CALIFORNIA PRISON
HEALTH CARE SERVICES

DRAFT

SERVICE DELIVERY MODEL

FOR THE NEW HEALTH CARE FACILITIES

APRIL 22, 2009

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Acknowledgements

The Service Delivery Model described within is recommended for the new health care facilities being built to meet the needs of California's inmate-patients. We wish to acknowledge the work of the Integrated Care Team in fleshing out the concepts within, and to thank them for their participation and contributions.

Integrated Care Team

Name	Functional Area
Rassen, Amy (Chair)	California Prison Receivership/Medical
Streater, Suzanne (Assistant Chair)	California Department of Corrections and Rehabilitation/Mental Health
Anderson, Jason	California Prison Receivership /Rehabilitation Programs
Anderson, Kimberly	California Department of Corrections and Rehabilitation /Mental Health
Baker, Karen	California Prison Receivership /Rehabilitation Programs
Barks, Michael	California Prison Receivership /Dental
Bender, Sherrie	California Prison Receivership /Rehabilitation Programs
Brewer, Vic	Department of Mental Health
Byrd, Helen	Department of Mental Health
Carlisle, Paul	California Prison Receivership /Physical Medicine and Rehabilitation
DeVore, Dawn	California Department of Corrections and Rehabilitation /Mental Health
Freeman, Tray	California Prison Receivership /Project Manager
Henry, Haunani	Coleman Representative
Hughes, Kerry	Coleman Representative
Hutchinson, Fountain	California Department of Corrections and Rehabilitation /Mental Health

Ives, Rollin	Department of Mental Health
Khoury, Nadim	California Prison Receivership /Medical
Knox, Catherine	California Prison Receivership /Nursing
La Mar, Sharon	California Prison Receivership /Custody
Lett, James	California Prison Receivership /Medical
Metzner, Jeffrey	Coleman Representative
Noble, Bonnie	California Prison Receivership /Medical Ancillary Services
O'Shaughnessy, John	California Department of Corrections and Rehabilitation /Mental Health
Page, Kathleen	California Prison Receivership/Nursing
Ricker, Cynthia	California Prison Receivership /Nursing
Schultz, Char	Department of Mental Health
Smith, Roger	California Prison Receivership /Mental Health
Still, Wendy	California Prison Receivership /Correctional Rehabilitation Programs
Swanson, Andrew	California Department of Corrections and Rehabilitation /Mental Health
Wright, Michael	California Prison Receivership /Process Manager

Dwight Winslow, MD

Acting CEO of California Prison Health Care Medical Services

Steve Cambra

Director of California Prison Health Care Services

Glossary of Abbreviations

ADL	Activities of Daily Living
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
AT	Administrative Team
Axis I Diagnosis	Major Mental Health Disorders
Axis II Diagnosis	Personality Disorders
CNA	Certified Nursing Assistant
CCCMS	Correctional Clinical Case Management System
CCR	California Code of Regulations
CDCR	California Department of Corrections and Rehabilitation
CPHCR	California Prison Health Care Receivership
CPHCS	California Prison Health Care Services
CTC	Correctional Treatment Center
DMH	Department of Mental Health
DOT	Directly Observed Therapy
EOP	Enhanced Outpatient Program
EMAR	Electronic Medical Record
IADL	Individual Activities of Daily Living
IC	Integrated Care
ICF	Inpatient Care Facility
IDTT	Interdisciplinary Treatment Team
ITRP	Individual Treatment and Rehabilitation Plan
LPT	Licensed Psychiatric Technician
LVN	Licensed Vocational Nurse
MD	Medical Doctor
MHCB	Mental Health Crisis Bed
PADL	Prison Activities of Daily Living
PBS	Positive Behavioral Support
PM&R	Physical Medicine and Rehabilitation
PDSA	Plan-Do-Study-Act
PSU	Psychiatric Services Unit
PWT	Primary Work Teams
QI	Quality Improvement
RN	Registered Nurse
RT	Recreation Therapist
SGP	Specialized General Population
TAO	Transition, Activation and Operations
TR	Therapeutic Recreation

Introduction

The prison population is aging in place. As noted in the 2006 Lumetra Report "*Aging Inmates: Challenges for Healthcare and Custody*," the numbers of California prison inmates age 55 and over more than doubled in the eight-year period from 1997 to 2005. The Department of Corrections and Rehabilitation (CDCR) reports that there has been an overall population increase of 335% from 1983 to 2008. However, the increase in the aged population for the same time period ranges from 1,643% to 1,750%. Even with a slight decrease in population in all age categories between 2006 to 2008, the age of the men and women in California's prisons continues to increase dramatically.[1]

Much has been written over the past few years that analyzes the aging of the prison population,[2] the effects of overcrowding on health care delivery,[3] the inadequacies of the health care system of delivery,[4] the changes recommended to the management of the health care system,[5] and the need for compliance with legislative regulations for rehabilitation services.[6]

In response, the Receiver has approved remediation plans to revamp health care[7] delivery in the existing 33 adult prisons and to create innovative systems that will also work in the soon to be built new health care facilities. Plans are underway to bring the health care's information technology system into the 21st century[8] and to ensure efficient contracting, procurement and supply chain strategies. Note: Within this document, health care refers to medical, dental, mental health, substance abuse and disability related services and programs.

> ***Charlie*** *is a 58-year-old male in a world where the body ages 10-15 years faster than the calendar age. He has eight diagnoses including depression, diabetes, hepatitis C, high blood pressure, oxygen-dependent chronic lung disease, heart disease, elevated blood fats and advanced arthritis with limited movement. He has multiple chronic conditions and limited physical movement.*
>
> *Charlie has been transferred from Mule Creek Prison and placed in High Acuity (HA) housing. HA patients require skilled nursing care 24 hours a day and represent the highest acuity level of health care services provided in the new facility.*
>
> *Charlie takes ten different medications twice a day. All are given by the nurse because of Charlie's poor eyesight and the high "street value" of his narcotic pain medication.*

Programs at the new facilities will be culturally competent and gender responsive, and will be inclusive of initiatives in progress at the 33 adult prisons. Patients will have appropriate access to their providers and active engagement in their treatment plans. Telemedicine will be used as widely as possible to increase patient access to specialists while also reducing the cost of care.

The new correctional health care facilities are designed specifically to address the health needs of inmates who cannot be cared for in the state prisons. These individuals are:

- Medically fragile/disabled and require more than three months of continuous medical supervision
- Mentally ill and require treatment for acute and chronic episodes of illness
- Unable to live in the general prison population due to serious medical or mental health conditions

This report describes a service delivery model to be used in the new health care facilities that will deliver medical, mental health, dental, rehabilitation and related treatment services to the men and women patient-inmates in California's prison system. The model is based on the concepts previously described in papers submitted to the Receiver on January 15, 2009 (*Patient-centered Care, Team-based Care, and Foundations of Patient Care)*, and also on 23 papers written by members of the Integrated Care (IC) Team.[9]

Patients in these facilities will include men and women. However, to make the text more readable, patients are referred to throughout the document as "he," which is intended to be inclusive of the female patient population as well.

While the Department of Mental Health (DMH) participated with input as part of the IC Team, this is the Receiver's document and DMH is not a signatory.

It should be noted that the service delivery model described within is new to the California Department of Corrections and Rehabilitation, and incorporates best practices in a manner that may not have been fully implemented anywhere before. This paper begins to describe how the model will work, but refinement will need to occur before and during implementation. In some cases, the descriptions herein, particularly the "A Day in the Life of" vignettes describing various patients' possible treatment scenarios, present a vision of what is possible in these new facilities that may not be totally practical. The purpose is to portray what may be possible, rather than limiting our thinking to the current and historical practices in the existing system.

The Report is divided into 14 sections:

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PART I: BACKGROUND

1.1 Mission

The mission of the California Prison Health Care Receivership (CPHCR) is to reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, cost effective and efficient medical care, and integrate the delivery of medical care with mental health, dental, disability and rehabilitation programs.

1.2 Vision

The vision of the CPHCR is: As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.

1.3 New Facilities Project

Goal 6 of the Receivership's Turnaround Plan of Action (June 6, 2008) is to "Provide Necessary Clinical, Administrative and Housing Facilities" for California's inmate-patients. The new facilities project is a key strategy to meet Objective 6.2: Expand administrative, clinical and housing facilities to serve up to 10,000 patient-inmates with medical and/or mental health needs.

The Receiver's Turnaround Plan of Action commits to bringing the level of prison health care services up to constitutional standards as quickly as practicable. A core component of the plan is the creation of expanded prison health facilities and housing for approximately 6 percent of the CDCR existing inmate population (i.e., approximately 10,000 inmates) whose medical and/or mental condition requires separate housing to facilitate appropriate, cost-effective access to necessary health care services.

The new facilities project is therefore designing new facilities to provide medical, mental health, dental, rehabilitation and other health care services for California's inmate population. This project is led by the CPHCR, in collaboration with the CDCR and the Department of Mental Health (DMH).

The new facilities are intended to be sustainable over time and are to provide efficient and appropriate health care based on three fundamental principles:

- Patient-centered care that emphasizes a recovery and wellness based treatment approach
- Integrated care (medical, mental health, dental, rehabilitation and other health care services) using an Interdisciplinary Treatment Team (IDTT) model
- A direct supervision custody approach which views these as secure health care facilities

1.4 Integrated Care Team Planning Process

A Transition, Activation and Operations (TAO) work group for the new facilities was created in September 2008. The group's goal was to define the organizational and governance structure as part of a strategic plan that would schedule, budget and activate new health care facilities for California's prison population.

A matrix defined program and support areas and the relationships between program, such as medical/nursing, and support, such as human resources.

