

3.1.4 Patient Education

(a) Policy

- (1) California Correctional Health Care Services (CCHCS) staff shall provide clinical and health education to patients regarding disease prevention, recommended treatment modalities, and available health care resources at all stages of their confinement within any California Department of Corrections and Rehabilitation (CDCR) facility. Patient education shall be a continuous and ongoing process designed to educate and inform the patient beginning with the patient's arrival at a Reception Center and continuing throughout incarceration.
- (2) The CCHCS/CDCR Patient Education Program supports the Complete Care Model by recognizing that the patient is an active partner in their own health care. The patient, their Primary Care Team, and other health care providers determine the most appropriate health care goals, interventions, and outcomes based on the patient's health care needs and personal objectives with the understanding that an informed patient delivers an improved patient outcome and reduces overall morbidity and mortality.
- (3) Patient education within CCHCS consists of two main components which are Clinical Patient Education and Health Education. Clinical Patient Education is a planned, systemic, and sequential program of teaching provided to patients in a clinical environment based on the patient's assessment, evaluation, diagnosis, prognosis, individual needs, and care requirements pursuant to the patients' health status and desired outcomes. Health Education is provided to all patients to promote general health and wellness, disease prevention, and is designed to change and improve health behaviors within the patient population.

(b) Purpose

To provide education that promotes wellness and empowers patients to actively participate in their disease management and prevention.

(c) Responsibilities

(1) Statewide

- (A) CDCR and 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 so that health care staff can successfully implement and maintain the Patient Education Program.
- (B) The Undersecretary, Health Care Services, CDCR, and the Directors of CCHCS are responsible for statewide planning, implementation, and evaluation of the Patient Education Program.
- (C) The Undersecretary, Health Care Services, CDCR, and the Directors of CCHCS shall designate a statewide committee with responsibility for the oversight of all aspects of the Patient Education Program within CCHCS/CDCR. The designated committee shall be multidisciplinary and consist of, at a minimum, the following members, or their designees, the Deputy Directors of Medical, Nursing, Mental Health and Dental Services, Pharmacy, Ancillary and Allied Health Services, and the Regional Health Care Executives (RHCEs). The committee shall be responsible for ensuring appropriate, standardized patient education material is developed and available for patients statewide and at all levels of care.

(2) Regional

RHCEs are responsible for implementation of this policy and 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 a system to provide management of Patient Education Programs in their institution. The CEO delegates decision making authority to designated health care executives for daily operations of the Patient Education Program and ensures adequate resources are deployed to support the program.
- (B) The CEO and all members of the institution leadership team are responsible for ensuring resources are in place to support the successful implementation of this procedure at all levels, which include access to and utilization of equipment, supplies, health information systems, patient registries and summaries, and evidence-based guidelines.
- (C) Institution-specific local operating procedures shall be developed and implemented based upon the tools provided by statewide health care leadership.

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- (D) Each institution shall designate a subcommittee in writing that has responsibility for the oversight and coordination of all Patient Education Programs within the institution. The designated subcommittee shall report to the institution's Quality Management Committee. At a minimum, the designated subcommittee shall ensure that patient education (clinical and peer mentoring) is provided based on the identified needs of their patient population by:
1. Identifying high-risk groups within their patient population.
 2. Facilitating health care events within CDCR and/or the Local Community (e.g., Substance Abuse Prevention, Influenza Campaigns, Heat Injury Prevention).
 3. Reviewing clinical and health education needs identified during discussions with Patient Representative Groups (i.e., Men's Advisory Council [MAC], Women's Advisory Council [WAC], and Inmate Family Council [IFC]).
 4. Identifying needs based on reviews of patient grievances.
 5. Identifying needs based on internal and external audits and reviews (e.g., Patient Safety, Medication Administration Process Improvement Program, Office of Internal Affairs, or Prison Law Office visits).
 6. Holding discussions with CDCR partners (i.e., custody, Inmate Education Services and Vocational/Prison Industry Authority [PIA] Training and Services).
- (E) Each institution shall ensure that clinical education, health education, and Patient Education Programs are:
1. Coordinated.
 2. Mutually supportive and meet the needs of the patient population as a whole.
 3. Address the needs of identified high-risk patient populations as well as the health care needs and goals self-identified by the patient population.

