3.1.7 Care Management/Care Coordination

(a) Procedure Overview

This procedure describes the systems and processes California Correctional Health Care Services (CCHCS) staff shall utilize to assist patients in reaching an optimum level of wellness and functional capability as a means of achieving patient wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Care Management/Care Coordination services are best offered in a climate that allows direct communication between the Care Manager/Care Coordinator, the patient, and appropriate service personnel in order to optimize the outcome for all concerned. This procedure also specifies roles and responsibilities for key staff involved in the care coordination system.

(b) Responsibility

(1) Statewide

California Department of Corrections and Rehabilitation (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 to ensure the Care Management/Care Coordination system is successfully implemented and maintained.

(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 Care Management/Care Coordination 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 Care Management/Care Coordination system and ensures adequate resources are deployed to support the system including, but not limited to, the following:

1. Access to and utilization of equipment, supplies, health information systems, patient registries and summaries and evidence-based guidelines.
2. Ensure that at least twice monthly, each Primary Care Team (PCT) 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, ensuring:
   a. Patients are linked to necessary services through Care Management/Care Coordination.
   b. All patients have timely access to appropriate care.
   c. Patients who are at increased risk for developing serious health complications and patients with chronic health care needs are identified and monitored.
   d. Preventive services are provided.
   e. Health education, wellness, and self-management are provided.
3. Adequately prepare new Care Team members to assume team roles and responsibilities with regards to Care Management/Care Coordination.
4. Assess competence of existing Care Team members.
5. Update procedures, roles and responsibilities as new tools and technology become available.
6. Work with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment.
7. Annual Review of Adult Immunization Schedule Chart and the Preventive Services Matrix. At a minimum, nursing leadership shall arrange a meeting with the Public Health Branch and the Chief Physician and Surgeon annually to review these documents and update them as needed based on the current recommendations from the Centers for Disease Control and Prevention and the United States Preventive Services Task Force.

(B) The CEO shall:

1. Establish relationships with community agencies, specialists, hospitals, and others to ensure connectivity within a network of service delivery points.
2. Understand the requirements of each of the service delivery points to ensure coordination of care.
3. Convey information about correctional health care and our processes to the service delivery network.

(C) The CNE is responsible for the overall daily operations, oversight, and management of the Care Management/Care Coordination systems, processes, and resources, including personnel.

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

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

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

(G) Institutional leadership shall, in consultation with the CCHCS Public Health Branch, develop a Local Operating Procedure to address standing orders for immunization, preventive screenings, and preventive medications. The nursing staff, as part of care management, may administer immunizations, order certain screening tests, and start preventive medications at the time of a Care Management/Care Coordination visit as long as there is a valid standing order.

(c) Procedure

(1) Responsibilities of the Nurse Care Manager/Care Coordinator

All members of the PCT assume responsibility for all aspects of patient care across the continuum and throughout the course of the patient's daily activities. Members work to anticipate patient care needs, develop treatment plans, and coordinate care to ensure that services are provided without interruption or delay. Each member of the PCT is accountable for developing relationships and networking with other members of the health care community to ensure the overall health care needs of the patient are met. The PCT shall follow the patient through the systems of care to ensure his/her needs are met and improve patient outcomes.

(A) The Registered Nurse shall:

1. Provide overall direction for the assigned Care Team patient panel. Assess, plan, implement, monitor, and evaluate patient care for an assigned patient group composed of patients mostly in the secondary prevention and tertiary groups.
2. Collaborate with the patient one-on-one to develop and maintain his/her treatment plan.
3. Interface with, and refer patients to other supportive services as appropriate.
4. Review data pertaining to the entire patient panel and coordinate patient care activities and education.
5. Direct the members of the care coordination team (e.g., Licensed Vocational Nurse [LVN], Psychiatric Technician [PT], and Office Technician) when coordinating the care of their patient panel.

(B) The LVN/PT shall:

1. Perform patient care activities within the assigned primary care patient panel. The LVN/PT may also be assigned a subpanel of patients composed of patients in the primary prevention group for more comprehensive targeted nursing care (e.g., wound management, medication compliance).
2. Collaborate with patients one-on-one regarding their treatment plan. The LVN/PT may provide education and services to patients in both one-on-one and group settings. The LVN/PT interfaces with and refers patients to other supportive services, as appropriate.
3. Use their skills according to their scope of practice, including collecting data, documentation, communicating patient information to the Registered Nurse (RN) as needed, and providing patient education.
4. Assist in the development of a treatment plan based on the information gathered. The development of the treatment plan shall include self-management goals in conjunction with the Care Team and implementation of interventions.
5. Work with the RN to ensure prioritization of patient care management services.