Champions -- team leaders -- of the fourteen areas identified on the matrix were named. Teams were formed. Champions and team members included representatives from the CPHCR, CDCR, and DMH. Champions were asked to itemize needed resources to ensure that at the end of the ninety-day transition phase, activation plans could be developed.

During this period of time, work groups began to develop a 24-month pre-activation schedule, gathered information from experts on such matters as direct supervision, and visited facilities whose designs were thought innovative.

In addition, champions from medical, nursing, ancillary services, mental health, custody and rehabilitation formed a special working group to develop a consensual understanding of the fundamental principles of integrated, patient-centered care.

At the end of October 2008, a new process for task completion was implemented. The TAO regrouped and the 14 TAO teams were consolidated into two teams. An IC Team, whose charge was to develop a program and organization design, was established and comprised of the following core areas:

- Medical/Long-term Care
- Nursing
- Mental Health
- Dental
- Rehabilitation Program
- Medical Ancillary Services
- Custody/Security

Concurrently with designing an integrated care model, IC Team members also prepared papers describing services and programs at the prototypical facility. IC Team members wrote 16 papers. Each of the 16 papers described goals, objectives and outcomes of a program area, the program structure, staffing and a literature search of evidenced-based best practices. The papers can be found in the Appendix.

1.5 Integration with the Existing 33 Adult Prisons

The Receiver's Turnaround Plan of Action outlines a broad organizational change effort for CDCR's health care program. The 33 adult prisons are currently in the process of making changes that will improve health care access within the existing institutions, employing the essential strategies suggested by the Institute of Medicine[10] as follows:

- Redesign of care processes based on best practices
- Information technologies for clinical information and decision support
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services and settings over time
- Incorporation of performance and outcome measurements for improvement and accountability

The new health care facilities will apply the above strategies and will also incorporate CPHCS Administration designed quality improvement systems and protocols into its programs, policies, procedures and expectations of employees. Staff of the new health care facilities will coordinate with colleagues in the 33 prisons to ensure uniformity of practice and policies. A system-wide team will create and implement a rational continuum of care for patients admitted to the new health care facilities and for patients returning to the 33 prisons. Criteria for admissions will specify medical and mental health conditions. Referral sources will discuss behavioral and social expectations prior to the patient's transfer to a new facility.

Patients of the new health care facilities will recover and be discharged to a CDCR prison, paroled to the community or transferred within the facility to higher or lower levels of care, or be maintained at an unchanged level of care.

PART II: A NEW CONCEPT IN CARE

2.1 Distinguishing Features of the New Health Care Facilities

Specific admission criteria will be applied in determining patient placement in the new health care facilities. Medical and mental health treatment will be closely coordinated and, to the extent possible, resources will be shared so that treatment is integrated around patient needs and strengths. Patients will be managed by direct supervision — i.e., custody staff working closely with clinical staff to ensure safety and achieve treatment outcomes — rather than a traditional custody approach.

The delivery system will encourage patients to actively participate in their treatment regime and to accept individual responsibility for achieving their treatment and rehabilitation goals. Staff will be selected based not only on their experience, but also their commitment to the mission and philosophy of the new health care facilities. Staff training will be extensive and

include specialty areas such as geriatrics, substance abuse, motivational interviewing, direct supervision, mental health and team-based care. Cross-training will be the norm. Each facility will have a single Chief Executive Officer responsible for directing the entire program, including custody, rehabilitation, medical, pharmacy, nursing, mental health, dental services and support services.

As described in a report submitted to the Receiver dated January 15, 2009 by the IC Team, care will be:

- Patient-centered
- Integrated
- Recovery and wellness-focused

The culture of the new health care facilities will reflect these core values:

1. Resources – people and products – are used efficiently and effectively so that the result is good value for the public expenditure.

2. Teams of staff working together, including health care, custody, rehabilitation and support services, ensure quality care for patients, a well-run facility and a safe, supportive and accountable environment for all staff.

3. Optimal care is delivered when the right patient is in the right place with the right provider and the right information at the right time.[11]

4. Within the parameter of providing a safe environment, care focuses on the individual needs of the patient.

5. Planning for successful patient reentry into the community begins upon entry into the health care facility.[12]

6. Patient behavioral expectations are clear and documented; patients who do not comply with standards for behavior — for reasons other than their illness — will be transferred out of the health care facility.

7. Patients are responsible and accountable for their recovery, as described in their Individual Treatment Plans and Rehabilitation Plans.

8. Health care professionals have responsibility and authority for diagnosis and treatment decisions, including admission to and discharge from the facility.

9. Nurse-Ombudsmen work with patients who have complaints, prior to patients filing an appeal.[13]

10. Patient and employee satisfaction lead to successful functioning of a facility.

11. Quality Improvement (QI) is continuous and involves all staff. QI processes are based on the Plan-Do-Study-Act (PDSA) model.[14]

12. Patient confidentiality is respected and observed; information is shared among staff only on a need to know basis.

2.2 Philosophy of Care

The philosophy of care at the new facilities has been described in the values and objectives articulated in Section 2.0 of the *Options Report: A Value Basis for Medical and Mental Health Care Services,* approved by the Receiver in April 2008, and in *Foundations of Patients Care*, submitted to the Receiver in January 2009 by the IC Team.

2.2.1 Tenets of Care

The tenets of care are as follows:

- **Care is patient-centered.** Patients at the new health care facilities move through a **continuum of care** based on their health care needs. Most patients have the ability to make responsible choices regarding personal health and wellness, if provided the appropriate guidance and support. This is made possible at the new health care facilities by an environment that embraces recovery and rehabilitation, reinforces positive behaviors, and fosters self-discipline. Nonetheless, patients bear responsibility for their behavior and relationships, and ultimately for their treatment outcomes.
- **Medical and mental health care is integrated**. Integration ensures that all services are coordinated and managed to address the broadest needs of patients — both at a given point in time, and across time. Resources are matched to patient needs. Staff assignments are in keeping with staff competencies, skills and expertise. Resources are also shared, and staff work together collaboratively within and across disciplines. Protocols and policies are consistent across the facility's departments.
- **Teams manage oversight of health care operations.** Interdisciplinary Treatment Teams (IDTT) support integrated patient care. Primary Work Teams (PWT), i.e. staff with similar job functions and responsibilities, ensure consistency of patient care throughout the health care facility. Administrative Teams (AT) support IDTTs and PWTs, and provide efficient services and systems that support staff to provide care for patients.
- **Patient and staff safety** is promoted by a fair, just, and open culture of learning, prevention, and accountability. Defined processes and protocols minimize the potential for error, as do the creation, training, and support of highly developed interdisciplinary teams and collaborative workgroups.[15]

- **Treatment of patients is wellness focused and addresses the patient's mind, body and spiritual needs**. Services are provided using a strength-based approach to maximize the patient's likelihood of recovery and self-sufficiency, key elements to improvement and reintegration into the community.
- **Health care and custody staff are interdependent** and share a common commitment to patients and the safety of staff, visitors, and the community. Management is by **direct supervision**, a relationship-based method of oversight that places officers in housing units, enables direct contact between officers and patients and results in improved patient behavior.
- The management and organizational structure for health care delivery is based upon an **interdisciplinary model of health care, rehabilitation and custody**. This ensures a safe and secure environment, while still promoting and advancing the principle of treatment and recovery, and not merely management of symptoms.
- Care is **cost effective**.[16]
- Care delivered draws on **evidenced-based best practices.** This includes, but is not limited to, medical interventions, mental health therapies, rehabilitation services and direct supervision.
- **Staff are accountable for appropriate service delivery**. The clinical and health outcomes of care provided to patients, as well as programmatic outcomes, are measured and reported to the providers of care. These results inform the facility's organization-wide program of continuous quality improvement.
- **A well-trained staff is committed to the mission of the health care facility** and is supported by quality supervision, ongoing staff development, adequate resources and an efficiently run organization.

2.3 Integrated, Consistent Care

Two strategies – integrated care and consistent care – work together to promote standardization and reduce variability in care, and thus have the potential to improve quality of care.[17]

2.3.1 Integrated Care

Integration is the glue that links together the facility's interconnected components — its departments and staff teams — with the patients. Without integration at multiple levels:

- Patients can get lost
- Services may fail to be delivered or be redundant
- Quality and satisfaction decline
- The potential for cost effectiveness diminishes[18]

Integration allows for greater efficiency and effectiveness, less duplication and waste, more flexible service provision, and better coordination and continuity.[19]

On the clinical level, integration takes place through shared understanding of patient needs, common professional language and criteria, the use of agreed-upon practices and standards, and ongoing communication among care providers.

Strategies commonly used to achieve integrated clinical care include:

- Common assessment tools
- Joint interdisciplinary care planning
- Care coordination
- Multi-disciplinary teamwork
- Co-location of services
- Coverage 24/7 or availability of emergency medical coverage
- Shared clinical information and records
- Centralized patient information systems and facility intake planning
- Integrated information systems

2.3.2 Consistent Care

Consistent care ensures that the patient's plan of care is known and applied throughout all levels and sites of care, and across all of the patient's care providers.

Consistency of care is especially relevant in the new health care facilities for three reasons:

1. The majority of patients will have both medical and mental health problems.
2. Consistency of care contributes to both cost-effectiveness and the achievement of treatment goals.
3. The facilities are designed to provide services on a continuum of care, from least to most intense.

