

3.1.9 Health Care Transfer

(a) Procedure Overview

- (1) The transfer of care between health care providers is a high-risk, complex, and multifaceted health care event. The goal of the California Department of Corrections and Rehabilitation (CDCR) is to perform each patient transfer in a manner that ensures the continuity of high-quality, safe care for each patient within CDCR. A transfer of care includes not only the processes and activities required to transport the patient, but also those activities, discussions, processes, and tasks required for admissions and discharges from differing locations, care settings, and levels of care within CDCR and external to CDCR. Transfers of care are accomplished by verbal communication between the sending and receiving care teams, with written documentation accompanying the patient as an adjunct to the conversation between health care providers.
- (2) Under the Complete Care Model, the health care transfer procedure is designed to ensure seamless continuity of patient care through the timely and complete communication of information between members of the patient's care team using a series of standardized systems and processes across the continuum of patient care activities. These procedures and processes mitigate risk, promote patient safety, maintain continuity of care, improve access, and enhance professionalism, teamwork, and the formation of new patient-provider care relationships.

(b) Responsibility

(1) Statewide

- (A) CDCR and California Correctional Health Care Services (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 that the Health Care Transfer Procedure is successfully implemented and maintained.
- (B) CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, are responsible for ensuring appropriate services are available for patients statewide, coordination of care, providing access to the appropriate level of care, development of decision support and technological tools, contact lists, and reducing the risks associated with handoff and transfer of patients between care teams, institutions, and levels of care.
- (C) The Headquarters Utilization Management Committee (HUMC) shall be responsible for ensuring processes are in place for continuity of care of high-risk medical patients and those with scheduled care needs as they transition from CDCR custody to the community (i.e., parole, probation, or discharge). CDCR/CCHCS Utilization Management (UM) collaborates with institutional staff, Division of Adult Parole Operations (DAPO), Post Release Community Supervision (PRCS), and community providers and agencies to ensure appropriate placement and services for patients who require ongoing care for chronic diseases after their release from CDCR facilities.
- (D) The statewide mental health program shall be responsible for ensuring processes are in place for continuity of care of mental health patients.
- (E) Health Care Placement Oversight Program (HCPOP), in coordination with the HUMC and/or the statewide mental health program, is responsible for the endorsement of patients between health care facilities if the institution cannot provide appropriate, medically necessary health care treatment to the patient. HCPOP facilitates the transfer of a subset of complex, high-risk patients between institutions in collaboration with clinical services.

(2) Regional

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

- (A) Regional leadership, 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 that this procedure is successfully implemented and maintained.
- (B) Regional leadership, in coordination with the Regional Quality Management Support Unit (QMSU), shall monitor and analyze the transfer process metrics outlined in Section (b)(3)(D)1-2 for their subset of institutions in order to identify trends, process lapses, and opportunities to mitigate risk to patient care.
- (C) Regional QMSU shall report trended data, analysis, and process improvement activities to the designated statewide committee, no less than quarterly. Identified patient safety issues shall be addressed through the

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Health Care Incident Reporting System within the timeframes specified in the Health Care Department Operations Manual (HCDOM), Section, 1.2.6 Statewide Patient Safety Program.

(D) The regional leadership team shall assist local leadership in the development of process improvement activities, best practices, and recommendations for improvement in the transfer process.

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and oversight of a system to provide management of the transfer of health care services within their institution. The CEO delegates decision-making authority to designated health care executives/leadership for daily operations of the health care transfer process, and ensures adequate resources are available to support the system.

(B) The CEO and members of the local leadership team are responsible for ensuring:

1. Resources are in place to support the successful implementation of this procedure at all levels including, but not limited to:
 - a. Institution level
 - b. Patient panel level
 - c. Patient level
2. Access to and utilization of equipment, supplies, health information systems, Patient Registries, Patient Summaries, and evidence-based guidelines.
3. There is monitoring to assess the transfer process, which includes, but is not limited to, feedback to successfully ensure that continuity of care is achieved such as utilization of available patient management tools, including Patient Registries and the Electronic Health Record System (EHRS).
4. An orientation and training program is established and maintained at a local level to ensure that staff serving as members of an interdisciplinary care team or supporting health care functions 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 transfer processes.
 - c. New information systems or technology that may increase the efficiency or effectiveness of transfer processes or forums.
 - d. Updates in clinical practice, including new CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
 - e. Training needs.

