

CALIFORNIA PRISON HEALTH CARE SERVICES



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Primary Care Model Policy and Procedure	Next Revision:

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POLICY:

California Prison Health Care Services promotes a team approach to primary care. Under this model, the Primary Care Team:

- Serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services.
- Provides patients with ready access to their provider or to an established back-up provider when the primary provider is not available.
- Provides health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses.
- Is organized to meet the health care needs of patients with undifferentiated problems, with the vast majority of patient health care concerns and needs being managed by the Primary Care Team.
- Includes providers and non-physician health professionals.

PURPOSE:

The purpose of the primary care model is to establish a consistent relationship between a patient panel and a Primary Care Team that results in:

- Fewer lapses in care.
- Improved patient adherence to treatment plans and interventions.
- Improved health outcomes.
- Cost-effective, efficient care.
- Clear assignment of responsibility among Primary Care Team members.
- Scheduling of patients which promotes continuity of care while addressing patients' primary care needs.

DEFINITIONS:

Patient Panel: A clearly defined group of patients that are assigned to a particular Primary Care Team. Every Primary Care Team has one panel of patients. Every inmate is assigned to a Primary Care Provider within the Primary Care Team.

Primary Care Team: An assigned inter-disciplinary team that is responsible for the health care of a panel of patients.

Primary Care Huddle: A meeting of the primary care team members to plan and coordinate the patient care activities of the team in order to reduce or prevent lapses of patient care.

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RESPONSIBILITIES:

The Health Care Manager at each institution is responsible for implementation of this policy.

A. ASSIGNMENT OF PATIENT PANELS

Each inmate will be assigned to a specific:

- Patient Panel
- Primary Care Team
- Primary Care Provider

1. Defining Patient Panels

Institution health care staff should adopt the method most likely to promote an ongoing relationship between a patient and his or her Primary Care Team to achieve operational efficiency, to ensure timely access to care, to optimize movement and escort capabilities, to balance workload, and to appropriately address patient acuity and complexity.

Panels may be defined in a variety ways, as dictated by needs of each institution, including assignment by:

- Alphabetical roster
- Last two digits of CDCR number
- Yard
- Housing unit
- Level of care / program participation
 - Security Housing Unit
 - Administrative Segregation Unit
 - Outpatient Housing Unit
 - Correctional Treatment Center
 - Behavioral Management Unit
 - Enhanced Outpatient Program
 - Psychiatric Services Unit
 - Reception Center
- Security / Custody Level
- Compatibility Group

2. Consistency in Panel Affiliation / Continuity

Consistency in a patient panel is helpful in preserving continuity of care. Institutions should consider steps that can be taken to minimize unnecessary changes in panel affiliation.

Each institution will adopt Local Operating Procedures to ensure that patient transfers from one panel to another are clearly, promptly, and effectively communicated to the new Primary Care Team and the previous Primary Care Team.

3. Roles and Responsibilities

The Health Care Manager is responsible for ensuring that all patients are assigned to a patient panel.

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Each institution shall adopt a Local Operating Procedure to ensure that all patients are notified of their panel assignment. Patients will be notified of both their Primary Care Team and Primary Care Provider designations. Among other methods, notification may occur through posters displayed in housing units or patient education materials distributed at the Reception Center or Receiving and Release.

4. Reporting

The Local Operating Procedure shall also establish a patient panel, and describe requirements for updating and maintaining the panel. The panel will be readily available for review, and should be updated as indicated.

B. PRIMARY CARE TEAMS

Each patient will be assigned to a Primary Care Team.

1. Team Purposes

- To ensure comprehensive, continuous, coordinated care.
- To provide an interdisciplinary approach to patient care that produces synergies, with defined essential roles and responsibilities.

2. Team Composition

At a minimum, Primary Care Teams will consist of the following members:

- Primary Care Provider
- Primary Care Nurse
- Clerical support

3. Continuity in Team Membership

To reduce disruptions in care, institutions should avoid unnecessary changes in the membership of the Primary Care Team. Each institution shall develop Local Operating Procedures that convey expectations regarding continuity of the team. Local Operating procedures will also address:

- Team coverage in the event of scheduled absences, such as vacations, leaves of absence, and sick leave (when advanced notice is available)
- Team coverage in the event of unscheduled absences, such as Administrative Time Off and sick leave (when advanced notice is unavailable)

Individual changes in Primary Care Team membership do not require formal notice to the patient panel. Patients will be provided with a list of their assigned Primary Care Team members upon request.