For example, a patient may first be admitted to the Mental Health Crisis Bed (MHCB) unit, then be referred to the Acute Psychiatric Program (APP) for further treatment and stabilization. MHCB patients often present with serious and multiple concurrent medical and mental health problems. The patient may have treatment goals related to a major mental illness, a co-occurring substance abuse disorder, a personality disorder, a history of suicide, violence, sexual offending, and prior sexual abuse, a history of self-injurious behavior, indications of neurological injury and significant cognitive deficits. In addition, the patient may also have significant and chronic concurrent medical issues such as diabetes, hepatitis, or hypertension. A complete and individualized treatment plan requires staff to address the mental health issues,

but also the medical issues, which may be complicated by cognitive deficits. Achieving consistency of care across the mental health and medical continuum requires that medical and mental health staff utilize common treatment and program approaches.

2.3.3 Mechanisms to Achieve Integrated, Consistent Care

Integrated and consistent care will be achieved at the new health care facilities through four mechanisms. Each is carried out utilizing the core values noted in Section 2.1 and ties together patient services:

- Patient Rounds
- Reports and Handoffs
- IDTT Meetings
- Quality Improvement Activities

Each of these is described in the following paragraphs.

2.3.4 Patient Rounds

Rounds elicit information and expert opinion from staff who are responsible for the patient's daily treatment. Rounds also incorporate the patient's report of his status, concerns, problems and achievements.

Rounds are used to assess the patient's response to the plan of care, set goals for care consistent with the plan established by the IDTT, and to specify the next steps to be taken in the provision of care for the patient (lab, consults, referrals etc.).[20] Finally, rounds are used to confirm the next steps in care for both treatment providers and the patient.

The patient has the right to participate, ask questions, and where appropriate, make final decisions involving his care. Strengthening relationships between the health care team and patient facilitates this process. According to Julie Rosen, executive director of the Schwartz Center at Massachusetts General Hospital, "There is no other forum across which all different groups of caregivers can connect with one another and renew their appreciation for patients."[21]

Patient care rounds increase patient safety, promote quality service delivery and create operational excellence in patient care.[22] Evidenced based research indicates that the use of rounds results in:

- Improving communication between disciplines
- Faster rate of recovery for the patient
- Reduction in the length of hospital stays
- Reduction in costs for outside services
- Reduction in the number of request for service/ call lights

- Reduction in staff fatigue
- Reduction in competition for charts
- Reduction in noise level on units
- Improving patient and family satisfaction[23]

The participants in patient care rounds vary; they may be a primary work group (nurses at change of shift), an individual provider (weekend rounds by the on call physician), or an inter-disciplinary group. Custody staff may participate in multidisciplinary rounds, as well as rounds by primary work groups at change of shift. The frequency of rounds may vary based on the needs of the patient and level of care (e.g., low acuity or high acuity). However, the focus of rounds remains the same: the exchange of information centered on the patient in order to establish immediate next steps in treatment, care and custody.

2.3.5 Shift Reports and Handoffs

Shift staff in each unit gather to report important information about patients in their care to the incoming shift. The report may point out changes in patient conditions, outstanding calls to Physicians, abnormal laboratory or x-ray results, significant changes in medications, patients who have been admitted or discharged, and other issues integral to assuring that care is seamless and continuous. Staff stand for these typically 15-minute meetings.[24] Also during these daily "huddles," broader issues are identified and solutions suggested. Concerns identified are reported to the appropriate discipline, the IDTT, or to leadership depending on the nature and seriousness of the problem.

Handoffs (transfer of patient care from one Physician, team or unit to another) include a timely report on the patient's status along with relevant documentation.

2.3.6 Interdisciplinary Treatment Team Meetings

As noted in Section 3.1, an IDTT develops a care plan with the input of the patient based on the patient's diagnoses, significant social issues, custody concerns, and other factors. The team, including the patient, monitors the plan, meets regularly to assess progress and makes changes as needed. Patient confidentiality is respected and observed; information is shared among staff only on a need-to-know basis.

2.3.7 Quality Improvement Activities

Quality Improvement (QI) is managed and implemented based on CDCR standards. QI mechanisms are performance and evidenced-based. Goals are set by CPHCS Administration with input from practitioners from all disciplines, and include data collection systems, measurements of quality, and approaches to improvement activities. CPHCS Administration oversees the centralized system, while individual facility leadership has accountability for site-level QI. Units and individuals at the site level are responsible for implementation of quality initiatives and outcomes in their respective areas.

At the facility level, two approaches to quality improvement are implemented. The first is a standard QI committee structure. Committee members include representatives from the interdisciplinary teams. Subcommittees are discipline-based. This is planned to be consistent with health care QI programs at the adult correctional institutions.

The second is the Plan-Do-Study-Act model, a proven Institute for Healthcare Improvement (IHI) methodology for quality improvement. This approach includes rapid cycle change — a problem is recognized and a tentative plan of action is applied to a small area of the facility. The results are then evaluated, refined and applied until it is felt to be "just right," then applied and refined in larger and larger areas of the facility until the entire system embraces the change.

As an example, following morning report the unit comes together and identifies a problem. The change they recommend to improve care focuses on the functioning of nursing stations. Staff then immediately applies the change to a single nursing station. Within days, the same group studies the results to see if the change has produced a better process of care. If so, the change is applied to more and more nursing stations until all are performing the change. If the initial study indicates no improvement, the change is refined and re-applied until the desired improvement is achieved. The solution is then implemented throughout the facility.

2.4 Care Coordination through Case Management

Case management is a formal strategy that coordinates and facilitates access to services for patients through a collaborative process of assessment, planning, facilitation and advocacy.[25] While strategies and practice vary from one setting to another, traditional case management consists of a social or mental health worker who secures and coordinates continued social, mental health, medical, rehabilitation and other services for the patient.[26] Case management best practices emphasize patient participation and engagement.

As noted in Section 2, care of patients will be coordinated across patient conditions, services and settings. Many Nurses, Clinicians and Therapists have distinct case management responsibilities in relation to carrying out patient care. The Social Work Care Coordinator and the Correctional Counselor have specific, overarching care coordination duties that dovetail with the case management provided by health care staff.

2.4.1 Rehabilitation Correctional Counselor

A Rehabilitation Correctional Counselor is assigned to the patient upon his entry into the facility. The Correctional Counselor will be responsible for the traditional classification, custody, and reentry responsibilities for the patients. In addition, the Correctional Counselor will be responsible to complete a risk and needs assessment,[27] to provide release planning for patients and to also work with other IDTT members to develop and monitor the patient's Individual Treatment and Rehabilitation Plan (ITRP).[28] The Correctional Counselor also works with the Social Worker Care Coordinator with re-entry and release planning and support.

2.4.2 Social Work Care Coordinator

Coordination of care in the new health care facilities is essential for several reasons. The average patient in these facilities will be living with multiple medical, physical and/or mental health problems and taking 10 different medications a day. Patients are initially assigned to a housing unit and level of care, but as a patient's needs change, housing may also change, as well as the medical, dental and/or mental health services they receive. Their daily treatment program of activities will also be reconfigured to adjust to their changing medical/mental health status. Care coordination is critical to ensure that the patient is followed throughout his stay at the facility and that changes are made as smoothly as possible.

In the new health care facilities the Social Work Care Coordinator will follow the patient from admission to discharge or transfer, and will coordinate access to mental health, medical and rehabilitation services. This person can also serve as an advocate for the patient to ensure a smooth flow between levels of care or transition either back to the prison setting or the community. As a participant in the IDTT, this person monitors and tracks the integrated care plan and makes sure the patient is working toward meeting his recovery or maintenance goals. The Social Work Care Coordinator will coordinate the tangible aspects of the patient's care plan and also support the patient's efforts to contact and connect with family and friends.

The Social Work Care Coordinator provides re-entry and discharge planning support working in conjunction with the Rehabilitation Correctional Counselor. Together, they ensure that a comprehensive, practical re-entry plan is created and implemented.

For patients paroled from the new health care facilities, successful re-entry services will require effective coordination with parole and community providers. Patients re-entering society will then have the needed transitional services in place to support a successful re-integration. The Social Work Care Coordinator assists the patient to transition from the prison setting into the community, including enrolling patients for benefits and establishing direct contact with the parole office, as indicated.

PART III: WORKING AT THE NEW FACILITIES

3.1 Types and Functions of Teams

The leadership of the facility consists of a Chief Executive Officer (CEO)/Executive Director (ED) Chiefs/Heads of Medical, Nursing, Dental, Mental Health, a Superintendant of Correctional Services and a Correctional Administrator of Support Services/CEA. Executive management operates as a team, each chief/head/superintendent/correctional administrator reporting to the CEO/ED, but with dotted line responsibility to each other and reporting obligations to the CPHCF and/or CDCR hierarchy.

The Leadership Team acts as a role model for three other types of teams. All are responsible for implementation of patient-centered, integrated care, as follows:

- IDTTs support integrated patient care. The IDTT includes staff from nursing, medical, rehabilitation, mental health and custody as well as the patient. Other disciplines participate as equal members on the IDTT based on the patient's care plan.
- Primary Work Teams (PWTs), i.e. staff with similar duty statements and responsibilities, ensure consistency of patient care throughout the health care facility. Members are expected to help each other and to back each other up.
- Administrative Teams (ATs), such as mid-level supervisors, manage oversight of health care operations. These teams are responsible for resource availability, efficient service delivery and making sure that systems exist and work to support the IDTTs and PWTs in patient care. ATs can be discipline-based or are multi-disciplinary.

All teams have specific performance goals, outcomes and decision-making authority. Patients are their first priority; thus, the success of the teams is measured by the achievement of the best health care outcomes possible for each patient.

Leadership of various teams will be determined by policy, appointed by management, or chosen by team members based on the requirements of the team for specific expertise.

Team members in the new health care facilities will be well trained in team functioning as well as coached and motivated to meet performance objectives.