(C) The institution's transfer Local Operating Procedure (LOP) shall contain provisions for the implementation, structure, and operation of a quality assurance process.

(D) Each institution shall designate a subcommittee in writing that has responsibility for the administration of the health care transfer process. The designated subcommittee shall report to the Institution Quality Management Committee (IQMC).

1. This subcommittee shall, at a minimum, address the following operational elements throughout the transfer process:
 - a. Communication of health care information.
 - b. Timely access to the appropriate level of care.
 - c. Continuity of care.
 - d. Access to necessary medications, Durable Medical Equipment (DME) and medical supplies, as ordered by the provider.
 - e. Health Information Management (HIM), including EHRS.
 - f. Identification of potential or actual risks to the patient as a result of the transfer process as well as risk mitigation strategies necessary to prevent potential or identified risks.
 - g. Performance improvement.
2. In addition, this subcommittee shall:
 - a. Review transfers of care to ensure that continuity of care is achieved for each patient.
 - b. Take corrective action to resolve and/or elevate concerns identified in the reviews.
 - c. Be responsible for reviewing, taking action, documenting, and forwarding best practices and recommendations for improvement to the IQMC.

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(c) Procedure

(1) Patient Handoff Overview

- (A) Each transfer of care within CDCR shall be facilitated through a handoff process where information is provided by the designated sending care team member to the designated receiving care team member.
 - 1. Transfers of care can occur between points of care (locations) (i.e., facility to facility), providers of care (i.e., Primary Care Registered Nurse [PCRN] to Primary Care Provider [PCP]), or between levels of care (i.e., Clinic to Correctional Treatment Centers [CTC], or Mental Health Crisis Beds [MHCB] to Enhanced Outpatient Programs [EOP]).
 - 2. For transfers of care between points of care, the patient's Primary Care Team (PCT) shall ensure that all outstanding primary care has been provided, ordered, and communicated to the receiving care team. For example, the PCT shall ensure that the patient's preventive care screening, immunizations, and/or routine lab work are current. This is particularly significant for high-risk and complex care patients.
- (B) Patient care handoffs shall be tailored to the circumstances necessitating the transfer of care and the individual patient's care needs.
- (C) Handoffs shall occur prior to the time of transfer, allowing for sufficient time for the sending and receiving care teams to ensure that all necessary supplies, equipment, medications, and other items necessary to provide care to the patient are available.
- (D) Handoffs shall include a verbal discussion and written documentation necessary to ensure that the patient's care needs are communicated to the receiving provider.
- (E) Transfer between levels of care shall include verbal communication between the designated sending and receiving RN.
- (F) For transfers involving a change in institution, the Receiving and Release (R&R) Nurse shall:
 - 1. Screen the health record prior to transfer for indications of potential and/or scheduled health care appointments.
 - 2. Coordinate with the patient's PCP, mental health clinician and/or dental provider to ensure that continuity of care is maintained before, during, and after the transfer.
- (G) Reasons for a patient care handoff include, but are not limited to:
 - 1. A transfer from one area of the institution to another, resulting in a new care team (i.e., intrafacility transfers).
 - 2. A transfer from one medication point of service (e.g., pill window) to another requiring the transfer of medications to the new point of service.
 - 3. A permanent (i.e., interfacility transfers) or temporary (i.e., Medical/Psychiatric and Return) transfer to another CDCR institution.
 - 4. An urgent/emergent (i.e., through an Emergency Department [ED]) or planned (i.e., a medical appointment or planned treatment/admission) outside facility transfer.
 - 5. Transfers to or from a different level of care within CDCR including, but not limited to:
 - a. Mental health levels of care
 - 1) Correctional Clinical Case Management System (CCCMS)
 - 2) MHCB
 - 3) EOP
 - 4) Acute Care Facility (ACF), including transfers to or from the Department of State Hospitals (DSH)
 - 5) Intermediate Care Facility (ICF), including transfers to or from DSH
 - b. Medical levels of care
 - 1) Ambulatory Care
 - 2) Specialized Health Care Housing (e.g., Outpatient Housing Unit [OHU], CTC, Skilled Nursing Facility [SNF]).
 - 6. Transfers to or from CDCR Division of Adult Institutions control
 - a. Intake - Reception Center
 - b. Release from custody
 - c. Temporary transfer to community custody (e.g., out-to-court)