(d) Procedure Overview

- (1) This procedure provides guidelines for the development, utilization, provision, and documentation of health care education to CDCR/CCHCS patients. The purpose of the Patient Education Program is to promote wellness and empower patients to actively participate in disease prevention and management. This program aims to reduce morbidity/mortality and overall health care costs.
- (2) Patient education shall be provided to each patient within CDCR on a continuous and ongoing basis using processes designed to educate and inform the patient beginning with arrival at a Reception Center (RC) and continuing throughout incarceration. The CCHCS/CDCR Patient Education Program consists of two main components which are Clinical Patient Education and Health Education, both of which are an integral part and support of the Complete Care Model.
- (3) CCHCS/CDCR Patient Education Program shall support the goals of the Public Safety and Rehabilitation Act of 2016 (Proposition 57) through clinical and peer mentor programs designed to encourage and enable patients to understand and take responsibility for their health care needs and decisions, gain insight, and actively and fully participate in rehabilitative programs in preparation for their reintegration into the community once they complete their incarceration and transition to supervision.

(e) Procedure

(1) General Requirements

- (A) The Patient Orientation to Health Care Services Handbook shall be available in each institution law library and shall be provided to each patient within 14 business days upon arrival and upon patient request by the Receiving & Release (R&R) or Primary Care Nurses at any CDCR institution.
- (B) Each Standardized Nurse Protocol/Procedure and Care Guide shall include a patient education component, including printed material that shall be provided to the patient.
- (C) All patient education material shall be provided in a manner that can be used by the patient population to which it will be distributed.
 1. The Statewide Patient Education Committee shall ensure printed materials are developed in both English and Spanish to the greatest extent possible. Languages other than English or Spanish shall have patient education material translated into the identified language.
 2. To the extent possible, printed materials shall also be provided in formats, or by methods, accessible by patients with visual impairments in accordance with the Health Care Department Operations Manual (HCDOM), Section 2.1.2, Chapter 28, Effective Communication (EC). Institutions where the identified

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visually impaired population (DPV) exceeds 10% shall coordinate with the headquarters Patient Education Committee to have selected patient education material published in a large print version.

(2) Reception Centers

Patient education shall begin with the patient's arrival into CDCR custody at the RC. The RC R&R nursing staff shall:

(A) Identify barriers to learning and ensure accommodations are documented in the health record. Examples include, but are not limited to:

1. Language.
2. Learning difficulties as documented in the patient's transfer records or reported by the patient such as necessary EC accommodations (visual, hearing, speech).

(B) Accommodations shall be provided based on the patient's reported needs until formal testing can be performed (i.e., Hearing Testing or Test for Adult Basic Education testing, or Developmental Disabilities Program [DDP] screening).

(3) Clinical Education Programs – Verbal and Written Patient Education

(A) As described in (e)(1) above, CDCR/CCHCS shall develop and/or provide written material designed to support patient education, develop health literacy, improve the overall quality of life and health care outcomes, and reduce morbidity and mortality.

(B) Individual face-to-face patient education

1. The most significant and effective method of patient education is direct verbal contact with a health care provider. Within CCHCS/CDCR, most patient education is performed during face-to-face clinical encounters. CCHCS/CDCR staff shall utilize every patient visit as an opportunity for therapeutic intervention and education.
2. CCHCS/CDCR staff who provide patient education shall document in the health record the education provided, the patient's understanding of the information provided, and EC accommodations used (if needed).

(4) Clinical Education Program – Institutional General Requirements

(A) Each institution shall develop a Patient Education Program tailored to the identified needs of their institution. At a minimum, the program shall include the following elements:

1. R&R patient education (i.e., Patient Orientation to Health Care Services Handbook, Sick Call Process for the institution, the conduct of pill lines, access to health care processes, etc.)
2. Patient education during clinical contacts as needed
3. Nursing-led Therapeutic Groups (NL-TGs)
4. Orientation to available self-management and substance abuse programs
5. Peer Mentor Program
6. Woman's Health Program (Central California Women's Facility, California Institution for Women, and Folsom State Prison-Women's Facility)

(B) The patient education process shall begin upon arrival at the institution. The R&R nurse shall ensure that each patient requiring accommodation has access to the Durable Medical Equipment necessary for effective learning and communication (e.g., glasses, hearing aids, and batteries).

(C) Patient education shall be a component of each health care visit. Documentation in the health record may include the following, as applicable:

1. Patient education provided
2. Printed material provided
3. Patient's understanding of the education provided
4. EC process used (if applicable)
5. Topics include, but are not limited to:
 - a. Wellness & Prevention
 - b. Newly Diagnosed Disease (Episodic or Chronic)
 - c. Treatment Plan
 - d. Patient Goals
 - e. Medications and Treatments (Therapies)
 - f. Procedures, Diagnostic Tests, and Preventative Screening