3.2 Custody and Direct Supervision

Equal consideration for inmate-patients' health needs and custody requirements is a central tenet for the operation of the new health care facilities. The scope of responsibility of custody staff are expanded to include awareness of patients' health conditions.

Custody staff assigned to the new health care facilities are active participants on all direct care teams and also take care of transport, safety and security. Correctional staff, in addition to health care professionals, are expected to develop relationships with patients and to help them meet their goals for wellness and recovery, as detailed in their care plans.

3.2.1 Direct Supervision of Patients

Use of the direct supervision model offers custody staff the opportunity to get to know the patients because, as noted in Section 3.2, direct supervision is a relationship-based method of oversight that places officers in housing units.

The facilities are designed such that lines of sight are unobstructed so that staff can easily view all areas under their supervision. Officers can provide frequent, nonscheduled observation of, and personal interaction with, patients. This enables direct contact between officers and patients, resulting in improved communication and patient behavior. Patients who do not comply with facility policies can be dealt with quickly.

Of course, a well-trained and supported staff is essential for successful implementation and sustainable results.[29, 30]

3.3 Staff Expectations and Professional Development

Hiring qualified staff is integral to successfully carrying out the mission and vision of the new facilities. Criteria for staff selection will be based on education, competency, experience, and expertise as well as communication skills, flexibility, and desire to learn and grow.

3.3.1 Expectations

All employees of the new health care facilities are expected to be knowledgeable and invested in the mission, philosophy of care, and treatment described above.

In addition:

- Within the framework of their job descriptions and licensure, all classifications and levels of staff are expected to be active members of care, treatment and teams that operate the facility and/or provide services to the patients.
- Staff are expected to be committed to efficient service delivery, quality care, and quality improvement, all of which are essential to patient recovery and wellness.
- All employees are expected to actively seek out supervision and mentoring. Likewise, supervisors are expected to make themselves available to advise, train and provide direction to their supervisees.
- Employees are expected to continuously learn, and to actively participate in staff development activities.
- Employees are held accountable for carrying out their own duties and also for assisting other staff or departments when requested.
- Employees are responsible for conducting themselves professionally and respectfully with patients and each other, and to willingly collaborate with colleagues and all staff regardless of classification or level to create an accessible, cooperative and transparent working environment that supports patient recovery and staff satisfaction.
- Staff are expected to comply fully with the intent and spirit of the facility's policies, procedures and standards and all laws governing each professional discipline to ensure compliance with quality care and treatment and the safety and security of all persons employed, housed and/or visiting the correctional health care facility.
- All staff are responsible for creating and supporting a humane, compassionate environment that is conducive to healing and recovery for patients and professionally rewarding for staff.

3.3.2 Professional Development

Investing in the workforce through learning enhances job satisfaction and retention, and impacts the quality and continuity of care provided to patients. Staff training is required to adequately and efficiently serve the patients of the health care facilities.

Staff in the new facilities will receive basic training and orientation provided by the professional development department on such subjects as:

- Mission, vision and core values of the health care facility
- Culture of the health care facility
- Expectations of all employees
- Administrative policies and procedures
- Professionalism and ethics
- Safety
- Human resources
- Emergency response
- State mandated training courses
- CPR

Multi-disciplined, specialized training may include, but not be limited to:

- Patient population and levels of care in the facility
- Health care policies and procedures
- Patient-centered care
- Team-based care
- Effective communication
- Continuous quality improvement
- Motivational interviewing
- Mental illness, including suicidal behaviors
- Direct supervision
- COMPAS Risk Assessment and Needs
- Individual Treatment and Rehabilitation Plan Development
- Substance abuse
- Geriatric care, including dementia and hospice
- Programs for delivery of health, mental health, dental, substance abuse and

rehabilitation services, with an emphasis on wellness and recovery

3.3.3 Cross-Training

Cross-training is the practice of instructing employees to perform the essential elements of more than one job within an organization. Examples include:

- Specialized General Population Nurses trained to work with High Acuity medical populations
- Certified nursing assistants assigned to Low Acuity medical patients trained to care for Enhanced Outpatient mental health patients

Cross training may be designed to broaden employees' span of knowledge, skill and ability so that they can be assigned to work in more than one area of the facility, within their job classification, as described in the former examples. Cross training can also develop employees in order to be promoted within the organization, such as Office Technicians working in the business office being trained to fill in for Ward Clerks on the units. Cross training is most successful when the organization requires it of all staff. Employees should have input in determining the purpose, their assignment, and schedule within the parameters set by management.

Expected results of cross training are:

- Increased knowledge, know-how, skills and performance
- Increased organizational performance and productivity
- Motivation and professional development of employees
- Increased coordination and teamwork; innovation resulting from broader perspectives
- Improved understanding of the contribution and challenges faced by different parts of the organization
- Flexibility in scheduling and assigning work to improve and maintain productivity
- Shared understanding and commitment to the organization's mission

PART IV: PATIENT HOUSING AND PLACEMENT

4.1 Housing Assignments

Following a nursing and safety assessment, patients are assigned to a housing unit. An interdisciplinary team completes an assessment within 48 hours of arrival. The IDTT, including the Social Work Care Coordinator, develops and manages a care plan that is congruent with the patient's needs. Changes to the plan are based on progress (or the lack thereof) in achieving the goals in the agreed-upon care plan. Should the goals not be met by the patient, the team will adjust the individualized treatment and rehabilitation plan accordingly. In the event that the patient fails to participate in the plan the team will make a recommendation as to the future placement for the patient.

4.2 Housing for Medical Patients

Approximately half of the housing and facilities will be for medical services, of which approximately three-quarters will consist of open-space dormitories for Specialized General Population (SGP) patients who have functional impairments and chronic conditions requiring ready access to health care services (e.g., advanced chronic obstructive lung disease, or wheelchair bound patients with spinal cord injuries). Approximately 18 percent will consist of assisted-living-quality housing for low acuity patients who have nursing needs (e.g., wheelchair with wounds that need routine dressing, or stroke patients who need help dressing), and less than ten percent will consist of nursing-home-quality housing for high acuity patients (e.g., patients with complicated wounds that need nursing attention daily, post surgery, patients undergoing chemotherapy, and patients who are completely bed bound).

4.3 Housing for Mental Health Patients

The other half of the housing and facilities will be for mental health services. Approximately 50 percent of this housing will consist of open-space dormitories for an Enhanced Outpatient Program (EOP), which treats patients who have a serious mental disorder and an inability to function in the general population. 25 percent will be for high-custody enhanced outpatients. The remaining approximately 25 percent will be for a mix of mental health crisis beds, acute beds, an intermediate care facility, and a high-custody intermediate care facility for patients who have a serious mental disorder and either exhibit marked impairment and dysfunction in Activities of Daily Living (ADLs)[31] requiring 24-hour inpatient care, are a danger to self or others as a consequence of a serious disorder, or are unable to carry out adequately one or more PADLs.[32]

4.4 Patient Movement Within and Out of the Facility

Patients in the new health care facilities will either recover and be discharged or be maintained at an unchanged level of care. Discharged patients may be paroled to the community, transferred within the facility to higher or lower levels of care, or transferred to one of the 33 existing prisons.

It is anticipated that a percentage of the SGP and the Enhanced Outpatient Population will improve sufficiently that they can return to the general prison population. Few of the low acuity, skilled nursing, dementia, or hospice will leave the facility, though they may move to lower levels of care within the facility.

According to the Penal Code, all patient-inmates must be offered opportunities to participate in rehabilitation services – programming that will prepare them for life outside of prison while also reducing the possibility of a repeat offense and incarceration.[33] At least 65 percent of patients offered the rehabilitation services will agree to participate in programming. Based on data from CDCR, it is expected that 35 percent to 40 percent of the facility's population will be paroled to the community from the health care facility.

Placement of patients within the facility will be determined as part of the IDTT process. The IDTT and the patient regularly review the goals of the care plan and identify areas in which goals have been met within the time frame allotted for goal achievement. Patient improvement may lead to placement on a housing unit with a lower level of care. On the other hand, patient deterioration may lead to placement on a unit where a higher level of care is provided. Patients may also be discharged from the health care facility or back to the general population at a CDCR prison.

PART V: PATIENT ENGAGEMENT AND BEHAVIOR

5.1 Patient Patti

Patti is a 36-year-old African American woman, a parole violator serving a new term of nine months for forgery/fraud. Her literacy level is the 5th grade, and she has no employable skills. She was transferred to the facility from an existing CDCR institution because she needed a higher level of care than could be provided for her. She has a chronic heart condition, is a long time substance abuser, was sexually abused as a child, and physically abused as an adult. She is a single mother of three ranging in age from three to 15, all who have been placed in foster care.

Patti lives in Specialized General Population housing and receives medical, dental and mental health services. In addition to heart medication, she takes anti-depressants. She attempted to take her own life two years ago during a previous incarceration, but has been stable since. She has extremely advanced tooth decay, or "meth mouth." Her dental treatment plan will require months of follow up appointments. Her IDTT has met with her and has designed a treatment

program that includes trauma-informed substance abuse treatment, education, and group therapy in addition to medical and dental treatment.

Patti's day may look like the following:

6:00 a.m. - Patti's day begins with breakfast in her housing unit where she interacts with other patients, many of whom now constitute her substitute family.

7:00 a.m. - Patti heads to the Diagnostic and Treatment Center to attend Trauma Informed Substance Abuse Treatment, a two-hour group session which is part of an ongoing program specifically designed for female offenders to be gender-responsive, trauma-informed, strength-based, family-focused and culturally competent.

9:30 a.m. - She is seen in the Diagnostic and Treatment Center Dental Clinic. After checking that her mouth has sufficiently healed from the dental procedures done during her previous visit, the dentist fits her for a partial.

