their patients, and effectively advocate for patients.

1. CCHCS shall establish interdisciplinary care teams at each institution, accountable for the care of defined patient panels.
2. Each patient shall be assigned a care team, and as much as possible, the patient's primary care encounters shall occur with members of the assigned care team.
3. CCHCS shall take action to minimize unnecessary patient transfers from one care team to another and shall design effective systems and processes to ensure that patient needs are communicated prior to transfers and patients receive timely access to necessary services before, during, and after transfer.

B. Comprehensive Care. The health care system shall be designed to meet the patient's health needs as a whole person, promote collaboration and coordination of services to address a single discipline, condition, or episode of care. CCHCS shall employ risk stratification, population management, and care management among the strategies used to achieve comprehensive care.

1. The care team shall be responsible for:
   a. Assessing and periodically evaluating patient health needs;
   b. Meeting health care needs, including prevention and wellness services, episodic care, chronic care, urgent or acute care, and end-of-life care; and
   c. Assessing health care needs beyond the scope of the health care team and referring patients to appropriate providers and services.
2. CCHCS shall implement programs for patients by risk stratification; provide care management services to patients commensurate with their individual needs and risk levels; and identify and manage subpopulations of patients per evidence-based guidelines.

C. Coordination of Care. Patient services shall be coordinated across all health care settings, levels of care, and specialty services.

1. The care team shall serve as the hub for organizing and scheduling health care services, facilitating appropriate delivery of health care services within and across systems, maintaining continuity of care, and managing exchange of information.
2. The care team shall establish reliable processes and systems to track the status and follow-up of specialty referrals, diagnostic studies, and treatment regimens.
3. CCHCS shall establish standardized expectations and processes for clear and open communication between the care team and other care providers, which shall include:
   a. Assuming accountability for transitions in care;
   b. Providing patient support and education before, during, and after transitions in care; and
   c. Building relationships with other health care staff providing services to patients within the patient panel.

D. Patient-Centered Care. Health care staff shall encourage patients to partner in their own care and to make informed decisions related to their health and health care choices. Health care staff shall incorporate the patients' goals, preferences, and needs into treatment plans whenever feasible and appropriate.

1. The care team and other health care staff shall actively engage and empower patients to participate in care planning and delivery, supporting patients in learning to manage their own care between appointments with health care staff.
2. CCHCS shall implement programs to assess and improve patient health literacy and promote self-management planning and activities.

E. Preventive Care. Health care staff shall provide preventive care to the patient population based on age, gender, and other clinical recommendations from the United States Preventive Services Task Force Guide to Clinical Preventive Services where health care staff can focus on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of patients at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Surveillance for infectious diseases, screening tests, health education, and immunization programs are common examples of preventive care.

F. Accessible Care. CCHCS shall ensure that patients receive timely access to the full range of necessary services, that communication with patients is delivered effectively, and adapted as necessary to the patient's needs.

1. Scheduling systems and processes shall incorporate strategies to optimize access to care and reduce wait times, including a flexible appointment system that accommodates visit lengths, same-day visits, and scheduled follow-ups, as well as strategies to increase efficiency, such as consolidated/bundled appointments.
2. When possible, health care staff shall consider patient preferences regarding access, such as providing appointment times that do not interfere with the patient's work shifts or classes.

G. Use of Health Information. Health care staff shall use health information systems to identify and manage individual patients and patient populations, apply evidence-based standards and guidelines, and to improve health care processes.

1. Health care records shall be timely, accurate, complete, and readily available prior to patient encounters.
2. Health Care Services shall develop connectivity via electronic or other information pathways to encourage timely and effective communication between providers caring for the same patient.
3. Health Care Services staff shall use clinical decision support to promote the application of current guidelines or standards as appropriate in the course of patient care.
4. Health Care Services shall produce reports for the management of individual patients and patient populations, such as registries, profiles, and care summaries, and health care staff shall use these reports regularly for purposes of care management, population management, and other patients care activities.

