## 3.1.3 Care Teams and Patient Panels

### (a) Procedure Overview

(1) The Complete Care Model Policy maintains 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.

(2) This procedure defines interdisciplinary Care Teams, identifying 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.

### (b) Responsibility

#### (1) Statewide

California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (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 the scheduling system is successfully implemented and maintained.

#### (2) Regional

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

#### (3) Institutional

(A) 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:

1. Ensuring access to and utilization of equipment, supplies, health information systems, patient registries, patient summaries, and evidence-based guidelines.
2. Assigning patients to a Care Team.
3. 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.
4. Ensuring consistent Care Team staffing with a back-up system for core members.
5. Providing Care Team members with the information they need during huddles (e.g., Huddle Report).
6. Ensuring protected time for Care Teams to hold daily huddles.
7. Documenting and tracking huddle actions and attendance.
8. Ensuring that at least twice-monthly, each Care Team conducts a Population Management Working Session utilizing tools such as dashboards, patient registries, patient summaries, and Electronic Health Record System (EHRS) tools to address concerns related to potential gaps in care and improve patient outcomes.
9. Adequately preparing new Care Team members to assume team roles and responsibilities.
10. Assessing competence of existing Care Team members.
11. Updating procedures, roles and responsibilities as new tools and technology become available.
12. 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 other decision support tools and address issues as necessary.
13. Providing Care Team members with adequate resources, including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
14. Working with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment.
15. 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.
16. 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.

(B) The CEO, or designee, and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork across disciplines.

(C) The CNE, or designee, is responsible for:

1. The overall daily operations of the scheduling system for health care within the EHRS.
2. The coordination of health care between health care scheduling systems (e.g., outside specialty appointments).
3. Oversight and management of the scheduling processes and resources, including personnel.
4. Ensuring that the institution has a designated scheduling lead to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
5. Ensuring that Scheduling Support staff is available for all clinical areas.

(D) The Chief Medical Executive (CME), or designee, is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(E) The Supervising Registered Nurse and Chief Physician and Surgeon or CME, or designees, shall meet as needed to review the Care Team's performance, including the overall quality of services, health outcomes, level of care utilization and shall utilize dashboards, patient registries, patient summaries, and all electronic decision support tools to address or elevate issues as necessary.

**(c) Procedure**

**(1) Patient Panels**

(A) 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.

(B) Each patient shall be assigned to a Care Team and be notified of the Care Team assignment.

(C) 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:

1. Housing unit.
2. Alphabetical roster.
3. Last two digits of CDCR number.
4. Custodial factors.
5. Mental health program assignment.
6. Medical factors and other special patient needs.

(D) All Care Teams shall have access to the master registry.

1. Institutions shall communicate any change in their strategy for panel assignment to headquarters to preserve the accuracy and reliability of the master registry.
2. The Care Team is responsible for tracking the status of the assigned patient panel and shall monitor the master registry and Huddle Report daily, identifying changes to the assigned patient panel and communicating changes to team members using the daily huddle or other appropriate forums.

**(2) Care Team Members**

(A) Care Team Composition

1. At a minimum, each Care Team shall consist of the following core members:
   a. Primary Care Providers (PCPs).
   b. Primary Care – Registered Nurse (RN).
   c. Provider support staff (e.g., Certified Nursing Assistants, Medical Assistants, or Licensed Vocational Nurses [LVN]).
   d. Medication Administration Nurse (LVN/Psychiatric Technician).
   e. Care Manager – RN
   f. LVN Care Coordinator.
   g. Administrative support staff.
   h. Other members, as needed.
2. 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 includes, but is not limited

to, custody staff, pharmacy staff, dietitians, specialists, specialty nursing staff, laboratory or imaging staff, and therapists (e.g., occupational, recreational, respiratory, and other types of therapists).

3. 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.

(B) Continuity in Team Membership

1. 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.
2. 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.
3. The institution CEO, CME, and CNE, or designees, shall ensure each core member of the Care Team:
   a. Is assigned and available.
   b. Has a consistent back-up staff member.
   c. Has a coordinated schedule to optimize continuity.
   d. Has scheduled hours of work in alignment with clinic operational needs.
   e. Has scheduled work hours and hours of clinic operation in alignment for the entire Care Team.
4. 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.

(C) 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:

1. 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.
2. Ensure that Care Team members are located in close proximity to each other when they are providing services to patients, wherever possible.

**(3) Roles and Responsibilities of the Care Team**

(A) 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 Appendix 1, Care Team Roles and Responsibilities).

(B) All Care Team members shall be required to:

1. Establish and maintain professional, effective, and therapeutic relationships with patients.
2. 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.
3. Promote clear and frequent communication between Care Team members.
4. 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.
5. 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.
6. 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.
7. Promote a safe, effective, efficient, and collaborative work environment.

(C) 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:

1. Document all patient contacts, interventions, observations, care and treatments provided and the results of the care and treatment in the health record at the time of service.
2. 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.