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(2) Transfer of Information During the Patient Handoff

(A) While each transfer of care may be unique, the transfer of information shall include, but is not limited to, as clinically indicated, the following:

1. Diagnosis
 - a. The patient's primary diagnosis including the reason for the transfer of care.
 - b. Other significant diagnoses that may impact patient care during the transfer process.
 - c. Diagnoses listed on the patient's current problem list.
 - d. Mental health Level of Care (LOC)
 - 1) Current suicide risk, self-harm risk, or precaution status
 - 2) Behavioral problems and effective interventions
2. Current Physical Status
 - a. Vital signs
 - b. Objective data
3. Pertinent past medical history
4. Recommendations for care, if applicable
5. Pre-release information, if applicable
6. Current medications
7. Current treatments
8. Allergies
9. Significant flags, if applicable. Examples of flags include, but are not limited to:
 - a. Physician Orders for Life-Sustaining Treatment (POLST)
 - b. Coccidioidomycosis restrictions
 - c. Clozapine restrictions
 - d. Suicide watch and precautions
 - e. Public health concerns
 - f. Infection control needs
 - g. Medication alerts
10. Limitations and accommodations
 - a. DME
 - b. Effective communication needs

(B) Designated health care staff shall prepare a transfer envelope for the patient depending on the location of the transfer (e.g., transfer to a location on the same yard may not require a transfer envelope). Contents may vary based on the patient's condition, the urgency of the transfer, and method of transportation. The transfer envelope shall include information necessary to ensure continuity of care which may include, but is not limited to, the following, as applicable:

1. Transfer-Bus Content
2. Patient Summary Sheet
3. CDCR 7465, Physician Orders for Life-Sustaining Treatment (POLST)/CDCR 7421, Advance Directive for Health Care
4. First Responder Data Collection Tool
5. Emergency Care Flow Sheet
6. Emergent Transfer Report
7. Inpatient Discharge Summary
8. Medications (e.g., Nurse Administered [NA]/ Direct Observation Therapy [DOT]/Keep-On-Person [KOP])
9. DME and Medical Supplies

(3) Patient Transfer Process

(A) Interfacility Transfer (Institution to Institution) – Sending Institution

1. Custody staff shall notify health care staff via a bus list of a patient's imminent transfer at least seven calendar days prior to the date of transfer.
2. The R&R Nurse shall:
 - a. Screen the health record for contraindications to transfer (e.g., inpatient, medical holds, potential medical holds, dental holds, specialty appointments).

