3.1.11 Outpatient Specialty Services

(a) Procedure Overview

This procedure describes the structures, processes and resources that California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) staff shall utilize to ensure patients have timely access to safe and cost-effective specialty services that are medically necessary in order to establish diagnoses, make recommendations for diagnostic work-up, provide therapy, and establish treatment plans that include frequency of follow-up appointments with the specialist and/or the Primary Care Provider (PCP).

(b) Responsibility

(1) Statewide

CCHCS and CDCR 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 patients have timely access to safe and cost-effective specialty services that are medically necessary.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the system at the institution. The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes interdisciplinary teamwork and continuous process improvement. The CEO delegates decision-making authority to the Chief Medical Executive (CME) and Chief Nurse Executive (CNE) for daily operations of specialty services to ensure that resources are deployed to support the system including, but not limited to, the following:

1. Providing access to equipment, supplies, health information systems, Patient Registries, Patient Summaries, and evidence-based guidelines.
2. Adequately preparing new Care Team members to assume team roles and responsibilities, including onboarding.
3. Providing Care Team members with adequate resources, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
4. Requiring that Care Team members review pertinent patient information related to access to specialty services.
5. Requiring that each Care Team conduct Population Management Working Sessions, pursuant to the Health Care Department Operations Manual (HCDOM), Section 3.1.6, Population and Care Management Services, utilizing tools such as Dashboards, Patient Registries, and Patient Summaries to address concerns related to potential gaps in specialty services.
6. Providing ongoing training and assessing competence of Care Team members.
7. Reviewing/comparing institution Care Team performance including the overall quality of services, health outcomes, assignment of consistent and adequate resources; utilization of Dashboards, Patient Registries, Patient Summaries, and decision support tools; and addressing issues as necessary.
8. Updating procedures, roles and responsibilities, and training as new tools and technology become available.
9. Collaborating with the Warden to ensure that custody staff are available to provide timely, safe, and efficient escort and transportation of patients to specialty appointments.
10. Requiring institution leadership to establish a back-up system to ensure that specialty services' scheduling is managed when staff are on leave or otherwise unable to meet daily demands.

(B) The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(C) The CNE is responsible for:

1. Ensuring that the institution has a designated Supervising Registered Nurse (SRN) to monitor specialty scheduling processes on a daily basis and identify and address or elevate barriers to access.
2. Managing and overseeing daily operations of the specialty scheduling system to include telemedicine and onsite and offsite scheduling processes.

3. Coordinating the delivery of health care services.

(D) The Chief Physician and Surgeon (CP&S), SRN, and appropriate specialty services staff shall meet on a weekly basis to ensure that patients with specialty referrals have timely access to these services.

(E) The Institution Utilization Management Committee shall meet pursuant to the HCDOM, Section 1.2.15, Utilization Management Program, to review trends in specialty services including, but not limited to, timeliness of services and unexplained or significant outlier patterns of specialty services in order to reduce avoidable and unnecessary utilization and costs.

(c) Procedure

(1) General Requirements

(A) Specialty services shall be ordered by PCPs who practice within CDCR. The ordering PCP shall complete a Request for Service (RFS) order for each specialty service referral and shall indicate the timeframe in which the service is necessary (e.g., emergent, high or medium priority, routine).

(B) The PCP shall inform the patient of the plan for specialty referral including a general timeframe of expected service.

1. If a specialty service is rescheduled outside of compliance timeframes, the Primary Care Team (PCT) shall evaluate and inform the patient that the requested service has been rescheduled.
2. The information provided to the patient shall be documented in the health record.
3. The specific date, time, and location of the offsite appointment shall not be shared with the patient.

(C) Patients with pending high priority specialty services shall be placed on a medical hold to prevent transfer and discontinuity of care pursuant to the HCDOM, Section 1.2.14, Medical Classification System.

(D) If a patient is approved for a medium priority or routine specialty service and is subsequently transferred to another institution before the service occurs, the receiving institution shall not cancel or void the specialty service unless the PCP at the receiving institution examines the patient and determines that it is no longer medically necessary or can be rescheduled to a later date. The PCP shall document their findings in the health record at the time the specialty service is cancelled or rescheduled.