11:00 a.m. - Patti is seen by her Primary Care Physician to assess her heart condition and review her medications.

11:30 a.m. - She eats lunch in the Day Room before heading for her afternoon appointments in the Treatment Mall.

12:00 p.m. - Patti attends education classes designed to improve her literacy level and get her closer to achieving a GED. Due to her short sentence (nine months), her successes will be measured in terms of grade level gains.

3:30 p.m. - She stops in the General Library to find material to complete a homework assignment. Using the Electronic Law Library she also researches a child custody matter.

Tomorrow she is scheduled to receive a visit from two of her three children, whose caretaker has agreed to a mediated parent-child visit, her first since re-incarceration.

5:00 p.m. - She returns to the Housing Unit for dinner and to study the materials she collected from the Library.

6:00 p.m. - Patti attends a special bible study session held in the Chapel before returning to the Housing Unit for the evening.

Key to effectively implementing patient-centered care as well as the wellness model is the active involvement of the patient in the care plan. Patients like Patti work closely with members of their IDTT to develop physical and/or mental health and rehabilitation care plans, including specific activities and goals. Based on their care plans, patients and their health care team plan their stay at the health care facility and determine appropriate daily activities.

Patients are held accountable for the choices they make and afforded opportunities to improve their conditions of confinement by making better decisions during their stay at the health care facility. Patients are able to enhance their problem solving skills by participating in treatment and programming opportunities as identified in the patient's care plan. Progress is acknowledged and rewarded.

5.2 Behavioral Incentive Program

CDCR Mental Health and DMH have behavioral incentive treatment programs in place. The CPHCS behavioral Incentive Program will incorporate incentives regulated by CDCR.

Most of the patients placed in the health care facilities have functional and cognitive deficits, as well as histories indicating anti-social behaviors, personality disorders, low literacy levels and substance abuse. Though the facility's environment will provide patients the opportunity to develop skills and knowledge that will lead to positive, permanent, pro-social change, outcomes are dependent on the patients – their attitude, participation in their treatment, and their behavior.

Positive behavior is reinforced through a program of rewards and incentives. Patients earn privileges over time when they comply with their care plans and maintain disciplinary-free behavior. A formal system of incentives impact conditions of confinement and earned sentence credits.

For example, patient behavioral incentives may be earned for:

- Positive behavior
- Adherence to medical/mental health treatment plan
- Completion of a substance abuse treatment program
- Completion of education programs including: functional literacy, general education degrees, post-secondary education programs, vocational, and pre-release programs
- Completion of cognitive restructuring, conflict resolution, cultural diversity, domestic violence, and parenting programs
- Volunteering within the facility and mentoring other patients
- Clean personal grooming, hygiene and housekeeping

Sanctions, too, are part of the behavioral incentive plan. Patients who refuse to participate in their care plans or present disciplinary challenges have privileges taken away and may face other consequences as authorized by the California Code of Regulations, Title 15.

PART VI: ADMISSIONS

6.1 Pre-Admission Process

The new health care facilities will accept only patients with serious health conditions that make it unsafe to reside in general prison housing (including physical frailty, chronic illnesses, or serious functional and cognitive conditions), and who require three or more months of treatment.

Based on criteria established and made known to the staff of the 33 adult prisons, a prison Physician or Psychiatrist forwards the patient's history and current diagnosis to the admitting health care facility Physician or Psychiatrist.[34] Once the patient has been accepted, additional documentation is sent electronically to the Patient Management Unit (PMU) at the health care facility. This includes information regarding time to serve, custody classification, medical condition, etc. Documentation is reviewed and discussed with custody staff. The sending facility is then notified that the patient may be transported and a date for transport scheduled.

On the day of scheduled admission, the patient is transported to the health care facility by the appropriate means of transportation, i.e., bus, van or medical/stretcher vehicle. Transports are scheduled to arrive at the health care facility throughout the day so that flow through the PMU does not result in excessive wait times or delays in admission processing. The patient is greeted on arrival at the PMU by custody and nursing staff who are timely, respectful, pleasant and professional, thus reflecting the facility's values noted in Section 2.1.

6.2 Admission Process

The nursing staff conducts an initial triage to make certain that the patient's condition has not deteriorated during transport such that immediate treatment is needed. A brief nursing assessment is performed prior to the patient being admitted. Custody is available to provide direct supervision of patients, as needed.

Patients who are physically unstable are moved to the Treatment and Triage Clinic (TTC) for immediate assessment and treatment. Custody also moves patients who are mentally or behaviorally unstable to the TTC for further evaluation and placement by a mental health clinician.

Based on the nursing assessment, custody processes the stable patient's personal property, exchanges his clothing and reviews the patient's custody classification. A determination of the patient's bed assignment is made in collaboration between health care and custody staff. The Social Work Care Coordinator and/or assigned Rehabilitation Correctional Counselor escorts the patient to his housing unit, orients him to the unit and program area, and gives the patient a packet of information that includes behavioral expectations for that unit.

6.3 Post-Admission Process

On the housing unit, the Nurse meets with the patient and begins the nursing assessment with the patient's medical history. A Physician examines the patient before the end of the first day of admission. In the case of a medical patient, both the Nurse and Physician assess the patient's mental health status to determine if the patient is suicidal, if a mental health referral is needed and if so how urgently the patient needs to be seen. The orders sent by the referring Physician are reviewed and used as sent or modified as needed.

An Assessment Tool[35] is administered that includes medical, nursing, psychosocial, mental health, dental and rehabilitation data. A level of care is determined and an IDTT meets with the patient to develop an initial treatment and rehabilitation plan. Custody is always a member of the IDTT along with involved health care professionals.

Goals for recovery or maintenance are identified, depending on the patient's treatment and rehabilitation plans. When patients have dental problems or need an assessment for physical, occupational, or speech therapy, additional professionals participate in the IDTT process. A care plan is developed identifying interventions, activities, goals, timelines, the responsible parties and anticipated outcomes. All members of the team sign off on the care plan, including the patient, if he is willing.

The team, working with the patient, then ensures that the care plan is implemented. A formal review of the care plan takes place during IDTT meetings. In addition, discussion among team members takes place as needed, and the patient has regular access to the members of his team. The treatment plan is revised as appropriate during the patient's stay as treatment goals are met and/or new goals develop.

PART VII: SERVICE COMPONENTS: THE NEW MODEL IN ACTION

7.1 Medical Services

Medical services are provided to patients with serious physical frailty, chronic illnesses and functional and cognitive conditions that make it impracticable for them to reside in general prison housing. Patients are transferred from the 33 prisons and accepted by the health care facility based on stringent functional and medical criteria.

Significant functional impairment is determined if patients meet any of the following six criteria derived from the Minimum Data Set (MDS):[36]

1. Requires extensive assistance or totally dependent on assistance to perform at least one Activity of Daily Living
2. Permanent inability to perform at least one Activity of Daily Living
3. Problem with decision-making

4. Problem with short-term memory
5. Problem with long-term memory
6. Difficulty making oneself understood

Significant medical impairment is characterized by functional impairment or by the nature of the treatment required and not just by the diagnosis. Conditions requiring placement may be acute or chronic. For example, a diagnosis, such as HIV is not sufficient to result in placement in the health care facility. On the other hand, diseases requiring daily parenteral medications or having moderate dementia will lead to placement in the health care facility.

7.1.1 Levels of Care

The Abt Associates Report, "*Chronic and Long-term Care in California Prisons: Needs Assessment*" dated August 31, 2007, identified the volume of patients and the range of levels of care to be designed for the new California Prison Health Care Facilities (CPHCF). It was noted that there are several levels of institutional care that are needed for the identified patient populations based on the medical, mental health, physical rehabilitation needs of patients; the length of time the patients may require care; or combination of factors, as follows:

- 73 percent of the medical services will focus on patients with functional impairments or medical conditions who may be able to care for themselves with limited assistance. These patients will live in Specialized General Population (SGP) housing in the new medical facilities.
- 18 percent of medical treatment is care of patients with time limited or chronic medical conditions who also need assistance with ADLs[37] and between eight and 16 hours of nursing care a day. These patients will have impairments in at least one of five PADLs or ADLs; and/or incontinence; and/or cognitive, vision, hearing or mobility impairment and will live in Low Acuity (LA) housing.
- Nine percent of the medical services patients in the new facilities will require 24 hour nursing support. These patients are not able to care for themselves and have either extensive medical problems requiring daily monitoring and/or intervention, or short-term care if they are recovering from surgery. These patients will be housed in high acuity (HA), dementia or hospice beds.

Patients housed within all three levels of care may suffer from the same diseases, such as osteoarthritis, hypertension, end stage renal failure, dementia, congestive heart failure, diabetes, cerebral vascular disease, HIV, blindness, etc. It is the severity of the disease and the patient's functionality that determine his level of care. For example, a patient with mild osteoarthritis and Class I congestive heart failure[38] will live in Specialized General Population housing, while a patient with severe osteoarthritis and Class III congestive heart failure will live in High Acuity (skilled nursing) housing. In both cases, the disease entities result in ADL deficiencies that require care.

In general, most[39] of the patients living in Low or High Acuity medical housing will suffer from

chronic diseases and disabilities, and are not expected to recover; instead the goal of treatment will be to delay deterioration and sustain function. In contrast, many of the patients living in Specialized General Population housing may well improve sufficiently to be transferred back to a prison setting.

7.1.2 Approach to Care Provision

As noted in Section 6, the pre-admissions process begins with a referral from a Physician at one of the 33 prison facilities and acceptance of the patient from the admitting Physician at the health care facility. Transport and admission to the health care facility is scheduled so that patients arrive with their medical records, which include transfer orders from the referring Physician. Dietary needs, the activity level of the patient, medication list, treatment, upcoming appointments and therapies are described in the transfer orders.