3. Ensure that all documentation complies with the documentation standards contained in the Health Care Department Operations Manual, Chapter 2, Article 3, Health Information Management.

**(4) Daily Care Team Huddle**

(A) The Care Team shall convene each business day in a Care Team Huddle to:

1. 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.
2. 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:
   a. Unscheduled Triage and Treatment Area visits.
   b. Medical holds.
   c. Transfers to and from higher levels of care.
   d. Pending consultations and specialty services requests.
   e. New patients assigned to the Care Team. Once seen in the clinic, the RN or PCP shall order a follow up based on their chronic care conditions.
   f. Abnormal laboratory findings.
   g. High risk patient/care management issues.
   h. Mental health issues (e.g., self-injurious behavior, suicidal/homicidal ideation, coordination of testing procedures).
   i. Medication line issues, including specialty medications that require coordination with offsite (e.g., chemotherapy, Narcotic Treatment Program methadone).
   j. Polypharmacy.
3. 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.
4. Discuss daily clinical operational problems, such as the following:
   a. Episodic care triage.
   b. Same day and next day relevant health information availability (e.g., diagnostic study reports, consultation notes, and discharge summaries) and add-on appointments.
   c. Review and resolution of scheduling concerns.
   d. Potential barriers to care, including lockdowns, restricted movement, fog lines, backlogs, and other considerations.
   e. Staffing issues, such as upcoming vacation, mandatory training, or other events affecting availability of staff.
   f. Supply/resource issues.
   g. Review and discussion of the Care Team's performance with respect to targeted disease management and preventive service metrics.
   h. Ongoing evaluation and improvement.

(B) Institutional leadership 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.

(C) Huddle Preparation

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 Report that prompts Care Team members to address topics mandated in this procedure (Refer to the Daily Huddle Script and Daily Huddle Report).
3. Determine who shall be responsible to have the Huddle Report at each daily huddle, and what other information shall be provided to the Care Team in advance of the huddle.

(D) Huddle Documentation

1. 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.
2. Each Care Team shall be responsible for monitoring the Daily Huddle Script, and Training Participation Sign-in Sheet.

**(5) Monitoring and Sustainability**

(A) Institutional leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the Complete Care Model monitoring activities. The Care Team shall:
1. Take corrective action to resolve and/or elevate concerns identified in the review.
2. Review and action shall be documented and forwarded to the designated committee.

(B) The CEO and institutional 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:
1. Accuracy and efficacy of panel assignment strategies.
2. Stability of Care Team staffing and use of back-up systems.
3. The amount of time each day that all Care Team members are working in the clinic together and any associated physical plant issues.
4. Inclusion of other team members/disciplines to manage patient care.
5. Care Team Huddle attendance.
6. Frequency, quality, and timeliness of daily Primary Care Huddles.
7. Documentation of Primary Care Huddle activities and necessary follow up.
8. Frequency and quality of Population Management Working Sessions.
9. Adverse events or barriers linked to Care Team processes described in this procedure.

(C) The CEO and institutional 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:
1. Clinical skills (e.g., history-taking, physical examinations, assessment, and treatment planning).
2. Adherence to policy guidelines, protocols, and decision support tools.
3. Recognition of patient care needs that fall outside the scope of what is provided by the Care Team and appropriate and timely referral.
4. Management of handoffs as patients move from one Care Team to another or across levels of care.
5. Care management of patients who are high risk or otherwise clinically complex.
6. Population and panel management, including provision of preventive services and managing subpopulations with specific chronic diseases.
7. Self-management planning and patient education.
8. Effective communication.
9. Optimizing access to care through use of co-consultation, appointment bundling, same-day appointments, and other strategies.
10. Redesigning clinic processes to increase efficiency and use team members to the full extent of their licensure.
11. Identification, analysis, and resolution of quality problems, including use of data to evaluate performance and investigate problems.
12. Application of available patient management tools, including patient registries and EHRS.
13. Overall contribution to the Care Team and a culture that promotes teamwork.

**(6) Training and Decision Support**

The CEO and institutional 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:

(A) Expectations in this procedure.
(B) Any changes to local Care Team processes.
(C) National health care industry advances pertinent to the Patient-Centered Health Home.
(D) New information systems or technology that may increase the efficiency or effectiveness of Care Team processes or forums.
(E) Updates in clinical practice, including new CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
(F) Training needs.