(C) Scheduling Support Staff shall:

1. Schedule appointments as necessary to meet the needs of the patient's treatment plan.
2. Assist in the completion of requested audits for the Care Team.
3. Run reports from the Chronic Care Master Registry and other databases as needed by the Care Team.
4. Use and maintain a system to track scheduling and completion of visits, tests, studies, consults, and educational training.

(2) Care Management Process

Care management begins when the patient enters into CDCR and continues throughout his/her stay within CDCR. The process is continuous and it transitions across institutions and patient care settings. The care coordination process is also instrumental in ensuring that the patient's treatment plan transitions to the community upon parole or discharge.

(A) Intake Screening (Reception Center or Receiving & Release)

1. All patients shall have an initial nurse care management visit within seven days of arrival at the reception center and within 30 days of arrival after an inter-institution transfer.
2. On a daily basis, the Primary Care Nurse identifies new arrivals to the panel, evaluates their health care needs through the use of the Master Registries, Patient Summaries, existing treatment plans, and other documents, and determines priority and timeline of initial care management visit.
3. The Primary Care Nurse collaborates with the PCT and other disciplines to initiate the coordination of the patient's health care services.

(B) Before the Care Management/Care Coordination Visit

The Primary Care Nurse/Care Coordinator shall:

1. Review the patient summary sheet, health record, and other available documents to identify the preventive services, immunization, and medication the patient has previously received or is currently prescribed.
2. Document this information in the treatment plan.
3. Identify recommended immunization and preventive services to discuss during the nursing care management scheduled visit.
4. Identify chronic disease history and current status.
5. Identify current risk stratification level.
6. Identify any effective communication barriers/disabilities and prepare a plan to meet those needs during the visit.
7. Prepare for any upcoming specialty care visits by collaborating with Specialty Services nurses to identify specific patient education materials, need for procedure preparation, and after care needs.

(C) During the Care Management/Care Coordination Visit

The Primary Care Nurse/Care Coordinator shall provide the following services to the patient as directed by the patient's current needs, goals and his/her treatment plan.

1. Perform comprehensive or focused assessment depending on nature of care management visit.
   a. A comprehensive assessment should be completed during initial and annual visit.
   b. A focused assessment should be completed during all other visits.
2. Ask the patient to describe his/her health status and progress since last visit.
3. Discuss assessment findings.
4. Compare to previous status.
5. Discuss observed progress or regression from last patient objectives/goals.
6. Ask the patient to explain his/her goals for this visit.
7. Discuss nurse suggested goals.
8. Discuss disease process including pathophysiology appropriate to the patient's understanding.
9. Discuss treatment and medication compliance (e.g., self-care, Keep-on-Person).
10. Discuss outcomes of any test results or studies.
11. Solicit for patient questions, concerns, and other factors in his/her life that he/she thinks might have an effect on his/her health care, psychosocial response to illness or health situation (e.g., anxieties/fears whether rational or not). Respond with active listening and information.
12. Discuss the need for any future tests or treatments.
13. Educate on warning signs and symptoms as well as how to seek emergency medical care.
14. Discuss opportunities for behavioral changes.
15. Make and document new goals with the patient.
16. Discuss patient status relative to the care management level, including celebrating improvements and goal achievements.
17. Discuss nursing and treatment plan implications of changing the care management level due to today's assessment findings.