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- b. Communicate with the patient's care team to resolve issues and concerns. The PCP shall update the Medical Classification Chrono and initiate a medical hold if necessary, pursuant to the HCDOM Section, 1.2.14, Medical Classification System.
 - c. Communicate with the pharmacy to identify transfer medications and establish the supply that shall be sent with the patient (e.g., high cost, nonformulary).
 - d. Notify the Classification and Parole Representative (C&PR) or designated custody representative if there is a contraindication to the patient's transfer.
 - e. Complete the Interfacility Transfer Screening.
3. The provider shall communicate verbally or electronically with the receiving institution's PCP or R&R Nurse regarding patients with special clinical requirements including, but not limited to, medications, treatments, or significant medical issues that may affect housing placement at the receiving institution.
 4. Designated health care staff shall prepare the transfer envelope for the patient as stated in Section (c)(2)(B).
 5. Within 24 hours prior to the transfer, the R&R Nurse shall conduct a face-to-face interview and assess the patient for contraindications to transfer.
 6. The evening prior to transfer, the medication nurse shall medicate the patient per provider orders and deliver patient-specific NA/DOT medications to R&R for transfer with the patient.
 7. On the day of transfer the R&R Nurse shall:
 - a. Provide required medications.
 - b. Verify receipt of the patient's NA/DOT and KOP medication.
 - c. Verify the patient's possession of DME.
 - d. Ensure items are placed in the white transfer envelope with the transfer documents.
 - e. Provide rescue medications to the patient for holding during the transportation process.
 8. The R&R Nurse shall complete the Pre-Boarding and ensure required handoff documentation is contained in the transfer envelope.
 9. The R&R Nurse shall verbally communicate with the receiving institution all information necessary to ensure the smooth transfer of care between institutions.
- (B) Interfacility Transfer (Institution to Institution) – Receiving Institution
1. The R&R Nurse shall complete the Initial Health Screening.
 - a. If the Initial Health Screening is completed by anyone other than an RN, and the patient answers "yes" to any questions, health care staff shall contact an RN for assessment and disposition of the patient. Health care staff, other than an RN, shall document the referral to the RN on the Initial Health Screening in the health record.
 - b. The RN shall document their assessment and disposition of the patient in the health record.
 2. Patients shall be screened for Tuberculosis (TB) and Coccidioidomycosis according to current public health guidelines.
 3. Pending specialty orders and other information shall be communicated to the UM RN, Specialty RN, and PCP via the Cerner Specialty message pool and the designated care team's message pool.
 4. The receiving institution shall ensure the patient is scheduled for an initial new arrival assessment encounter as clinically indicated, as follows:
 - a. High Risk/Complex Care: PCP encounter within seven calendar days.
 - b. Medium/Low risk patients with one or more chronic conditions with prescribed medications: PCP or PCRN encounter within 30 calendar days or as ordered by the provider.
 - c. Medium/Low risk patients without known chronic conditions with prescribed medications shall be seen by a care team member as needed, or based on applicable care guides.
 - d. Mental health LOC patients: Initiation of a Mental Health PowerPlan previously ordered in a planned state. If a Mental Health PowerPlan has not been ordered in a planned state, the patient shall be referred to mental health via the Mental Health Primary Clinician (MHPC) or Psychiatrist Routine Consultation (MHMD).
 5. The PCP, or designee, shall complete order reconciliation by the close of the next business day.
- (C) Non-CDCR Institution Transfers (Out-to-Court, Release from Custody)
1. Prior to the patient's transfer, the R&R Nurse shall complete the steps in Section (c)(3)(A)5-7.
 2. Release from custody

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- a. Custody staff shall notify health care staff of pending transfers via the Parole/Transportation List.
 - 1) Patients in a community health care facility – Custody staff shall notify Headquarters UM who shall assist with obtaining an appropriate community placement and the transfer of health records, as needed to ensure continuity of care.
 - 2) Patients housed in a CDCR facility with ongoing health care needs (i.e., pending surgery, on TB treatments) – Custody staff shall notify institutional UM staff who shall:
 - a) Coordinate with HIM to obtain the required medical Release of Information.
 - b) Coordinate with community health care providers, DAPO, and PRCS to ensure continuity of care.
 - c) Coordinate with the PCT to ensure that the patient is provided educational materials and a 30-day supply of medications and health care supplies. Medication orders shall be compliant with current pharmacy policy and regulatory limitations.
 - 3) Patients housed in a CDCR facility who have ongoing acute mental health needs (e.g., housed in a MHCB or higher LOC facility, on Clozapine) – the patient’s mental health clinician shall coordinate with the appropriate CDCR, DAPO, and PRCS staff to ensure continuity of care upon release from CDCR custody (refer to the Statewide Mental Health Program Pre-Release Program Policy and Procedure).
3. Out-to-Court
 - a. C&PR staff shall notify health care staff in advance of scheduled court dates as outlined in the institution’s transfer LOP.
 - b. The R&R Nurse shall screen the health record for contraindications to transfer (e.g., medical holds, potential medical holds, dental holds, specialty appointments) and contact the PCT to resolve. If issues are identified, the following shall be completed, as applicable:
 - 1) The provider or care team shall contact the institution’s C&PR for assistance in contacting the gaining jurisdiction’s PCP.
 - 2) If the PCT determines a patient is too ill, unstable, or unable to participate in the court proceedings effectively, institutional clinical leadership (e.g., Chief Medical Executive, Chief Nurse Executive, CEO, Warden) shall contact the CCHCS Office of Legal Affairs to coordinate and determine options for the patient.
 - 3) For mental health patients at the MHCB, ICF, or Acute Psychiatric Program, procedures established by the statewide mental health program shall be followed.
 - 4) The provider or care team shall coordinate with the Pharmacist-in-Charge and the out-to-court provider for transfer of unusual medications, (i.e., Factor IX[®], Harvoni[®], transplant medications) to ensure continuity of care.
 - c. Out-to-Court Returns – seven or more calendar days
 - 1) The R&R Nurse shall:
 - a) Process patients who are out-to-court for seven or more calendar days as an interfacility transfer upon return.
 - b) Complete an Initial Health Screening and registration.
 - c) Ensure High-Risk/Complex Care patients have a PCP encounter within seven calendar days.
 - d) Ensure Medium/Low Risk patients have a PCP or PCRN encounter within 30 calendar days or as ordered by the provider.
 - e) Initiate a Mental Health PowerPlan previously ordered in a planned state for mental health LOC patients. If a Mental Health PowerPlan has not been ordered in a planned state, the patient shall be referred to mental health via the MHPC or MHMD.
 - 2) The PCP, or designee, shall complete order reconciliation by the close of the next business day.
 - d. Out-to-Court Returns – less than seven calendar days
The R&R Nurse shall:
 - 1) Complete an Initial Health Screening.
 - 2) Notify the PCT to ensure that order reconciliation is completed by the close of the next business day.

