Chapter 3 – Health Care Operations

Article 1 – Complete Care Model

3.1.1 Complete Care Model

(a) Policy

California Correctional Health Care Services (CCHCS) in partnership with other California Department of Corrections and Rehabilitation (CDCR) divisions 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. Within the CCM, staff shall utilize a Whole Person Care approach which recognizes that the best way to improve health outcomes is to consider the full spectrum of a patient's needs – including medical, behavioral, socioeconomic, and beyond. This model improves patient care, reduces the need for hospitalizations and emergency services and enhances staff satisfaction. The CCM includes the following foundational principles and requirements:

(1) 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.

(A) CCHCS shall establish interdisciplinary Care Teams at each institution, accountable for the care of defined patient panels and the exchange of relevant clinical information between treatment teams.

(B) 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.

(C) 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.

(2) 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 case management among the strategies used to achieve comprehensive care.

(A) The Care Team shall be responsible for:

1. Assessing and periodically evaluating patient health needs;
2. Meeting health care needs, including prevention and wellness services, episodic care, chronic care, urgent or acute care, and end-of-life care; and
3. Assessing health care needs beyond the scope of the health care team and referring patients to appropriate providers and services.

(B) 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.

(3) Coordination of Care. Patient services shall be coordinated and health information exchanged across all health care settings, levels of care, and specialty services.

(A) 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.

(B) The Care Team shall establish reliable processes and systems to track the status and follow-up of specialty referrals, diagnostic studies, and treatment regimens from all disciplines including the Division of Rehabilitative Programs.

(C) CCHCS shall establish standardized expectations and processes for clear and open communication between the Care Team and other care providers, which shall include:

1. Ensuring accountability for transitions in care;
2. Providing patient support and education before, during, and after transitions in care; and

3. Building relationships with other health care staff providing services to patients within the patient panel.

(4) 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.

(A) 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.

(B) CCHCS shall implement programs to assess and improve patient health literacy and promote self-management planning and activities.

(5) 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.

(6) 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.

(A) 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.

(B) 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.

(7) 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 promote continuity and coordination of care and interoperability of health care documentation to improve patient outcomes.

(A) Health records shall be completed timely, accurately, and thoroughly, and records from outside the Electronic Health Record shall be readily available prior to patient encounters.

(B) CCHCS shall develop connectivity via electronic or other information pathways to encourage timely and effective communication between providers caring for the same patient.

(C) CCHCS staff shall integrate clinical decision support into electronic systems to promote the application of current guidelines or standards as appropriate in the course of patient care.

(D) CCHCS shall produce reports for the management of individual patients and patient populations, such as patient registries, patient profiles, and patient summaries, and health care staff shall use these reports regularly for purposes of care management, population management, and other patients care activities.

(8) 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.

(A) Leaders shall champion cultural change, as well as specific improvement strategies, such as initiatives from the institution's annual improvement plan.

(B) Responsibility for conducting improvement activities shall be shared by all staff, from leadership to team members.

(C) CCHCS 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.

(D) CCHCS 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.

(b) Purpose

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

(1) Quality of care and patient outcomes.
(2) Efficiency and value of care.
(3) Patient and staff satisfaction.

(4) Adherence to legal and regulatory requirements.

(c) Responsibility

(1) Statewide

(A) CCHCS and CDCR 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.

(B) The Director, Health Care Operations and Corrections Services, and Director, Health Care Services, are responsible for statewide planning, implementation, and evaluation of the CCM.

(2) Regional

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

(3) Institution

The Chief Executive Officer is responsible for implementation of this policy at the institution level.

References

- United States Preventive Services Task Force
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.pcmh.ahrq.gov/
- California Association of Public Hospitals and Health Systems – Whole Person Care in California Public Hospitals and Health Systems https://caph.org/publication/whole-person-care-in-californias-public-health-care-systems/
- 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

Revision History

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