(D) After the Care Management/Care Coordination Visit

The Primary Care Nurse/Care Coordinator shall:

1. Document the interventions provided in the appropriate locations in the health record (e.g., Patient Immunization Record, Problem List, Interdisciplinary Progress Note, treatment plan) such as:
   a. The topic and counseling provided (e.g., smoking cessation).
   b. Immunization administered.
   c. Medication and/or treatments ordered.
   d. RFS or lab slip for recommended screening.
   e. The referrals to the PCP regarding recommended screenings and preventive medications.
   f. The referral to other health care disciplines (e.g., mental health, dental).
   g. The follow-up Care Management/Care Coordination visit.
2. Print and supply any discharge instructions.
3. Print and supply education/information materials suggested by the nurse and/or requested by the patient.
4. Communicate any nurse-suggested changes to the treatment plan, solicit for the patient's input on changes to the treatment plan, and engage the patient in discussion of how to reconcile and synthesize the two input sources (nurse and patient).
5. Ask the patient which objectives he/she wants to commit to working on until the next visit. Note the patient's priority objectives and discuss steps to reach the objectives.
6. Update the treatment plan and provide a printed copy to the patient.
7. Confirm the next appointment interval with the patient and schedule an appointment.
8. Communicate the results of the visit and any new plans to the PCT, and other health care staff and/or disciplines to ensure coordination (e.g., during huddle, ad-hoc clinical discussions, or Population Management Working Sessions).

(3) Management and Sustainability

(A) Care Team

At least monthly as part of the population management meeting, the Care Team shall evaluate the effectiveness and efficiency of the Care Management/Care Coordination process. The Care Team shall:

1. Review population management performance trends and take action to improve care.
2. At a minimum, review Health Care Services Dashboard information but may also consider monitoring reports, internal audits and surveys, and reviews by stakeholders such as court experts, the Prison Law Office, and the Office of the Inspector General.
3. Evaluate patients' responses and the effectiveness of current treatment plan(s) and adjust plan(s) as appropriate. The Care Team shall endeavor to anticipate educational, treatment and/or diagnostic needs of the patient based on identified trends, and adjust treatment plan(s) to improve outcomes for individual patients and patient populations.
4. Review patient registry flags and alerts indicating abnormal clinical findings, specialty services reports, community hospital reports, sentinel events, etc.
5. Review access to care data and statistics.
6. Review potentially avoidable hospitalizations for any patients within the panel.
7. Review new patients and patients leaving the panel in the context of their impact on the overall risk stratification of the patient panel (e.g., workload management and resource demand).

(B) Institutional Leadership

Institutional leadership shall periodically review the composition of patient panels, particularly relative to the number and proportion of patients that fall into each risk category, to ensure available staff resources are distributed in order to provide the required population management services and procedures, templates, and roles and responsibilities are updated as new tools and technology become available.

(C) System Monitoring

The CEO and the institution leadership team shall review institution-wide care coordination data monthly in the context of Quality Management Committee and subcommittee meetings. To ensure efficiency of the care coordination system, the institutional leadership shall:

1. Periodically evaluate the care coordination program through methods such as a review of trends in:
   a. Possible avoidable hospitalizations.

b. Sentinel events.
c. Utilization of episodic care.
d. Emergency Department or Triage and Treatment Area visits.

2. Take effective action to remedy problems by including, creating or revising decision support tools, updating desk procedures, and redesigning orientation and training strategies.
3. Re-validate problematic data monthly until the program goals are met.

(D) Training and Decision Support

The CEO and the 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 Management/Care Coordination functions fully understand their roles and responsibilities prior to assuming their duties. Elements of the program shall include, but are not limited to, the following:

1. Reviewing expectations described in this procedure.
2. Training in care coordination for all institution staff. A system for the orientation, mentoring, and cross-training of all critical positions in the care coordination team shall be maintained.
3. Developing or adopting decision support tools (e.g., desk procedures) to prompt health care staff in different roles in Care Management/Care Coordination to fulfill their roles and responsibilities, including prompting clinic staff to communicate clearly to other members of the Care Team and reminding staff of new disease management procedures.
4. Providing ongoing training for staff involved in Care Management/Care Coordination regarding changes to the primary and chronic care programs and processes as they evolve as well as periodic refresher training on their particular roles and responsibilities.
5. Utilizing new information systems or technology that may increase the efficiency or effectiveness of Care Management/Care Coordination processes or forums.
6. Incorporating updates in clinical practice, including new CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.

References

- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.1, Complete Care Model
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.3, Care Teams and Patient Panels
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center https://www.pcmh.ahrq.gov/
- National Committee for Quality Assurance – Patient-Centered Medical Home Recognition http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- Robert Wood Johnson Foundation - Improving Chronic Illness Care http://www.improvingchroniccare.org/
- Institute of Medicine - Crossing the Quality Chasm – A New Health System for the 21st Century http://iom.nationalacademies.org/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Revision History

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