**Appendices**

- Appendix 1: Care Team Roles and Responsibilities

**References**

- Health Care Department Operations Manual, Chapter 2, Article 3, Health Information Management
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- 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

**Revision History**

Effective: 06/2016
Revision: 12/2020

**Appendix 1**
**Care Team Roles and Responsibilities**

| Care Team | Roles and Responsibilities |
|---|---|
| Primary Care Provider | a. Attend and actively participate in the daily huddle.<br>b. Diagnose and manage the patients' episodic illnesses, chronic conditions, preventive care, and their complex needs.<br>c. Order and coordinate patient care services including, but not limited to, specialty and higher level of care.<br>d. Support Transitional Services Team (Resource Registered Nurse [RN]) in transition planning for complex medical conditions. |
| Mental Health Clinician and/or Psychiatrist | a. When indicated, attend and actively 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.<br>b. Coordinate mental health care, as needed.<br>c. Provide relevant mental health history.<br>d. Support Transitional Services Team (Resource RN) in transition planning for complex mental health conditions. |
| Dentist | a. When indicated, attend and actively participate in Primary Care Huddles to provide input concerning dental treatment needs.<br>b. Coordinate patient care services including, but not limited to, oral surgery services, lab tests, diagnostic imaging and diagnostic procedures.<br>c. Consult with other care team members on the patient's episodic illnesses, chronic conditions, preventive care needs, and mental health conditions.<br>d. Provide input on dental infections/conditions, refusals of dental care and planned dental care that may affect other aspects of the patient's overall health care needs. |
| Primary Care Provider Support Staff | e. Attend and actively participate in the daily huddle.<br>f. Prepare patients for visits (e.g., vital signs, weights, gathering specialty reports and diagnostic results, other health information preparation).<br>g. Conduct/perform Point-of-Care testing and administration of treatments in accordance with licensure/certification.<br>h. Assist with tracking and access to Durable Medical Equipment. |
| Primary Care RN | a. Attend and actively participate in the daily huddle.<br>b. Manage the patient's episodic illnesses, chronic conditions, preventive care needs, and their complex care management using established protocols and other decision support.<br>c. Advocate for the patient.<br>d. Coordinate the patient care services for the designated patient panel. |

| Care Team | Roles and Responsibilities |
|---|---|
| | e. Manage medication for patients assigned to the team.<br>f. Provide patient education.<br>g. Conduct/perform Point-of-Care testing.<br>h. Participate in discharge planning. |
| Licensed Vocational Nurse Care Coordinator | a. Attend and actively participate in the daily huddle.<br>b. Advocate for the patient.<br>c. Monitor designated patient panel registries and report any changes to the team members.<br>d. Coordinate the patient care services for the designated patient panel.<br>e. Manage medication for patients assigned to the team.<br>f. Provide patient education.<br>g. Conduct/perform Point-of-Care testing.<br>h. Participate in discharge planning. |
| Supervising Registered Nurse (SRN) II | a. Attend and actively participate in the daily huddle as indicated.<br>b. Oversight of key clinical processes including, but not limited to, scheduling and medication management, and management of refused orders inbox.<br>c. Audit compliance for a variety of nursing measures including, but not limited to, quality of care.<br>d. Identify opportunities for improvement.<br>e. Communicate staffing needs.<br>f. Coordinate with custody to mitigate barriers affecting access to health care.<br>g. Facilitate conflict resolution.<br>h. Provide clinical support as indicated. |
| Primary Care Team Office Technician | a. Attend and actively participate in the daily huddle.<br>b. Ensure all patients are appropriately scheduled.<br>c. Ensure access to care barriers are made known to the full Care Team.<br>d. Retain records from daily huddles.<br>e. Prepare information for daily huddles.<br>f. Maintain attendance records for daily huddles.<br>g. Schedule patients in the scheduling system in accordance with policy timeframes.<br>h. Ensure Care Team workload is balanced for scheduled patients.<br>i. Maintain a current and accurate schedule for the clinic.<br>j. 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. |
| Transitional Services Team (Resource RN) | a. When indicated, attend the Daily Huddle to provide pertinent information to Care Team members regarding transitional planning for qualifying complex patients, and communicate any needed |

| Care Team | Roles and Responsibilities |
|---|---|
| | support from Primary Care Team (PCT) members.<br>b. Assessing identified patients with complex care needs across all health care domains, and liaise with other internal and external stakeholders to ensure care needs are addressed prior to release to the community, and when possible, prior to entry into the prison system.<br>c. Support the PCT when transition planning to the community involves specialty health care and rehabilitative services.<br>d. Coordinate with community health care and rehabilitative agencies to ensure continuity of care for qualifying complex patients.<br>e. Coordinate care with prisons and jails for patients departing on a temporary basis, such as transfers related to court appearances, higher levels of care for medical, mental health, or dental reasons.<br>f. Communicate identified needs with parole offices and probation offices and arranging specialize care services with community health care providers, when and where appropriate. |
| Medication Administration Nurse | a. Attend and actively participate in the daily huddle when possible.<br>b. Ensure timely delivery of prescribed medications to patients on the panel.<br>c. Alert the Care Team of adherence issues and adverse medication events.<br>d. Alert pharmacy or the SRN II when prescribed medications are unavailable.<br>e. Report medication errors.<br>f. Alert the SRN II to medication administration access issues.<br>g. Reconcile medication orders in the Electronic Health Record System.<br>h. Perform routine vitals that are associated with medications.<br>i. Conduct/perform Point-of-Care testing as associated with medication delivery. |