7.1.3 Medical Management

Care is delivered in the Diagnostic and Treatment Center and at the bedside, based on the patient's functional status.

Care is managed by a specialized interdisciplinary team. Representatives of medicine, nursing, custody and other treatment disciplines comprise the team; mental health staff joins the team as needed. The care plan focuses on symptom management, how to proceed with the treatments that best assure the most rapid recovery or improvement, and maximizing function and independence. Changes to the plan are based on progress or lack of progress in the recovery from the injury or illness. Should the patient fail to participate in the plan, the team will make a recommendation as to the future placement for the patient.

Each patient has a care team responsible to work with him towards recovery or maintenance.

Five activities define medical management:

1. Nursing and Physician Assessment
2. Care Management Process
    a. Overall care is order driven or described in the facility's clinical policies and procedures.
    b. Each patient is assigned a Primary Care Physician (PCP) for continuity of care who evaluates the patient's treatment progress and condition. The PCP revises treatment as indicated by writing new orders.
    c. Nursing staff provide patient education, assist the patient to adhere to the treatment plan, track routine and specialty care appointments and arrange for preventive health care, such as flu shots, mammograms and colonoscopies.

3. Multi-Disciplinary Rounds

    a. Rounds are made as needed based on the patient's acuity level and take place at the bedside. The patient's concerns, condition, treatments and progress are discussed. Recommendations from the rounding team are referred to the IDTT to incorporate into the patient's overall plan of care.
    b. Prior to change of shift reporting, the oncoming and off going Nurses "walk the unit" to share pertinent information. Change of shift rounds and reports are used to ensure safe handoffs from provider to provider or Nurse to Nurse.
    c. Team rounds, including Nursing, Physician and other health care staff as needed, are additionally used to monitor patient care and progress.
    d. Patient bedside visits during rounds are "mini-PDSA" events, evaluating prior care, determining if that treatment was beneficial, and reacting accordingly.

4. IDTT Plan Review and Monitoring

    a. The IDTT develops and monitors the care plan based upon input from the rounding team and other health care professionals.
    b. The team compares rounding team input with the existing care plan.
    c. Progress is compared with the goals previously established.
    d. Modifications to the plan are made as needed.

5. Ongoing Nursing and Physician Care

    a. Care planning and treatment is evidenced based and follows approved practice and medication guidelines.
    b. System-wide consistency of care is maintained through clinical policies, procedures and protocols.
    c. Nursing and Physician staff are actively involved in quality improvement processes to make sure that system problems are addressed and corrected.

7.1.4 Specialty Care

Patients in all levels of care have access to medical specialists for routine care or problems that fall outside the scope of the Primary Care Physician and Nursing staff. Specialty care is generally delivered in the Diagnostic and Treatment Center or the Treatment Mall. Some services can also be provided at the patient's bedside or in the Diagnostic and Treatment Center through telemedicine. Specialty care is provided in the community as medically indicated when it cannot be accessed via telemedicine or on-site.

Specialty services include, but are not limited to:

- Optometry and ophthalmology
- Dermatology
- Podiatry
- Physiatry[40]
- Endocrinology
- Cardiology
- Gastroenterology
- Otolaryngology
- Psychiatry
- Dialysis

7.1.5 Pharmacy

A central pharmacy operated offsite by Maxor[41] provides the majority of prescriptions to the facilities. An Electronic Medical Record (EMAR) is in place allowing Directly Observed Treatment (DOT) prescriptions to be dosed from stock cards. Onsite pharmacy staff:

- Enter prescriptions into the computer
- Complete the pharmacist clinical review
- Authorize medications
- Interact with clinicians to optimize pharmacotherapy
- Release Direct Observed Therapy (DOT) prescriptions to the EMAR for administration
- Release Keep On Person (KOP) medications to central pharmacy to be filled and delivered back the next morning

Urgently needed prescriptions and replacement cards are provided to medication areas the day they are requested. All refills come from the central pharmacy.

7.2 Specialized General Population

7.2.1 Patient Philip

"I am a 31-year-old Caucasian man who has had many drug problems outside and inside prison. I graduated from eighth grade, but never completed high school. Drugs and drug dealing got in the way of furthering my education. I never had a job and have no skills in getting a job when I get out. Sometimes I get so frustrated with myself and others I become violent. I was diagnosed in prison with diabetes and have had it for a few years. No one has taught me how to control it. I eat whatever I want and I only take insulin when I think I need to. The medical staff tell me I

am out of control but I don't know what that means. They tell me I need to eat better and come get my insulin daily, but I don't understand.

(Philip's day may look like the following:)

I get up in the mornings about 6:15. The Nurse helps me with my finger stick (f/s) and gives me insulin; she talks with me about what to eat for breakfast and my daily activities. By 6:30 I go to the day room to eat breakfast. I am finished by 7:00. I help clean the day room and I push my buddy to his physical therapy appointment, which is at 7:30. After he is finished, I bring him back to the unit. I am able to go to canteen today and get some extra supplies and food. Today is also laundry exchange day. I will turn in all of my clothes and receive clean clothes and bedding. I go to school for four hours so I can get my GED.

It is the afternoon and I am back in my unit for lunch. Because I am uncontrolled diabetic I must do another f/s to see where my levels are and to see if I need any insulin. Today the Nurse says I am okay and do not need insulin. Again we discuss what I need to eat for lunch; the Nurse tells me there will be a meeting during our lunch about what types of food diabetics should eat. She called the person a dietitian.

Again I help with cleaning the day room after lunch. Listening to the dietitian helps me understand why the Nurse keeps talking to me about my food intake and asking me questions.

I am going to an anger management class in the Diagnostic and Treatment Center to help with my temper. It is supposed to help me understand why I get so mad and help me to redirect my anger. This class is with the mental health people. I will be meeting with my clinician who is doing the group therapy.

I just finished my anger management class and today I go to vocational education to start to learn a trade. This should be helpful for when I get out, or at least help me pass the time I have in prison. The time I spend here helps me think of ways I need to readjust my life.

It is time for me to go back to my unit, I have to do anther f/s and take my insulin before dinner. I help set up the day room and push my buddy to the table. We eat together and I help the officer clean up the dayroom after dinner. I now have some free time to watch TV.

Tonight there is a substance abuse program. I push my buddy to our session with a volunteer. The volunteer is another inmate who has had the same problems as me. He can relate to what it is like being an addict.

After the NA program it is time for count, and I have to be on my bunk. Lights are out at 10:00 p.m."

7.2.2 Specialized General Population (SGP) Program Description

According to the Abt Report, within the CHCF environment, Specialized General Population (SGP) provides housing services for patients with functional impairments or medical conditions who can care for themselves with limited assistance. Patients assigned to this level of care are generally characterized by some combination of the following attributes:

- Vision, hearing, or mobility impairment
- General frailty or complications due to medical conditions such as diabetes, colostomy, sleep apnea, episodic oxygen administration, asthma, and wheelchair bound or prosthetic devices

Care is provided at the Diagnostic and Treatment Center for all SGP patients. Nursing staff are available to this population 16 hours a day, with 24-hour emergency care access. The role of nursing staff for this population is to provide hands on assistance as needed and to assist patients to learn how to care for themselves (how to take medications, monitor blood pressure, exercise etc.). Nursing staff model pro-social behavior, normalize the environment of care, and provide reminders and other assistance to improve adherence to prescribed treatment. Depending on their own care needs, SGP patients may be able to assist wheelchair bound, visually impaired or end-of life patients. Individual treatment and rehabilitation plans detail patient goals and activities.

It should be noted that approximately 30% of SGP patients also have been diagnosed with a mental illness and receive both medical and mental health services. A description of the mental health services provided to this population can be found in Section 10.5.

7.2.3 Patient Goals

1. To increase patients' ability to function at the highest level of independence and/or return to the community or prison at the earliest time possible
2. To be engaged in developing and implementing an individualized care plan

7.3 Low Acuity (Assisted Living) Patients

7.3.1 Patient John

John is a 20-year-old Caucasian male who has been a paraplegic since age 18 when he was shot in a gang related incident. He is confined to a wheelchair and has open wounds on his buttocks and tailbone because he sits much of the time. He is also unable to urinate or have a normal bowel movement on his own. His medications are few, but normal for a paraplegic that has back spasms, occasional urinary tract infections, chronic constipation and special wound care requirements.

John has been diagnosed with an anti-social personality disorder. For example, he is not always agreeable with his care plan and wants to be in control of everything, even how his wheelchair is parked for the night.

Due to his history of over medicating himself, he is not able to keep his medications on his person, but is on "directly observed medication administration" by a Nurse.

John's arms are very strong. During the night he is able to change positions without assistance. However, in the morning and several times throughout the day, he needs assistance with catheterizing himself. Following morning medications and breakfast, he returns to his room for bowel care that requires assistance from a certified nursing assistant.

John's day may look like the following:

It is 8 a.m. and time to head to the Diagnostic and Treatment Center for his 8:15 a.m. appointment in the special wound care clinic. The officer gave him a ducat (pass) from the housing unit to the clinic, and it included a ducat from the clinic to the 9:00 educational program area so he can continue working toward getting his GED, an important part of his care plan.

At noon school is over for the day, so he wheels himself back to the living unit for afternoon medications and lunch. He will just have enough time to empty his bladder before his physical therapy appointment at 2:00 p.m. The Physical Therapist is working on trying to straighten his legs: they have contractures of the hips and knees caused by the gunshot wound that damaged his spinal cord. The appointment is very painful and tiring.