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(D) Layovers

The R&R Nurse shall:

1. Complete a face-to-face observation of patients who were added to the bus list less than seven days prior, which shall include vital signs, before the patient leaves the layover institution.
2. Document the patient's status and vital signs in the health record.
3. Register the patient and complete an Initial Health Screening.
4. Notify the PCT/MHPC to ensure that order reconciliation is completed by the close of the next business day.

(E) Intrafacility Transfer (Yard-to-Yard)

1. Custody staff shall notify the sending facility's nursing staff (medication point of service) via the Pending Bed Assignments Report or other approved notice.
2. The sending facility care team shall review the Patient Summary Sheet and Medication Administration Record (MAR).
3. The sending medication nurse shall:
 - a. Review the patient's MAR for NA/DOT medications.
 - b. Note the number of KOP medications the patient shall have in their possession and communicate that number to the escorting custody staff.
 - c. Place the Patient Summary Sheet and NA/DOT medications in a labeled, sealed envelope and provide it to the escorting custody staff.
4. The sending care team shall verbally communicate the following alerts or other significant health care information to the receiving care team and other necessary care providers (e.g., Triage and Treatment Area [TTA] RN, Specialty Clinic, Mental Health provider):
 - a. Unusual medications (e.g., Factor IX[®], Harvoni[®], transplant medications), unusual treatments, and missing medications, as some medications may be located and/or administered in locations other than the patient's usual medication administration location.
 - b. Pending appointments.
5. Custody staff shall ensure that the following occurs after the record review by the care team:
 - a. The patient has all of their KOP medications in possession by verifying against the count provided by the care team.
 - b. The patient is in possession of required DME and medical supplies.
 - c. The care team has provided a sealed envelope containing the Patient's Summary Sheet and NA/DOT medication, if applicable.
6. Custody staff shall notify the Supervising RN II and Custody Sergeant if there are difficulties complying with the steps above.
7. Upon the patient's arrival, the receiving care team shall complete the following:
 - a. Review the Patient Summary Sheet.
 - b. Verify pending appointments are transferred to the new care team schedule.
 - c. Reconcile all medications with the patient's MAR and obtain missing medications to prevent interruption in administration.
 - d. Verify that the patient is in possession of all required DME and medical supplies, and obtain missing items to ensure care is continued without interruption.