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- g. Compliance/Adherence
 - h. Men's/Women's Health to include disease prevention and family planning
- (D) During Primary Care Team Huddles, Population Management Working Sessions, and/or mental health (MH) Interdisciplinary Treatment Team (IDTT), health care staff shall identify therapeutic groups which would be beneficial to include in a patient's treatment plan or plan of care. This may include NL-TGs, mental health groups, self-management, etc. Any discussions and recommendations shall be documented in the health record.
- (E) Patient education for patients participating in the Mental Health Services Delivery System (MHSDS) shall receive patient education as described in the MHSDS Program Guide.
- 1. Patient education provided under this section shall supplement the clinical patient education provided under this procedure and be designed to meet the patient's unique mental health needs as identified in their MH Interdisciplinary Treatment Plan.
 - 2. The patient's MH treatment team shall coordinate with the patient's primary care team to meet the full range of clinical education needs through the development of adaptations to the educational process necessitated by clinical and mental health diagnosis (e.g., adapting IDTT plan based on visual problems, or Chronic Care Plan based on MH diagnosis, [i.e., schizophrenia or DDP status]).
- (F) Dental patients shall receive patient education as described in the HCDOM, Chapter 3, Article 3, Dental Care. Dental staff shall coordinate with the patient's primary care and MH Health Treatment Teams (as applicable) to coordinate education activities and necessary adaptations to the standard dental education program and/or materials.
- (G) Where indicated, health care staff shall coordinate with other institutional staff to coordinate Patient Education Programs based on identified needs for rehabilitation and success such as:
- 1. Division of Rehabilitative Program staff for educational, vocational, and Cognitive Behavioral Therapy programs.
 - 2. PIA to develop works skills.
 - 3. Community Transition Program staff to coordinate pre-release activities and possible parole needs, etc.
- (5) Clinical Education Programs – Nursing-led Therapeutic Groups**
- (A) Each patient shall be provided the opportunity to participate in nursing-led group activities that provide education on disease processes, positive health behaviors and health improvement, therapeutic interventions (clinical and self-directed), and are designed to improve the patients overall quality of life and health status.
- (B) Content development
- 1. An approved set of NL-TGs shall be developed to meet identified patient needs on a statewide basis.
 - 2. Content and curricula shall be developed and standardized statewide. A multidisciplinary team shall develop NL-TGs under the direction of a Headquarters Chief Nurse Executive (HQ CNE).
 - 3. Each NL-TG shall meet established guidelines and quality metrics as determined by the Statewide Patient Education Committee.
 - 4. The HQ CNE shall designate a Nurse Consultant Program Review (NCPR) to lead the NL-TG development process. The NCPR shall collaborate with other disciplines to ensure content is accurate, relevant, and evidence-based.
 - 5. NL-TGs will be written in a manner to qualify for Milestone, Rehabilitative Achievement, or other inmate participation credits as delineated in California Proposition 57.
 - 6. NL-TGs shall be separated into broad categories. Each category may have multiple individual lesson plans which support the overall category patient education goal. A list of approved NL-TGs shall be maintained under the direction of the designated HQ CNE.
- (C) NL-TG Scheduling
- 1. The institution CNE shall coordinate with the Community Resource Manager as outlined in the established [workflow](#) and collaborate with medical, mental health, dental, and custody staff to create a Master Schedule of Groups offered within the institution.
 - 2. The institution CNE is responsible for approving and signing the Nursing Master Schedule and ensuring that it is included in the designated subcommittee's discussion and minutes.
 - 3. The institution CNE shall build upon the Nursing Group schedule utilizing the needs of the patient population being served to ensure the quality and variety of the NL-TGs as well as their relevance to the patient population.

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4. NL-TGs may be scheduled and offered seven days per week on both second and third watch (See Appendix 1).
5. Groups shall be considered for all patients including those in the general population, patients with physical disabilities, cognitive impairments or substance use disorders, and all participants in the DDP and/or MHSDS.
 - a. Individual patient factors to be considered may include:
 - 1) Patient classification and/or housing
 - 2) Groups available on the master schedule
 - 3) Times groups are scheduled
 - 4) Any current behavior issues or concerns, any precipitating event
 - 5) Perceived knowledge deficit
 - b. Institutional factors to be considered may include:
 - 1) Whether classifications of patients (i.e., DDP and Enhanced Outpatient Program patients) are permitted to mix for therapeutic purposes
 - 2) Physical plant limitations – available space
 - 3) Custody support
- (D) Based on the category, the Primary Care Registered Nurse (PCRN) or Mental Health Registered Nurse (MHRN) shall determine specific groups to be provided from those that are made available in the statewide nursing education library available on Lifeline. When possible, suggestions for classes shall be discussed with the patient before scheduling. This discussion shall be documented in the health record.
- (E) The PCRN or MHRN shall place an order in the health record for each category of the group.
- (F) The patient shall be scheduled for a group encounter via the Health Care Priority Ducat Scheduling System by category and specific group content desired.
- (G) At the conclusion of each therapeutic group session, the nurse facilitator shall document participation, attainment of goals, and other pertinent information in each attendee's health record. Attendance shall also be documented in the patient scheduling system.