4. Primary Care Roster

Each institution will maintain a roster of all Primary Care Teams and their membership.

5. Roles and Responsibilities of Team Members

All team members are required to:

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- Establish and maintain professional, effective, and therapeutic relationships with all patients.
- Establish and maintain professional and effective relationships with all Primary Care Team members.
- Be accountable for their individual practices and the continuity of care delivered.
- Give priority to the patient's health care needs; however, not all patients' requests are health care needs or priorities.
- Participate constructively in the Quality Improvement process.
- Participate in team activities, including routine Primary Care Team meetings (huddles), emergency response reviews, and other meetings and consultations.

Each institution will establish Local Operating Procedures that assign to a coordinator accountability for:

- Ensuring that Primary Care Teams fulfill the functions described in this policy, and
- Documenting of Primary Care Team activities.

Each Primary Care Team will have a member of the team as the assigned coordinator.

6. Roles and Responsibilities of the Primary Care Provider

Each Primary Care Provider is responsible for diagnosing and treating the majority of patient health care needs.

The provider must:

- Provide quality care
- Use resources efficiently
- Effectively communicate with the patient, team, and others
- Provide patient education
- Promote patient satisfaction within the context of evidence-based care

7. Role and Responsibilities of the Primary Care Nurse

The Primary Care Nurse is responsible for using the Nursing Process for the benefit of the panel's patients. The Nursing Process includes assessment, planning, intervention, and evaluation.

The Primary Care Nurse must:

- Demonstrate knowledge of the system of care
- Organize nursing and Primary Care Team activities to meet the health care needs of the patients.
- Effectively communicate with the patient, team, and others
- Act as a patient advocate
- Provide patient education

8. Role and Responsibilities of Clerical Support

The clerical member of the Primary Care Team ensures that all patients are appropriately scheduled, that access to care barriers are made known to the full Primary Care Team, and that

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Primary Care Team members have the information they need for planned patient encounters. Areas of responsibility include:

- Scheduling of appointments
- Chronic Disease Registry interface (data entry, production of registry reports)
- Unit Health Record
 - Record requests and / or delivery to the clinic
 - Diagnostic study reconciliation
 - Consultation referral reconciliation
 - Current medication list
 - Returns to the Medical Records Department
 - Filing

C. PRIMARY CARE HUDDLE

To reduce or prevent lapses in patient care and to plan and coordinate patient care activities, the Primary Care Team will meet on all scheduled patient care days.

1. Composition

Preferably, all members of the Primary Care Team will attend the Primary Care Huddle. At a minimum, the Primary Care Provider, Primary Care Nurse, and scheduler must be present. The Primary Care Huddle may occur without a Primary Care Provider if the Primary Care Provider is not scheduled to see patients.

2. Frequency

The Primary Care Team will meet or “huddle” to plan and coordinate the patient care activities at least once every patient care day.

3. Topics

Topics covered during the Primary Care Huddle include but are not limited to:

- Unscheduled Triage and Treatment Area visits
- Emergency Department transfers
- Transfers to other levels of care
- Returns from higher level of care
- Medication/Pill Line issues
- Add-on appointments
- Sick Call triage
- Case management issues
- Review of ducat list to plan and triage patient visits and ensure that everything needed for appointments is available – including the Unit Health Record, Registry reconciliations, Diagnostic study reconciliation, consultation referral reconciliation, and a current medication list and available problem list.
- Backlog considerations
- Staffing issues
- Supply/resource issues
- Pending consultations and specialty services requests

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- Potential barriers to care, including lockdowns, restricted movement, fog lines, and other considerations
- Review of communications logs.

Each institution will establish a Local Operating Procedure that will define the roles and responsibilities for the Daily Huddle including:

- Ensuring that the daily huddle is occurring;
- Ensuring that the daily huddle is functioning appropriately and efficiently;
- Fixing responsibility for documentation; and
- Designating a huddle coordinator.