Back in his room at 3:15 p.m. he hits the bed for a nap before dinner. At 5:30 a buddy tries to wake him up for dinner. He refuses to get up and an Officer who has been observing the wake-up process intervenes.

After dinner it's TV, a short card game and ordering canteen before going to see the Nurse for bedtime medications. Catheterization and bed follow.

7.3.2 Low Acuity Program Description

According to the July 2008 CHCF Program Facility Statement, 30% of the patients assigned to a Low Acuity living unit are likely to be wheelchair-bound.

Patients like John actively participate in their care, even though they need ongoing Nurse monitoring and assistance with ADLs. Their care needs fall between those of SGP patients and the High Acuity population, and are similar to the more dependent "assisted living patients"[42] who live in the community.

They are generally characterized by the following needs:

- Nursing availability eight to 16 hours per day for assessment, monitoring, and/or patient management, with 24-hour emergency care access

- Medication administration including directly observed therapy (DOT) and self-administered medications; IV hydration and IV antibiotics administered by nursing staff
- Wound care regimen
- Continuous assistance with ADLs

A Physician or Nurse Practitioner sees Low Acuity patients at least every 30 days for routine care. Rounds are made by health care staff on Low Acuity patients on a daily basis. Nursing staff also assess these patients three times a day during medication administration to note and address any change in condition indicating potential for deterioration in health status or functioning.

7.3.4 Patient Goals

1. To return to the highest level of functioning, including preparation for transfer to a CDCR prison, the SGP setting or discharge to the community, as appropriate
2. To manage symptoms and comfort level

7.4 High Acuity (Skilled Nursing Care) Patients

7.4.1 Patient Sam

Sam is an angry 45-year-old African American man who has been in prison for five years. He has diabetes mellitus, hypertension, reduced kidney function from his blood pressure and diabetes, hepatitis C and a history of drug abuse. A fight in the yard resulted in a broken leg and two cracked teeth. At discharge from the acute care hospital he was placed in the high acuity medical unit of the new health care facility for therapy along with control of his blood sugars.

A team of rehabilitation specialists (physiatry, physical and occupational therapy, speech/language pathology) worked together to delineate the exact nature and severity of Sam's impairments. Through the assessment, it was determined that Sam has lingering effects of head trauma from his altercation. Further evaluation was provided by a neuropsychiatrist. The neuropsychiatrist concluded that the history of aggression and anger was likely due to frontal lobe brain damage. Consequently, the care plan established by the IDTT alerted all caregivers (including custody) to use special approaches that minimized the potential for further aggression. In addition, Sam was referred for mental health services and placed in counseling for anger management and impulse control.

The medical team initiated insulin as well as oral medications to control Sam's diabetes and monitored Sam's hypertension, kidney problems and hepatitis C. After initially worsening, his liver and kidney problems stabilized as blood sugars and blood pressure improved.

The head trauma also suggested problems with executive functioning, the ability to perform critical thinking and problem solving. His Mental Health Therapist, Occupational Therapist and Speech/Language Pathologist performed additional assessments to determine Sam's living

skills. These examinations revealed significant deficits in comprehension and reasoning. His care plan was then revised by the IDTT to include physical activities that would build up his ability to handle daily life situations.

Physical and occupational therapy established a baseline assessment of functional abilities in the areas of ADL and Prison Activities of Daily Living (PADLs). Sam's cast made walking distances very hard. A wheelchair was prescribed and appropriately modified to fit his particular needs. The Physical Therapist also assisted Sam in learning how to modify his ADLs and PADLs to accommodate the lower extremity cast. Since the cast wasn't due to be removed for six weeks, the Physical Therapist educated Sam about some simple exercises to maintain his strength and endurance. Nursing staff was instrumental in maintaining adequate pain relief utilizing the feedback from the patient and the therapy team. (Pain control in a patient with a history of drug use problems is always difficult.)

Once stabilized, Sam was transitioned to the low acuity unit. After the removal of the cast, he was reassessed and a new care plan was designed by the IDTT to re-strengthen the effected leg and to promote independent functioning. Shortly afterwards Sam was able to transition to SGP housing. However, he was unable to return to a CDCR institution because of his cognitive deficits and need for mental health care.

7.4.2 High Acuity Program Description

High Acuity patients generally have complicated chronic diseases, drug abuse and physical trauma histories. These patients require access to nursing care 24 hours a day for assessment, monitoring and provision of complex or high-risk medication regimen, complex wound care and ongoing assistance with ADLs. Unlike Sam, most High Acuity patients are totally dependent on others for their care and do not recover. Rather, they have chronic, long-term conditions, functional and/or cognitive impairments from which recovery is not possible.

All High Acuity patients are assessed for immobility associated with patients who are largely bed or wheelchair bound. These include fall risk, skin integrity, continence, confusion, depression, and anxiety. Patient responsibility is encouraged through patient education programs and one-on-one meetings with care providers. In addition to medical and mental health care, a full range of supportive services is required to maximize the patient's ability to reach the highest level of functioning such as physical therapy, occupational therapy, and other services. Maximum recovery not only benefits the patient, but also limits burdens on the health care staff and reduces costs to the prison health care system.

A Physician or Nurse Practitioner sees High Acuity patients at least every week for routine care. Rounds are made by health care staff on High Acuity patients on a daily basis. Nursing staff checks on patients every hour. Nursing staff are vigilant in assessing each of these patients three times a day during medication administration to note and address any change in condition indicating potential for deterioration in health status or functioning.

7.4.3 Patient Goals

1. To sustain and improve functional and cognitive status to achieve the highest degree of independence possible
2. To control pain
3. To control or stabilize medical problems to the degree possible
4. To participate in the care plan in order to promote personal responsibility in health care
5. To return to a CPHCS medical facility from community medical care sites as soon as soon as possible to provide continuity of care and a reduction in expensive outside medical care

7.5 Dementia Care Patients

7.5.1 Patient Ray

Ray is a 63-year-old Asian male who has been in prison for 22 years for a double homicide. He is serving a life sentence for the murder of his wife and his wife's lover. Ray has been denied parole on numerous occasions because his crime was premeditated and very brutal. He was incarcerated for nine years in maximum security before being transferred to the California Mens Colony (CMC). Ray was disciplinary free for the first 17 years of his confinement, excelling in educational and vocational programs. He eventually became a Lieutenant's clerk.

Approximately five years ago his behavior began to change. He seemed forgetful, started missing assignments, and ultimately lost his clerk position. Ray also received three rule infractions for failing to follow orders and two for being out-of-bounds. He suffered multiple injuries in an altercation when he entered someone else's cell and took food. While this change in behavior was initially dismissed as manipulation, he was eventually referred to a Physician. Evaluation determined Ray was suffering from early dementia, likely Alzheimer's disease. His medical issues include high blood pressure, arthritis and a small stroke two years ago.

Ray takes a blood thinner, two types of blood pressure medications, an arthritis drug, two medications for his memory and one to control his increasingly unacceptable behaviors.

Ray was transferred to the California Prison Health Care Facility (CPHCF) in San Diego. His behavior over the last year has further deteriorated. He has lost his ability for most abstract thought, is very forgetful and acts impulsively. He often forgets or refuses medications stating "There's nothing wrong with me."

Ray's day may look like the following:

Ray's day begins around 7:00 a.m., with assistance in his personal hygiene and medication administration. Although he usually can get through these activities with little help, there are

times he needs to be directed to the dining area and encouraged to eat. He insists in sitting at one specific table and becomes upset if someone is in "his place" at the table.

At 8:30 a.m. Ray participates in physical activities to use up his nervous energy to avoid untoward behaviors. Although his participation will vary, he does seem to enjoy catching and bouncing basketballs or volleyballs. Afterwards he and two of his fellow patients usually engage in conversation, recounting their childhood and adolescence, telling the same stories daily.

At 10:00 a.m. Ray insists on watching the latest rerun of his favorite television show, but he has difficulty identifying the characters or anything to do with the plot of the show.

Depending on the weather, at 11:30 a.m. Ray goes outside to water and weed "his" plants.

Ray eats lunch at exactly 12:45 p.m. because "his" table is free and he and his friend, Jocko, can eat together. At 2:00 p.m. he takes a nap. At 3:30, he is taken to the Diagnostic and Treatment Center to see a Physician about a problem he has with infected ulcers on his feet. The appointment results in antibiotics and wound care orders. Because of his tendency to wander off, an escort remains with him whenever he leaves the unit.

Once a week, at 4:30, Ray meets with his Care Coordinator, who is an MSW. He has at times gotten quite agitated when asked to meet with a substitute Care Coordinator as he does whenever his routine is varied. With his assigned Care Coordinator, he can become quite loquacious and intermittently insightful. He at times recognizes that his mind is failing, expressing despair at being a shell of his former self. The Care Coordinator makes a note to have Ray evaluated for depression by mental health at the next IDTT meeting. He seems to have no recollection of the offense that led to his incarceration or why he is at the CPHCF.

He eats dinner at "his" table at around 5:30 p.m. After dinner he usually watches TV. On those evenings when he does not watch TV, he finds a quiet place to read the Bible, often re-reading the same page repetitively, or looks at the pictures in a National Geographic magazine.

Ray typically goes to bed at around 10:30 p.m.

7.5.2 Population Served

Dementia is a progressive deterioration of intellectual functions such as memory, reasoning and social interactions. Decline in mental and social/behavioral function occur while other brain functions such as those controlling movement and the senses are retained. Demented patients' general inability to remember, think, learn and understand significantly interferes with their ability to communicate, comply with instructions and live safely on their own. By the nature of this disorder, patients with dementia have a terminal disease with a variable, but progressive, downward course.

Dementia is a high-risk disease in the CDCR population. The inability to understand directions from other prisoners and custody personnel, and a lack of understanding of how to avoid risky situations, places prisoners with dementia in harm's way on a daily basis.