(E) The PCP shall continue to monitor the patient as clinically indicated until the initial specialty service has occurred. The PCP shall document the patient encounters in the health record.

(2) Pre-authorization Process

(A) Emergent health care requests are exempt from the pre-authorization process.

(B) The PCP shall submit the RFS order for electronic routing to the Utilization Management (UM) nurse. The UM nurse shall complete the first level review to determine if the RFS order meets evidence-based clinical decision support criteria.

(C) Upon completion of the UM nurse review, the RFS order will be electronically routed to the CME or CP&S for second level review.

(D) At their discretion, the CME or CP&S may obtain input from other medical providers at the regularly scheduled provider meetings in order to determine medical necessity. The decision-making authority to approve or deny the RFS order at the second level remains with the CME or CP&S.

1. Requests for high or medium priority specialty services shall be processed in a manner that allows for both the first and second level of review to be completed within five calendar days from the date of the RFS order.
2. Requests for routine specialty services shall be processed in a manner that allows for both the first and second level of review to be completed within seven calendar days from the date of the RFS order.

(E) The Statewide Medical Authorization Review Team (SMART) is the third level of review and shall review cases appealed by the PCP within 14 calendar days of a request for high or medium priority services and within 60 calendar days of a request for routine services.

(F) If the RFS order is denied, the reason for the denial shall be documented in the health record, and the PCP will be notified via the health record. The PCP shall discuss the decision and provide the patient with alternate treatment strategies during the next encounter which shall be within 30 calendar days of the denial of the specialty service.

(G) If the RFS order is approved, the UM nurse or other designated specialty clinic staff shall determine if the services can be provided onsite or require an offsite appointment and schedule as appropriate.

(3) Specialty Appointments Occurring Outside the Institution

(A) The designated health care staff shall complete the clinical portion of the CDC 7252, Request for Authorization of Temporary Removal for Medical Treatment, for health care services that are provided offsite.

(B) The designated health care staff shall include relevant information for transportation staff regarding infectious precautions and disabilities requiring accommodation as well as any medical transportation needs in the "Remarks" section of the CDC 7252.

(C) The designated health care staff shall sign the completed CDC 7252 and forward it to the designated custody staff.

(D) Custody staff shall prepare the "Custodial status" of the CDC 7252 and shall ensure all necessary signatures are obtained. Custody staff shall contact the institutional transportation team that provides transportation for the patient to the scheduled appointment.

(E) The CME or CP&S shall prioritize the scheduled appointments when transportation needs exceed custody availability. Appointments shall be rescheduled and should not exceed the initial timeframe based on clinical needs.

(F) The designated health care staff shall place a copy of the RFS order and any other pertinent clinical information in an envelope and provide it to custody staff for delivery to the specialty provider. Custody staff shall obtain the clinical documentation including, but not limited to, the specialty consultation report, prescriptions, clinical notes, discharge summaries, and brief operative notes, from the specialty provider and return the clinical documentation to the Triage and Treatment Area (TTA) upon return of the patient to the institution.

(G) All patients who receive specialty services outside the institution shall be processed in the TTA upon return to the institution.

(H) The TTA RN shall assess the patient, review the findings and recommendations made by the specialist, and document their findings in the health record.

1. The TTA RN shall notify the PCP or on-call provider of any immediate medication or follow-up requirements.
2. The TTA RN shall enter and implement all telephone orders given by the PCP or on-call provider including but not limited to, housing, Durable Medical Equipment (DME), treatments, and scheduling. For a follow-up appointment with the PCT, the provider shall remain on the line until the order has been read back and verified.
3. The TTA RN shall submit the clinical documentation to Health Information Management (HIM) staff for scanning into the health record.

(I) If a patient returns without the clinical documentation, the TTA RN shall call the specialty provider to obtain a copy of the clinical documentation.