(6) Health Care Education – Peer Education Programs

- (A) Peer Health Care Education (PHE) is an effective means of providing health care education in a manner that is relevant and relatable for the individual patient. Each institution shall develop a Patient Education Program designed to improve overall health literacy based on the needs identified by their patient population.
- (B) PHE shall be developed collaboratively with input from each health care discipline and institutional stakeholders (e.g., custody, MAC/WAC, IFC).
- (C) Patients may be referred to a PHE group by any CDCR/CCHCS staff member, or they may request enrollment by submitting a CDCR 22, Inmate/Parolee Request for Interview, Item or Service, and/or CDCR 7362, Health Care Services Request, per the local operating procedure. The patient shall be notified of the results of the request in writing via institutional mail within 14 business days of the request.
- (D) General Requirements
 1. The CDCR/CCHCS Patient Education Program is designed to provide ongoing peer mentoring and informal education for the management of chronic health issues (e.g., diabetes mellitus, pain, weight control) using an evidence-based curriculum.
 2. The CDCR/CCHCS Patient Education Program is a partnership between health care, institutional staff, and the patients, each of whom are equally involved in the program's development and implementation.
- (E) Inmate Peer Mentors (IPMs) provide their peers with structured health information and education which will help create the kind of cultural change that benefits the incarcerated, parolees, their families and communities through a common frame of reference and set of shared experiences relevant to the patient.
- (F) Each institution shall coordinate with institutional custody leadership to establish a sufficient number of paid IPM positions to meet the identified needs of the institution. IPMs shall be assigned, monitored, supervised, and evaluated in compliance with the requirements set forth in California Code of Regulations, Title 15, and the Department Operations Manual for participation in the Inmate Work Incentive and Training Program (IWTIP). Nursing Supervisors may be designated as supervisors for the IPMs working in patient education.
- (G) Trained staff shall facilitate the Patient Education Program. While the primary support for the program shall be provided by nursing staff, each discipline shall provide expertise as necessary.

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1. Each institution shall designate one Lead PHE Facilitator and a sufficient number of PHE coordinators to coordinate and, as necessary, conduct activities related to the implementation and administration of the Patient Education Program.
 2. These positions do not necessarily need to be licensed clinical staff; however, if they are not, a Registered Nurse shall be designated as a resource for the Lead PHE Facilitator.
- (H) Program Development (Curricula)
1. A multidisciplinary team shall develop each Peer Health Group curriculum under the direction of a HQ CNE.
 2. PHE classes shall include, but not be limited to:
 - a. Vaccines
 - b. STDs
 - c. HIV
 - d. Hepatitis C
 - e. Norovirus
 - f. Healthy Lifestyle
 - g. Depression
 - h. Grief
 - i. Substance Use
 3. Nursing staff shall collaborate with other health care professionals and interact with patients to ensure that health-related information discussed in peer mentoring meetings is of reasonable accuracy so as to promote health maintenance.
- (I) Each institution shall develop a program in which IPMs are randomly observed to ensure the quality of material and to support the IPMs in group facilitation activities.
- (J) Each IPM shall be trained and their “mastery” of the material verified prior to their conducting of any peer health care education activities. Training, competency, and periodic observations shall be documented in the IPM’s IWTIP files.
- (K) A local community connection is a valuable resource for the IPMs. It is important that each institution coordinate their Patient Education Program with programs offered by community-based organizations. Community-based organization shall be encouraged and recruited to participate in facilitating the program training patients and in the sharing of resources, expertise, and follow up upon release from CDCR custody.

Appendices

- Appendix 1: Sample NL-TG Schedule

References

- California Penal Code, Part 3, Title 2, Chapter 3, Sections 3407 and 3409
- California Proposition 57: The Public Safety and Rehabilitation Act of 2016
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 3, Article 3, Dental Care
- California Correctional Health Care Services, Performance Improvement Plan 2016-2018: Improvement Strategies (2017). Retrieved from:
 - <http://lifeline/HealthCareOperations/QualityManagement/Documents/ImprPlan-2016-2018.pdf>
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- U.S. Department of Health and Human Services (2017). Agency for Healthcare Research and Quality: Guide to patient and family engagement in hospital quality and safety. Retrieved from:
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Revision History

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Appendix 1

Sample Nurse Lead Treatment Group Schedule

Institution: Anywhere State Prison

Day of Week	Hours	Title	Location
Monday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 1)	A3-101
Tuesday	1300-1400	Anger Management (Module 2)	A5-102
	1415-1545	Men's Health	A5-102
Wednesday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 1)	A3-101
Thursday	0900-1000	Stress Management	A5-102
	1030-1200	Men's Health	A5-102
	1230-1400	Diabetes's Education & Spt. Gp	A3-101
	1415-1545	Asthma Education & Spt. Gp	A5-102
Friday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 2)	A3-101