(F) Level of Care Changes – To or From Higher Levels of Care, Non-Mental Health

1. A handoff shall be completed for each level of care change.
2. The PCP/TTA RN/R&R Nurse shall:
 - a. Screen the health record.
 - b. Notify custody staff that the patient is being transferred and provide the required method of transfer based on the patient's clinical condition (e.g., State car, Americans with Disabilities Act van, bus, ambulance).
 - c. Communicate pertinent health care data to the receiving health care facility.
3. Designated health care staff shall:
 - a. Prepare a transfer envelope for the patient as stated in Section (c)(2)(B).

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- b. Provide rescue medications to the patient for use during the transfer as clinically indicated (i.e., KOP or with an escort).
 4. Patients transferring to or from a higher LOC including, but not limited to, CTC, SNF, PIP, MHCB, community hospital or other community-based licensed inpatient facility, or OHU shall go through the TTA.
 5. The TTA Nurse shall contact the PCP, or designee, to obtain orders for medication, therapies, and diagnostics, as indicated, to ensure continuity of care.
 6. Patients discharged to an outpatient setting from a community hospital, ED, or any non-mental health CDCR health care bed shall be seen by their PCP within five calendar days of discharge.
- (G) Level of Care Changes – To or From Higher Levels of Care, Mental Health
1. A handoff shall be completed for each level of care change.
 2. The PCP/TTA RN/R&R Nurse shall screen the health record; a History & Physical is not required prior to any transfer for mental health care and treatment.
 3. Patients on a medical hold shall remain at the institution due to medical necessity until the PCT can assess and collaborate with mental health to determine the patients' most appropriate location and transfer. Patients not on a medical hold shall be considered medically cleared for transfer.
 4. Upon return to the patient's prior LOC (e.g., return to EOP from a MHCB), the mental health clinician shall coordinate daily follow-ups with licensed nursing and custody staff.
 - a. Mental health patients shall be seen by their clinician as specified in the Mental Health Services Delivery System Program Guide.
 - b. Discharging mental health clinicians may order additional follow up care as part of the discharge planning process. This is particularly significant after extended stays at higher LOC (e.g., ACF, ICF, PIP).
 5. Patients transferring to or from a higher LOC including, but not limited to, CTC, SNF, PIP, MHCB, community hospital or other community-based licensed inpatient facility, or OHU shall go through the TTA.
 6. The TTA Nurse shall contact the PCP, or designee, to obtain orders for medication, therapies, and diagnostics, as indicated, to ensure continuity of care.
 7. Patients discharged to an EOP LOC from a MHCB or PIP bed shall be seen by the mental health RN Care Manager within 3 calendar days of discharge and by a psychiatrist within 14 calendar days of discharge.
 8. Patients discharged from a MHCB or PIP bed to a CCCMS LOC, and on psychiatric medications at present or in the last 6 months shall be seen by a psychiatrist within 14 calendar days of discharge.
 9. If the MHCB or hospital psychiatrist asks that a patient be seen sooner than 14 calendar days after discharge, the psychiatrist's order for when the patient should be seen shall be followed.

References

- California Code of Regulations, Title 22, Division 7, Chapter 12, Article 3, Section 97520.13, Patient Transfer
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.14, Medical Classification System
- Health Care Department Operations Manual, Chapter 2, Article 2, Section 2.2.1, General Use and Disclosure of Protected Health Information
- Health Care Department Operations Manual, Chapter 3, Article 1, Complete Care Model
- Health Care Department Operations Manual, Chapter 3, Article 2, Section 3.2.6, Medication Continuity with Patient Movement: Transfer/Parole/Release
- Health Care Department Operations Manual, Chapter 3, Article 3, Dental Care
- Health Care Department Operations Manual, Chapter 3, Article 5, Section 3.5.28, Transfer Medications
- Health Care Department Operations Manual, Chapter 3, Article 6, Section 3.6.1, Durable Medical Equipment and Medical Supply
- Health Care Department Operations Manual, Chapter 3, Article 7, Section 3.7.1, Emergency Medical Response System
- Health Care Department Operations Manual, Chapter 3, Article 8, Section 3.8.6, Tuberculosis Program

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- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 6, Article 12, Section 62080.15.2
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision
- California Department of Corrections and Rehabilitation, Electronic Health Record System (EHRS) Approved Workflows

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