1. The telephone contact shall be documented by the TTA RN in the health record.
2. If the specialty provider is unavailable, the TTA RN shall contact the PCP or on-call provider for direction.
3. The TTA RN shall inform the appropriate health care staff to obtain the clinical documentation which is required to be submitted by the specialty provider within 48 hours of the encounter.

(4) Specialty Clinic Appointments Occurring Within the Institution

(A) If trained and provisioned access, the onsite specialty provider shall document their recommendations and findings in the health record or provide written documentation to the designated nursing staff on the day of the encounter.

(B) The designated nursing staff shall:

1. Review the findings and recommendations made by the specialty provider.
2. Notify the PCP or on-call provider of any immediate medication or follow-up requirements.
3. Implement all telephone orders given by the PCP or on-call provider including, but not limited to, housing, DME, treatments, and scheduling. For a follow-up appointment with the PCT, the provider shall remain on the line until the order has been read back and verified.

(C) All written documentation shall be forwarded by the designated nursing staff to HIM staff for scanning into the health record.

(5) Follow-up with the Primary Care Team after Specialty Services

(A) The PCP shall review and sign the specialty consultation report within three business days of receipt.

(B) The patient shall be seen by the PCP within five calendar days after a high priority specialty services appointment.
(C) Following a medium priority or routine specialty services appointment, the PCT shall review the clinical documentation and schedule the patient for a follow-up appointment with the PCP or RN, as clinically indicated.
(D) At the follow-up appointment, the PCP or RN, shall discuss the specialty provider's findings and recommendations with the patient, as clinically appropriate, and document the discussion in the health record.
1. Ongoing cancer treatments such as chemotherapy, radiation therapy, and follow-up with the oncologist require only an initial approval to initiate the series of treatments and consultations.
2. If the specialty provider recommends a new procedure, surgery, or specialist consultation, and the PCP agrees with the specialty provider's recommendations, a new RFS shall be submitted. A new request for imaging shall be submitted if the PCP agrees with the specialist's recommendations.
3. Follow-up with the specialty provider after a procedure or surgery does not require another RFS order if completed within the global surgery schedule timeframes.
4. All other specialty follow-up services occurring six months or later from the date of the original service require a new RFS order.
(E) Specialty providers may not directly order follow-up consultations, diagnostic studies or treatments. The specialty provider shall make recommendations and the PCP shall review these recommendations to determine the need based on clinical guidelines, if applicable, and medical necessity.
1. If there are questions regarding medical necessity, the PCP shall discuss the case with the CME and/or CP&S including possible referral to the SMART.
2. If it is determined that the follow-up consultations, diagnostic studies or treatments recommended by the specialty provider do not meet clinical guidelines and are not medically necessary, the PCP shall document the reason in the health record.

(6) Statewide Medical Authorization Review Team

The SMART is the third level of review and shall review cases appealed by the PCP or that meet criteria for a higher level of review to determine if the specialty service is medically necessary.

(A) Membership

1. The SMART Chairperson shall be designated by the Deputy Director, Medical Services.
2. The SMART membership shall consist of Regional Deputy Medical Executives, at least two other headquarters-based physician managers, and two physician managers from the field.

(B) Meetings

1. The SMART shall meet as often as is necessary to conduct its business within established timeframes, but not less frequently than monthly.
2. A quorum is met when a minimum of 50 percent of the members are in attendance, either in person or telephonically. A quorum must be present to take action on any agenda item.

(C) Committee Proceedings Documentation

1. Records of committee proceedings shall be kept at a secure, accessible medical program site for a period of three years. At minimum, the record shall describe all committee actions and recommendations.
2. The proceedings and records of the SMART shall be confidential and protected from discovery to the extent permitted by law.

References

- California Civil Code, Division 1, Part 2.6, Section 56, et seq.
- California Evidence Code, Division 9, Chapter 3, Section 1157
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.14, Medication Classification System
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.15, Utilization Management Program
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- California Department of Corrections and Rehabilitation, Department Operations Manual, Section 62070.9.3
- Centers for Medicare and Medicaid Services Global Surgery Booklet

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