D. TRACKING KEY PATIENT EVENTS

To reduce preventable lapses in care that are caused by gaps in information flow, the Primary Care Team will track and communicate key patient events on an ongoing basis, including:

- Transfers to a higher level of care – Transfers to or from the Outpatient Housing Unit, Correctional Treatment Center, General Acute Care Hospital, Skilled Nursing Facility, or Hospice.
- Triage and Treatment Area visits - Unplanned medical care provided at the Triage and Treatment Area.
- Outside emergency services visits - Medical care provided at an Emergency Department outside the institution.
- Significant diagnostics - Routine and urgent laboratory tests and imaging ordered by the primary care team's providers or by Triage and Treatment Area providers.
- Transfers between housing units within an institution - Patients that are moved in a way that changes their panel/primary care team affiliation.
- Specialty medical consultations
- Transfers between institutions - Patients that are moved from one institution to another.
- Return from out-of-state care or out to court status - Patients that return from outside the system, such as out to court or out of state.

1. Reporting

Each month, the Institutional Quality Management Committee shall consider:

Higher Level of Care

Number of patients who returned from the hospital during the reporting period

Number of patients who had a medication discontinuity (lapse in medication administration, change in medication not implemented) after return from hospital

Triage and Treatment Area Visits

Number of Triage and Treatment Area visits during the reporting period

Number of repeat Triage and Treatment Area visits within two weeks

The number of Triage and Treatment Area visits pertaining to missing medications

The number of hospitalizations within two weeks after a Triage and Treatment Area visit

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Outside Emergency Services Visits

Number of hospital returns during the reporting period

Number of patients who had a medication discontinuity (lapse in medication administration, change in medication not implemented) after return

Number of outside Emergency Services visits during a period

Number of repeat Emergency Services visits within two weeks

Number of hospitalizations within two weeks after a Emergency Department visit

Significant Diagnostics

Number of patients sent to the Triage and Treatment Area for critical lab values

Number of critical lab values during the reporting period

Number of critical lab values that were not addressed within four hours of report

Percentage of diagnostic results that were not reported to the patient within policy timelines

Oldest, undrawn routine lab test

Oldest, incomplete imaging test

Transfers between Housing within an Institution

Number of patients who left the panel and went to another panel within the institution during the reporting period

Number of patients added to the panel from within the institution

How many medications did not arrive with the patient

Transfers between Institutions

Number of patients who left the panel and went to another panel from another institution during the reporting period

Number of patients added to the panel from another institution

How many medications did not arrive with the patient

Number of patients who did not arrive with an Unit Health Record

Each institution will establish a Local Operating Procedure that addresses the specific tracking, follow-up, and reporting methods for these key patient events. Sources of information include:

- Utilization Management bed management report
- Daily movement sheet
- Triage and Treatment Area log
- Laboratory Accession log
- Receiving and Release log
- Clinic Communications log
- On-call sign outs
- Specialty Care schedule
- Clinical orders

The institutional Local Operating Procedure must include:

- Who is responsible for tracking each area
- How often the tracking is reviewed
- Who is responsible for providing continuity in response to the events

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- Who is responsible for the communication of the key event
- How each key patient event is tracked
- How the information reaches the Primary Care Team
- Triggers for further action
- Methods for reconciling orders and actions

The institution will ensure the Local Operating Procedure is approved through the Local Governing Body and the Regional Leadership Team (Regional Administrator, Regional Medical Executive, and Regional Nurse Executive).

E. PERFORMANCE ASSESSMENT AND IMPROVEMENT

The Primary Care Team will periodically assess its performance and takes actions to improve its performance based on the assessment.

1. Monthly Performance Improvement Meetings

The Primary Care Team will meet formally at least monthly to consider the results of its reporting and tracking, lessons learned from its operations, and input/judgments of the team members. During these meetings, the team will identify the most important areas for improvement, and plan and implement changes in order to improve care.

2. Methodology: Rapid Cycle Change.

The Primary Care Teams should use rapid cycle change methods in its performance improvement activity. (Refer to Inmate Medical Services Program Policy and Procedure Quality Improvement, Volume 3).

3. Required Areas of Assessment

At a minimum, Primary Care Teams will evaluate their performance in accordance with the following program goals:

- Duplicated patients are seen or accounted for and managed each day.
- All critical medications are refilled on time.
- All significant diagnostic results are managed appropriately.

4. Reporting

The Primary Care Team must complete documentation and report to the Chief Medical Officer or designee for reporting to the Institution Quality Management Committee at least monthly.

Reviewed and Approved By:

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Name

Date