H. Continuous Improvement. At all levels of the organization (statewide, regional, institution, and care team or program), leaders shall be responsible for establishing a culture of teamwork, continuous learning, and innovation. Activities to continuously evaluate and improve health care processes shall be incorporated into the day-to-day work of health care staff.

1. Leaders shall champion cultural change, as well as specific improvement strategies, such as initiatives from the institution's annual improvement plan.
2. Responsibility for conducting improvement activities shall be shared by all staff, from leadership to team members.
3. Health Care Services shall establish an effective communication system to keep staff at all levels of the organization appraised of improvement priorities, organizational goals, and performance evaluation findings.
4. Health Care Services shall use data and statistical tools to provide care teams with feedback about their performance in critical health care processes and the health outcomes of patients within their assigned panel.

II. PURPOSE

To establish a standardized and integrated care model that organizes and delivers core primary care functions to improve:

- Quality of care and patient outcomes.
- Efficiency and value of care.
- Patient and staff satisfaction.
- Adherence to legal and regulatory requirements.

III. DEFINITIONS

Care Coordination: The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services and minimize the danger of care fragmentation.

Care Management: A collaborative process of patient assessment, evaluation, advocacy, care planning, facilitation, and coordination. The extent of care management services varies according to the complexity of the patient.
Care Summaries: Written descriptions maintained in the patient record and provided to the patient after an episode of care which describes the condition treated during the encounter and the care rendered, provides patient instructions and educational information, and often lists important clinical and demographic information.
Care Team: An interdisciplinary group of health care professionals who combine their expertise and resources to provide care for a panel of patients.
Chronic Care: Ongoing care for a current health problem that impacts or has the potential to impact a patient's functioning and long-term prognosis and has lasted, or is expected to last, for more than six months.
Episodic Care: Services to assess and treat exacerbation of a pre-existing condition or symptoms of a new condition, often unplanned and initiated when a patient submits a request for services.
Health Care Services: CCHCS and Division of Health Care Services (DHCS); medical, mental, and dental health services.
Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Patient Panel: A clearly defined group of patients that are assigned to a particular care team. Every care team has one panel of patients, and every patient is assigned to a care team.
Patient Profiles: Individual patient reports that provide important clinical data in one screen or document.
Patient Registries: Lists of patients with specific conditions or eligible for certain preventive services that include clinical information helpful to the management of these patients.
Population Management: Systematic assessment, monitoring, and management of the health care needs of identified groups of patients.
Prevention and Wellness Services: Services focused on disease prevention and health maintenance.
Risk Stratification: Continuous use of data and predictive modeling to differentiate patients into risk levels.
Self-Management: Patient activities to manage health on a day-to-day basis, in between contacts with the health care system. Self-management may also refer to collaborative processes between care teams and patients to develop specific plans and objectives to improve the patient's health status.

IV. RESPONSIBILITY

California Department of Corrections and Rehabilitation and CCHCS departmental leadership, at all levels of the organization shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available so that care teams can successfully implement the CCM.

The Directors of CCHCS and DHCS are responsible for statewide planning, implementation, and evaluation of the CCM. Regional Health Care Executives are responsible for implementation of this policy at the subset of institutions within an assigned region, and the Chief Executive Officer is responsible for implementation of this policy at the institution level.

V. REFERENCES

- United States Preventive Services Task Force
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.pcmh.ahrq.gov/
- The Joint Commission Primary Care Medical Home Certification, http://www.jointcommission.org/accreditation/pchi.aspx
- National Committee for Quality Assurance – Patient-Centered Medical Home Recognition, http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- Commonwealth Fund – Safety Net Medical Home Initiative, http://www.commonwealthfund.org/interactives-and-data/multimedia/videos/2011/safety-net-medical-home-initiative
- Robert Wood Johnson Foundation / Improving Chronic Illness Care – The Chronic Care Model, http://www.improvingchroniccare.org/index.php?p=About_US&s=6
- Robert Wood Johnson Foundation / Improving Chronic Illness Care – Reducing Care Fragmentation, http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf