VOLUME 4: MEDICAL SERVICES	Effective Date: 06/2016
CHAPTER 1.2	Revision Date:
4.1.2 CARE TEAMS AND PATIENT PANELS PROCEDURE	Attachments: Yes ☒ No ☐

I. PROCEDURE OVERVIEW

The Complete Care Model Policy establishes a Patient-Centered Health Home for each patient consisting of an interdisciplinary Care Team responsible for delivering comprehensive care for patients in accordance with their health care needs, directly providing the majority of clinical care services, and coordinating care when patients require services beyond what the Care Team provides.

This procedure establishes interdisciplinary Care Teams, describing the team members and outlining their roles and responsibilities. In addition, this procedure outlines the process for assigning each patient to a Care Team, presents the expectations for notification to patients and panel management, and introduces daily and twice-monthly forums that Care Teams shall use to monitor and manage both clinic operations and changes in the patient panel.

II. DEFINITIONS

Administrative Support: Administrative member of a Care Team who ensures the team has the necessary information they need for planned patient care.

Backlog: An undesirable condition that occurs when today's work (both the planned work and the work that is unplanned, but needs to be accomplished by today) is not completed today.

Bundling: When a patient has multiple pending appointments, setting appointments sequentially on the same day so that a patient need only be seen in one encounter for multiple purposes. Bundling helps increase clinic efficiency, meet mandated timeframes, and limit the need for custody escorts, lessening redundant work for custody and health care staff as well as making appointments more convenient for the patient.

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 Team: An interdisciplinary group of health care professionals who combine their expertise and resources to provide care for a panel of patients.

Chronic Disease: Any current medical problem that impacts or has the potential to impact a patient's functioning and long-term prognosis that has lasted, or is expected to last for more than six months. Chronic diseases include, but are not limited to, cardiovascular disease, diabetes mellitus, some gynecological disorders or diseases, chronic infectious diseases, chronic pulmonary diseases, and seizure disorders.

Disease Management: A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. This system supports the physician or provider/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based proactive guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Ducat: A common term for a CDC 129, Inmate Pass. There are two types of ducats, "Priority" and "Non-Priority." Priority ducats are embossed with the word "Priority" and are used for scheduled health care appointments. Non-Priority ducats are printed on plain white paper and are used for unscheduled appointments and/or unescorted movement from one location to another.

Health Home: A care model that involves the coordinated care of an individual's overall health care needs and where individuals are active in their care.

Non-Business Days: Saturdays, Sundays and State holidays.

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.

Population Management: Systematic assessment, monitoring, and management of the health care needs of identified groups of patients.

Primary Care Huddle: A meeting of Care Team members to plan and coordinate the patient care activities, panel management, and clinical operations to reduce or prevent lapses of patient care and improve patient outcomes.

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.

III. RESPONSIBILITIES

A. Statewide

California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available to ensure the scheduling system is successfully implemented and maintained.

B. Regional

Regional Health Care Executives are responsible for the implementation of this procedure at the subset of institutions within an assigned region.

C. Institutional

1. The Chief Executive Officer (CEO) has the overall responsibility for implementation and ongoing oversight of the scheduling system at the institution and patient panel level. The CEO delegates decision-making authority to the Chief Nurse Executive (CNE) for daily operations of the scheduling system and ensures adequate resources are deployed to support the system including, but not limited to, the following:
   a. Ensuring access to and utilization of equipment, supplies, health information systems, Master Registries, Patient Summaries, and evidence-based guidelines.
   b. Assigning patients to a Care Team.
   c. Maintaining a list of the core members of each Care Team which shall be available to all institutional staff. Patients shall be informed of their assigned Care Team members at intake and/or upon request.
   d. Ensuring consistent Care Team staffing with a back-up system for core members.
   e. Providing Care Team members with the information they need during huddles (e.g., communication of on-call information).

f. Ensuring protected time for Care Teams to hold daily huddles.
g. Documenting and tracking huddle actions and attendance.
h. Ensuring that at least monthly, each Care Team conducts a Population Management Working Session utilizing tools such as Dashboards, Master Registries, and Patient Summaries to address concerns related to potential gaps in care and improve patient outcomes including, but not limited to:
   - High risk patients.
   - Contract Management.
   - Patient safety alert.
   - Trends in access to care.
   - Surveillance of communicable disease.
   - Patient risk stratification.
i. Adequately preparing new Care Team members to assume team roles and responsibilities.
j. Assessing competence of existing Care Team members.
k. Updating procedures, roles and responsibilities as new tools and technology become available.
l. Reviewing/comparing institution Care Team performance, including the overall quality of services, health outcomes, assignment of consistent and adequate resources, utilization of Dashboards, Master Registries, Patient Summaries, and decision support tools and address issues as necessary.
m. Providing Care Team members with adequate resources, including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
n. Working with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment.
o. Ensuring, in collaboration with the Warden, that the institution establishes a Local Operating Procedure by which priority health care ducats are issued and delivery by custody staff is verified and documented.
p. Requiring institution leadership to establish a back-up system to ensure scheduling queues are managed when Scheduling Support staff are on leave or otherwise unable to meet daily monitoring requirements.

2. The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork across disciplines.
3. The CNE is responsible for:
   a. The overall daily operations of the scheduling system for medical care.
   b. The coordination of health care between health care scheduling systems.
   c. Oversight and management of the scheduling processes and resources, including personnel.
   d. Ensuring that the institution has a designated lead scheduling supervisor to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
   e. Ensuring that Scheduling Support staff is available for all clinical areas.
4. The Chief Medical Executive (CME) is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

5. The Supervising Registered Nurse and Chief Physician and Surgeon shall meet to review the Care Team's performance, including the overall quality of services, health outcomes, level of care utilization and shall utilize Dashboards, Master Registries, Patient Summaries, and decision support tools to address or elevate issues as necessary.

IV. PROCEDURE

A. Patient Panels

1. Institution leaders shall adopt methods to promote a consistent, ongoing relationship between patients and their Care Teams to achieve operational efficiency; ensure timely access to care; optimize movement and escort capabilities; balance workload; address patient acuity and complexity to support patients in the management and organization of their care.
2. Each patient shall be assigned to a Care Team and be notified of the Care Team assignment.
3. Assignment to a Care Team may be organized in a variety of ways, as dictated by the needs of patients and the institution including, but not limited to, assignment by the following:
   - Housing unit.
   - Alphabetical roster.
   - Last two digits of CDCR number.
   - Custodial factors.
   - Mental health program assignment.
   - Medical factors and other special patient needs.
4. All Care Teams shall have access to the Master Registry.
   a. Institutions shall communicate any change in their strategy for panel assignment to headquarters to preserve the accuracy and reliability of the Master Registry.
   b. The Care Team is responsible for tracking the status of the assigned patient panel and shall monitor the Master Registry daily, identifying changes to the assigned patient panel and communicating changes to team members using the daily huddle or other appropriate forums.

B. Care Team Members

1. Care Team Composition
   a. At a minimum, each Care Team shall consist of the following core members:
      - Primary Care Providers (PCPs).
      - Nurses.
      - Registered Nurse (RN).
      - Medication Administration Nurse (Licensed Vocational Nurse/Psychiatric Technician).
      - Licensed Vocational Nurse Care Coordinator.
      - Administrative support staff.
      - Other members, as needed.
   b. Depending on the mission of the institution and the needs of the patient panel, members may be added to the Care Team as core members. For example, if there is a high proportion of patients with serious mental illnesses in a patient panel, a Primary Mental Health Clinician and/or Primary Psychiatrist may serve as members of the Care Team.

c. Other team members may be added to the Care Team on a per-patient basis. For example, the Care Team would include a dentist and other dental staff when planning, delivering, and coordinating services for a patient with complex dental needs. The range of possible Care Team members encompasses, but is not limited to, pharmacy staff, dietitians, specialists, laboratory or imaging staff, and therapists (e.g., occupational, recreational, respiratory, and other types of therapists).

2. Continuity in Team Membership
   a. Institutions shall avoid unnecessary changes in the membership of the Care Team to reduce disruptions in care. Individual changes in Care Team membership do not require formal notice to patients.
   b. The institutions' CME or designee shall ensure the Care Team has assigned and available Care Team members at all times with minimal disruptions to continuity.
   c. The institution CEO, CME, and CNE shall ensure each core member of the Care Team:
      1) Is assigned and available.
      2) Has a consistent back-up staff member.
      3) Has a schedule coordinated to optimize continuity.
      4) Has scheduled hours of work in alignment with clinic operational needs.
      5) Has scheduled work hours and hours of clinic operation in alignment for the entire Care Team.
   d. Contingency plans shall be in place to optimize continuity in the event of scheduled absences and, whenever possible, in the event of unscheduled absences. Back-up designations shall be included in the Care Team.
3. In recognition that communication and collaboration between Care Team members is greatly facilitated by being present in the same clinic space at the same time, institution leaders shall:
   a. Review the schedules and work locations of Care Team members, at least annually, and take action to optimize the number of hours that core members work in the clinic together and have access to patients.
   b. Ensure that Care Team members are located in close proximity to each other when they are providing services to patients, wherever possible.

C. Roles and Responsibilities of the Care Team

1. The entire Care Team shall be accountable for the outcomes of patients in the assigned patient panel, and each Care Team member shall be responsible to ensure efficiency and effectiveness of the Care Team (refer to Attachment A, Care Team Roles and Responsibilities).
2. All Care Team members shall be required to:
   a. Establish and maintain professional, effective, and therapeutic relationships with patients.
   b. Create a climate of mutual respect in which individual Care Team members feel comfortable sharing their concerns about unsafe, ineffective, or inefficient processes, systems, or operations, including the inappropriate management of individual patients.
   c. Promote clear and frequent communication between Care Team members.

d. Participate fully in the Care Team's collective efforts to manage the patient panel, including identifying necessary patient care activities and allocating work among Care Team members.
e. Maintain an up-to-date knowledge of trends, best practices, and guidelines in clinical practice and operations as relevant to each Care Team member's respective licensure.
f. Evaluate the quality of clinic processes and services in the course of day-to-day work and collaborate with other Care Team members to investigate and resolve quality problems.
g. Promote a safe, effective, efficient, and collaborative work environment.

3. Documentation of patient care and the patients' response to care is essential for effective communication between health care providers and providing quality health care. To ensure accurate recording of patient care activities and to ensure the transfer of information between the members of the interdisciplinary care team, health care staff shall:
   a. Document all patient contacts, interventions, observations, care and treatments provided and the results of the care and treatment in the patient's health record.
   b. Record documentation using the Subjective, Objective, Assessment, Plan, Education format or use other forms of documentation such as narrative charting, charting by exception, focused assessment, etc., as indicated by the clinical situation. However, all documentation shall contain subjective and objective patient care data at a minimum regardless of format.
   c. Ensure that all documentation complies with the documentation standards contained in Inmate Medical Services Policies and Procedures, Volume 6, Health Information Management.

D. Daily Care Team Huddle

1. The Care Team shall convene each business day in a Care Team Huddle to:
   a. Monitor changes to the patient panel, such as transfers to and from the panel, and take action to continue and/or coordinate care for these patients.
   b. Discuss recent health care events, problems and trends that impact patients within the assigned patient panel, identify services that may need to be provided to patients, and determine how and when services will be provided including, but not limited to the following:
      - Unscheduled Triage and Treatment Area visits.
      - Medical holds.
      - Transfers to and from higher levels of care.
      - Pending consultations and specialty services requests.
      - Review of communication logs.
      - New patients assigned to the Care Team, including determining and documenting within what period an appointment with the RN or PCP is required.
      - Abnormal laboratory findings.
      - High risk patient/case management issues.
      - Mental health issues (e.g., self-injurious behavior, suicidal/homicidal ideation, overdose, coordination of testing procedures).
      - Medication/pill line issues.
      - Polypharmacy.

c. Manage day-to-day clinic operations, including preparation for that day's encounters, conferring with custody, addressing security or construction impacts to clinic processes, and planning coverage of clinic services while staff are on leave.
d. Discuss daily clinical operational problems, such as the following:
- Episodic care triage.
- Same day and next day relevant health information (e.g., diagnostic study reports, consultation notes, and discharge summaries) and add-on appointments.
- Review and resolution of scheduling concerns.
- Potential barriers to care, including lockdowns, restricted movement, fog lines, backlogs, and other considerations.
- Staffing issues, such as upcoming vacation, mandatory training, or other events affecting availability of staff.
- Supply/resource issues.
- Review and discussion of the Care Team's performance with respect to targeted disease management and preventive service metrics.
- Ongoing evaluation and improvement.

2. Institution leaders shall establish a standard start time for Care Team Huddles to ensure that Care Team members have protected times for huddles and that huddles begin on time.
3. Huddle Preparation
   a. Institutional leadership shall work with Care Team members to:
      1) Incorporate the use of the Patient Summary.
      2) Use a standard Daily Huddle Script and Daily Huddle Activity Sheet that prompts Care Team members to address all topics mandated in this procedure. (Refer to Attachment B, Daily Huddle Script, and Attachment C, Daily Huddle Activity Sheet).
      3) Determine how information required for daily huddles shall be provided to the Care Team in advance of the huddle.
4. Huddle Documentation
   a. Care Teams shall document patients and issues discussed during the Primary Care Huddle and actions taken as a result, monitoring to ensure that necessary follow-up has occurred.
   b. Each Care Team shall be responsible for monitoring the Daily Huddle Script and CDCR 844, Training Participation Sign-in Sheet.

E. Monitoring and Sustainability

1. Institution leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the Health Home system monitoring activities. The Care Team shall:
   a. Take corrective action to resolve and/or elevate concerns identified in the review.
   b. Review and action shall be documented and forwarded to the designated committee.
2. The CEO and institution leadership team shall establish an ongoing monitoring program to periodically assess the quality of Care Team services and adherence to this procedure including, but not limited to:
   a. Accuracy and efficacy of panel assignment strategies.

b. Stability of Care Team staffing and use of back-up systems.
c. The amount of time each day that all Care Team members are working in the clinic together and any associated physical plant issues.
d. Inclusion of other team members/disciplines to manage patient care.
e. Care Team Huddle attendance.
f. Information flow relative to required huddle elements.
g. Frequency, quality, and timeliness of daily Primary Care Huddles.
h. Documentation of Primary Care Huddle activities and necessary follow-up.
i. Frequency and quality of Population Management Working Sessions.
j. Adverse events linked to Care Team processes described in this procedure.
k. Barriers.

3. The CEO and institution leadership team shall utilize or implement a monitoring process to assess the Care Team members and staff supporting Care Team processes. The monitoring process shall include, but is not limited to, feedback about skills required to successfully provide or support primary care services such as:
   a. Clinical skills (e.g., history-taking, physical examinations, assessment, and treatment planning).
   b. Adherence to policy guidelines, protocols, and decision support tools.
   c. Recognition of patient care needs that fall outside the scope of what is provided by the Care Team and appropriate and timely referral.
   d. Management of hand-offs as patients move from one Care Team to another or across levels of care.
   e. Care management of patients who are high risk or otherwise clinically complex.
   f. Population and panel management, including provision of preventive services and managing subpopulations with specific chronic diseases.
   g. Self-management planning and patient education.
   h. Effective communication.
   i. Optimizing access to care through use of co-consultation, appointment bundling, same-day appointments, and other strategies.
   j. Redesigning clinic processes to increase efficiency and use team members to the full extent of their licensure.
   k. Identification, analysis, and resolution of quality problems, including use of data to evaluate performance and investigate problems.
   l. Application of available patient management tools, including patient registries and electronic health record systems.
   m. Overall contribution to the Care Team and a culture that promotes teamwork.

F. Training and Decision Support

The CEO and institution leadership team shall establish an orientation and training program to ensure that all staff serving as members of a Care Team or supporting Care Team functions fully understand their roles and responsibilities prior to assuming their duties. Elements of the program shall include, but are not limited to review of:

1. Expectations in this procedure.
2. Any changes to local Care Team processes.
3. National health care industry advances pertinent to the Patient-Centered Health Home.
4. New information systems or technology that may increase the efficiency or effectiveness of Care Team processes or forums.

5. Updates in clinical practice, including new CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
6. Training needs.

V. ATTACHMENTS

- Attachment A: Care Team Roles and Responsibilities
- Attachment B: Daily Huddle Script
- Attachment C: Daily Huddle Activity Sheet

VI. REFERENCES

- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 1.4, Population and Care Management Services Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 6, Health Information Management
- 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
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.ahrq.gov/
- 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, and Reducing Care Fragmentation, http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT A – Care Team Roles and Responsibilities

Care Team	Roles and Responsibilities
Primary Care Provider	a. Attend and actively participate in the daily huddle. b. Diagnose and manage the patients' episodic illnesses, preventive care, and their complex needs. c. Order and coordinate patient care services including, but not limited to, specialty and higher level of care.
Mental Health Clinician and Psychiatrist	a. Attend and actively participate in the daily huddle as indicated for patient care. b. Provide relevant mental health history. c. Coordinate mental health and medical care, as needed. d. Participate in Primary Care Huddles to provide mental health input into patient behaviors, compliance, and treatment options as they relate to the patient's mental health condition.
Primary Care Provider Support Staff	a. Attend and actively participate in the daily huddle. b. Prepare patients for visits (e.g., vital signs, weights, gathering specialty reports and diagnostic results, other document preparation). c. Route orders, forms, and requisitions to the appropriate entity. Complete administrative areas of the forms. d. Conduct/perform Point of Care testing and administration of treatments in accordance with licensure/certification. e. Manage deficient documentation or orders submitted to diagnostic or therapeutic services. f. Assist with tracking and access to Durable Medical Equipment.
Primary Care Registered Nurse	a. Attend and actively participate in the daily huddle. b. Manage the patient's episodic illnesses, preventive care needs, and their complex care management using established protocols and other decision support. c. Advocate for the patient. d. Coordinate the patient care services for the designated patient panel. e. Manage medication for patients assigned to the team. f. Provide patient education. g. Conduct/perform Point of Care testing.
Supervising Registered Nurse II	a. Attend and actively participate in the daily huddle. b. Oversight of key clinical processes including, but not limited to, scheduling and medication management. c. Audit compliance for a variety of nursing measures including, but not limited to, quality of care.

ATTACHMENT A – Care Team Roles and Responsibilities

Care Team	Roles and Responsibilities
Supervising Registered Nurse II (continued)	d. Identify opportunities for improvement. e. Communicate staffing needs. f. Coordinate with custody to mitigate barriers affecting access to health care. g. Facilitate conflict resolution. h. Provide clinical support as indicated.
Scheduler	a. Attend and actively participate in the daily huddle. b. Ensure all patients are appropriately scheduled. c. Ensure access to care barriers are made known to the full Care Team. d. Ensure Care Team members have relevant health information they need for planned patient encounters. e. Retain records from daily huddles. f. Prepare information for daily huddles. g. Maintain attendance records for daily huddles. h. Schedule patients in the scheduling system in accordance with policy timeframes. i. Ensure Care Team workload is balanced for scheduled patients. j. Maintain a current and accurate schedule for the clinic. k. Support improvements in the design of the clinic schedule to optimize efficiency and access to care, such as open access scheduling, or consolidation of multiple appointments for the same patient into a single encounter. l. Complete administrative sections of the Patient Service Plan.
Medication Administration Nurse	a. Attend and actively participate in the daily huddle. b. Ensure timely delivery of prescribed medications to patients on the panel. c. Alert the Care Team of adherence issues and adverse medication events. d. Alert pharmacy or the Supervising Registered Nurse II when prescribed medications are unavailable. e. Report medication errors. f. Alert the Supervising Registered Nurse II to medication administration access issues. g. Reconcile medication orders with the pharmacy manifest. h. Order routine vitals that are associated with medications. i. Conduct/perform Point of Care testing as associated with medication delivery.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT B – Daily Huddle Script

Care Team Huddle Script

Date:

Team:

Huddle must begin by _____ AM daily. All members must attend and be prepared.

Record attendance and do introductions if guests are present.

Effective Huddles

1. All Care Team members present
2. Huddle begins on time
3. Huddle no longer than 20 minutes

INFORMATION REQUIRED	TOOL/RESOURCE NEEDED	ACTIONS TO CONSIDER	STAFF REPORTING			
			PCP	PCRN	OT	Other
1. Were any of our patients seen by the On-Call Provider?	❑ POC Log/Report ❑ TTA Log ❑ Other	Team reviews treatment plan per TTA documentation. Does the team agree with the treatment plan? If not, what should it be? What needs to be done, which team members should handle it, and within what timeframe?				
2. Patients Returning from Higher Level of Care	❑ TTA Log ❑ Other	Ensure records for patient have been obtained for review. Ensure a follow-up appointment occurs within the appropriate timeframe. Review the Patient Summary. Ensure orders are clinically appropriate, modify if necessary, and then implement.				
3. Patients Transferred to Higher Level of Care	❑ Automated Huddle Report ❑ POC & TTA Log ❑ Specialty Appt List ❑ Team Records/UM Nurse ❑ Prior POC Logs ❑ Movement List/SOMS	Team determines if any information needs to be communicated to the receiving HLOC team. Discuss and anticipate what preparations are needed upon patient return.				
4. Patients with Significant Lab or Diagnostic Reports	❑ Warfarin/HCV Rx and other relevant registries ❑ Faxed diagnostic reports	Review glucose, Coumadin, and HCV tx logs; identify late/missing results; determine follow-up for patients with abnormal results.				
5. Patients New to Care Team within the Past 7 Days	❑ Automated Huddle Report ❑ Patient Summaries of at least all the High Risk new patients	Are any new patient high risk? Should high risk patients be referred for case management? Do new patients have an appointment to be seen? Does the patient need to be seen earlier?				
6. High Risk Patients Who Left Care Team within the Past 7 Days	❑ Automated Huddle Report	For patients leaving the panel, the care team should consider any communication / coordination that might be necessary as part of the handoff to the new care team.				
7. Patients with Medications that Expired in the Past 3 Days *Discuss any medication administration related issues that impact the patient panel (questions, non-adherence, no-shows, renewals, or refills).*	❑ Automated Huddle Report ❑ Expired Medications Registry Report ❑ Medication Log/MAR ❑ Med Nurse/Other Staff/128C3	Handle medication-related questions, non-compliance, renewals, or refills.				
8. Patients with Medications Expiring in the Next 3 Days	❑ Automated Huddle Report ❑ Expiring Medications Registry Report ❑ Medication Log/MAR ❑ Med Nurse/Other Staff/128C3	Handle medication-related questions, non-compliance, renewals, or refills.				

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT B – Daily Huddle Script

9. Other Medication Concerns						
10. Patients with Appointments Today	❑ Patient Summary ❑ Discharge Summaries ❑ Specialty Reports ❑ Diagnostic Results	Ensure all necessary documentation is available for today's appointments. Identify future appointments, consider consolidating with today's appointment if appropriate. Identify opportunities for co-consultation. Identify patients with medication issues that need to be addressed at appointment. Review high risk labs and address at appointment as appropriate.				
11. Unscheduled or Overdue Appointments within 4 Days of Compliance						
12. Scheduling/Backlog *OT gives a weekly report of any current or anticipated backlog.* *OT reports how many Nurse Triage patients from the previous day required booking into a new provider schedule.* *OT informs the Team of any upcoming provider or staff time out of the clinic such as vacations, education time, on call, etc.* *All Team members will share anticipated time off.*	❑ Automated Huddle Report ❑ Backlog ❑ Daily Clinic Schedule ❑ Staff Vacation Calendar ❑ Back-Up Schedule	Is there any health information missing (e.g., discharge summary, specialty report, lab result) that needs to be hunted down prior to the encounter? Are there FTF triage patients that are clinically complex or presenting with especially concerning symptoms that would be good candidates for co-consultation with provider? Are there opportunities for efficiencies here - could some appointments be consolidated to tackle multiple problems at once? Why is backlog occurring? What actions need to be taken to eliminate backlog? Ensure designated backups are in place to cover all staff during leave.				
13. Custody *Any barriers to care such as lockdowns or restricted movement that might affect clinic access? Any specific patient/inmate concerns?*					Custody Staff	
Does the Care Team have the resources needed for today's work?					All Team	
14. Close general huddle *LVN/CNA/MA and OT begin their work.* *RN/ Provider review 7362's with symptoms and determine disposition for patients.*						
MANDATED FOLLOW-UPS						
*RHLOC Hospital/Specialty Next Day F/U *Return from higher level of care – 5 calendar days *Return off-site referral urgent – 3 business days *Return off-site referral routine – 14 calendar days		* TTA urgent visit F/U – 5 calendar days * F/U RN triage (7362) PCP urgent referral – 24 hours * F/U RN triage (7362) PCP routine referral – 14 calendar days				

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

DAILY HUDDLE ACTIVITY SHEET		Facility Clinic:
DATE:	**TIME:**	**NOTE TAKER:**

Care Team 1: _____		Care Team 2: _____	
POSITION	**SIGNATURE**	**POSITION**	**SIGNATURE**
PCP		**PCP**	
PCRN		**PCRN**	
PC LVN/MA		**PC LVN/MA**	
Scheduler/OT		**Scheduler/OT**	
Medication LVN		**Medication LVN**	
Other (MH, Pharma, D, DDS)		**Other (MH, Pharma, D, DDS)**	
Other:		**Other:**	

SECTION 1: CRITICAL CLINICAL INFORMATION – ENTIRE PATIENT PANEL

1. **Were any of our patients seen by the On-Call Provider?** Resource: TTA and POC Log/Report

CDCR #	Last Name	Reason	Dispostition

2. **Patients returning from Higher Level of Care** (includes Community Hospital, TTA, OHU, CTC, MHCB, DSH, Specialty)

CDCR #	Last Name	Risk Level	Return Date	Facility	Reason	Report Avail.	Next PCP Appt.

3. **Patients Transferred to Higher Level of Care**

CDCR #	Last Name	Risk Level	Admit Date	Facility	Reason

4. Patients with Significant Lab or Diagnostic Reports

CDCR #	Last Name	Abnormal Result / Reason	Plan

5. Patients New to Care Team within the Past 7 Days

CDCR #	Last Name	Risk Level	Complex Care	Transfer Date	Transferred From	Next PCP Appt

6. High Risk Patients Who Left Care Team within the Past 7 Days

CDCR #	Last Name	Transfer Date	Transferred To

7. Patients with Medications that Expired in the Past 3 Days

CDCR #	Last Name	Risk Level	Complex Care	Cell Bed	Medication	Start Date	Exp Date	Expired

8. Patients with Medications Expiring in the Next 3 Days

CDCR #	Last Name	Risk Level	Complex Care	Cell Bed	Medication	Start Date	Exp Date	Expiring

9. Other Medication Concerns (e.g. 602 issues, medication non-adherence, errors, drug-drug interactions, NF or availability issues, problematic side effects)

CDCR #	Last Name	Medication Issue	Plan	Comments

SECTION 2: TODAY'S PATIENTS

10. Patients with Appointments Today

CDCR #	Last Name	Risk Level	EC	Appt. Time	Today's Appointment	Future/Overdue Appointment	Expiring/Expired	Med Admin Alert	High Risk Labs	Registry Alerts

SECTION 3: CLINICAL OPERATIONS

11. Unscheduled or Overdue Appointments within 4 Days of Compliance

CDCR #	Last Name	Risk Level	Appointment Type	Appointment Location	Appt. Date	Appt. Status	Compliance Date	Status

12. Upcoming Staff time off

Staff Name	Start Date	Return Date	Assigned Backup	Comments

13. Custody: Discuss any potential/actual barriers to access (Lockdowns, other modified programs, fog, etc.)

14. Resources/Supplies Anticipated supply or resource issues?

Close Huddle – PCRN and PCP Review of 7362's