7.5.3 Dementia Care Program Description

Once admitted to the dementia unit, the patient is given a comprehensive medical and psychiatric evaluation to identify and develop a care plan addressing the patient's cognitive, neuropsychiatric (behavioral), and functional deficits. Additional assessments focus on nursing needs, appropriate activities, nutritional requirements and spiritual desires. The IDTT meets and an initial plan of care is implemented on the day of admission and revised as additional assessment data is gathered. Once the initial assessment is complete (within seven days), the IDTT reviews and finalizes the plan of care. Follow-up monitoring includes quarterly nutritional, spiritual and activity assessments; and, periodic (per team decision based on need) cognitive, physical health, nursing and functional assessments. The dementia unit care team receives special training in dealing with this population. Re-directing instead of punishment is required, or verbal or physical violence may result. Handling outbursts by patients differs here, often demanding withdrawal by caregivers instead of subduing the offender. Everyone, including custody, nursing and medical staff are educated in dementia care and have an integral role in achieving safe care.

The care process and resultant care plan are interdisciplinary. Care team members include the Physician, Nursing and Pharmacist as well as expertise in dietary/nutritional concerns including swallowing problems, behaviors, geriatrics, spiritual issues, appropriate recreation and activities and social work.

Group activities – communal eating, art classes and memory classes – help patients to maintain their limited ability to function. All patients, but especially "wanderers" and patients who do not sleep at night ("sundowners"), are monitored closely by all unit staff.

7.5.4 Patient Goals

1. To maintain the ability to perform daily activities such as eating, dressing and toileting independently, or with the least assistance necessary, for as long as possible

   This reduces staff time, reduces costs and costly outside transfers for care.

2. To prevent patient and staff injury from impulsive behaviors or offensive but unintended intrusions into other's belongings or personal space

3. To better control behaviors with an environment that understands dementia based behaviors and how to best deal with them (Avoidance of dangerous actions avoids staff and patient injuries that are costly to staff retention and expensive to treat.)

7.6 Hospice and Palliative Care Patients

7.6.1 Patient William (Bill)

Bill is a 50-year-old Caucasian male. His pain has a never-ending presence but in the middle of the night Bill is very much alone with it and the diagnosis of cancer that brings the pain on. He can't remember the last time he slept peacefully; being a lifer he is used to the sounds and rhythms of men's fitful nights. This is different though; cancer is now his constant companion, separating him from others who still believe they will return to their communities, friends and family. He is alone, angry about his circumstances and anxious about what will come next.

Bill's day today begins very early.

3:00 a.m. - A nursing assistant is at the door and gazes over the clutter in the room. She asks a few questions: "Not sleeping so well, eh?" "What is the pain like on a scale of 1 -10?" She helps him into a more comfortable position and fills the paper cup with ice chips to soothe his throat. She then reports his level of pain to the Nurse.

6:00 a.m. - The nursing assistant helps Bill use the toilet. He washes his hands and face with the washcloth and rinses the foul taste of night out of his mouth. Bill is not really hungry but eating the small cup of custard on his tray soothes his throat and gut. He still relishes the aroma of coffee and even though he can't keep it down, he insists on having a cup this morning.

6:30 a.m. - After breakfast the nursing assistant helps him into a new gown and changes the bed linens. The Registered Nurse asks him asks him some familiar but specific questions about his level of pain, bowels, nausea, and so forth. He asks about some new symptoms that he is feeling and she suggests that he bring these up when the doctor makes rounds later in the morning. She gives him his prescription medication and asks that he do the breathing exercises that have been recommended.

8:30 a.m. - Bill has dozed off and is awakened by the doctor and other members of the treatment team. Every morning they gather around him to discuss events of the day before and list what is to happen that day. The Nurse prompts Bill to describe his new symptoms, adds information about his vital signs and symptoms over the last day. The Correctional Counselor notes that the IDTT will meet today to address Bill's recent misconduct.

9:00 a.m. - The Physical Therapist sees Bill. He discusses a series of mental and physical exercises Bill can do to help control symptoms of pain and anxiety. He gives Bill a self-study workbook and an audiotape and they do the first exercise together. He suggests that Bill work on the first two lessons and that he will follow up with him in a couple days.

9:30 a.m. - Bill is exhausted. Why work on all this when there is nothing to look forward to but more pain and anxiety? He is tired of having this cancer and everybody else rule over him. He calls the Nurse and complains about his pain. She agrees that it has been a busy morning and suggests that he rest. She also suggests that he listen to the first lesson on the audiotape at his bedside. She turns on the tape, shuts the lights and tells him that she will be back with his medication. The nursing assistant brings more ice in a cup and helps him get into a comfortable position. He falls asleep still angry and tense.

11:30 a.m. - The hospice volunteer brings Bill's lunch tray. They spend the next couple of hours together. The volunteer helps Bill eat. He is another lifer and they have other things in common so they spend easy time together. They talk about mutual friends and old times together. He or one of the other hospice volunteers visits every day. He can talk with them about the some of the things that really bother him about ending his time still doing time.

2:00 p.m. - The unit Correctional Officer and Nurse come and get Bill to attend the interdisciplinary treatment team meeting. He listens to the others describe his condition and current status and then answers their questions. They discuss how to dose the pain medication so that he is able to sleep more of the night. He agrees to try and maintain the schedule of activity during the day.

Bill had asked one of the Nursing Assistants to bring in a non-allergenic lotion. One of her co-workers noticed and pointed out that she was bringing in contraband. They brought the lotion to the Unit Charge Nurse and a disciplinary report was written on Bill. Since this is the second time in 30 days that Bill has sought this kind of favor from a staff member, the consequence for this violation is seven days loss of privileges. The Correctional Counselor points out to Bill that further rule violation will result in a return to prison. Bill is quiet since it's a pretty minor violation and he is just testing the staff.

2:30 p.m. - The nursing staff discusses Bill's rule violation during shift report. Staff are reminded about contraband and how to respond to inappropriate requests from patients. The Unit Nurse follows up with Bill and sees signs of an allergic skin reaction on his shoulders, hips and elbows. She notes the skin sensitivity on his care plan and indicates how to reduce the redness and itching associated with soap products.

4:00 p.m. - The Social Worker stops by Bill's room and comments that she remembers that he has no family. She asks if there are friends or acquaintances he would like to her to contact on his behalf. Bill shrugs his shoulders and says he will think about it. Privately he wonders about the people in his life; he is not sure how to approach them. As the Social Worker leaves she says that she will talk with him again after he has time to think.

Shortly after she leaves the Nursing Assistant brings his dinner tray. Again he is vaguely nauseated. The TV drones out his thoughts as he picks from among several small dishes of "easy-to-digest" foods.

6:00 p.m. - The loss of privilege sanction means that he will not be able to sit outside in the evening as he has done almost since he got here six weeks ago. This is the time of the day that he most enjoys because he can escape the sounds, smell and commotion of the unit and imagine that he is not dying.

8:00 p.m. - The Nurse brings his evening medication. The Nurse asks him to describe his pain, has him show her especially how the pain travels or is experienced, what makes it better or worse. She also asks him to describe his feelings of nausea, what makes it better or worse and so forth. They talk next about his sleep, hygiene and daily activity levels. She looks at the skin irritation caused by the soap.

Bill shows the Nurse the book and tapes provided by the Physical Therapist earlier in the day and comments that it is supposed to help him with anxiety and pain. The Nurse comments that she has seen other patients helped quite a lot with these exercises. She encourages Bill to work on the material.

7.6.2 Population Served

Like Bill, the population served by the hospice and palliative care program are patients with serious, terminal illnesses and their families. These patients are unlikely to recover or stabilize from end-stage dementia, terminal cancer, severe disabling stroke, and other catastrophic illnesses. For these patients, the predominant focus is pain and symptom control. Involvement of family members assists the patient with closure as well as symptom relief; it also reduces morbidity and mortality of family members associated with inadequate grieving.

Examples of patients with conditions appropriately referred for hospice and palliative care services include:

- Dementia with inability to eat or perform personal care
- Coma or vegetative state without expectation of recovery
- Strokes with marked paralysis, leading to inability to move, care for themselves or eat
- Terminal cancer after treatment failure
- End-stage lung disease such as emphysema
- Terminal stages of HIV/AIDS

7.6.3 Hospice Program Description

Hospice and palliative care are a series of services designed to aid patients like Bill and their families at the end of life. Hospice and palliative care includes:

- Providing humane assistance to manage the symptoms of the disease and preparing the patient and their family for the dying experience
- Meeting the needs of dying patients and their families in flexible and dynamic ways

- Providing continuity for each patient in care giving and planning across a continuum of settings and services
- Preparing the patient and family for the dying process and for death

Hospice uses an interdisciplinary treatment team to design care centered on the needs and desires of the patient and family. Physical needs of patients in hospice and palliative care are met by providing a safe, calming and comfortable place for dying, control of pain and other symptoms, psychological and spiritual counseling, personal care, information about the changes in physical condition expected over time, and bereavement services for the family after the patient's death.

Emotional needs include respect for the dying person's dignity, respect for the dying person's wishes, information about the emotional changes to expect, counseling to help the patient come to terms with their situation, assistance with advance planning for death, and attending to spiritual concerns. Social needs include companionship, maintenance of social functioning as possible, assistance in "telling one's life story" to others, help resolving broken relationships and taking care of other "unfinished business."

Medical treatment and direction is provided by a Physician and Nurse Practitioner; patient care is under the direction of a Registered Nurse. Also available are mental health counseling to address depression and adaptation during the dying process, spiritual care, and coaching in life closure, as well as information, education and assistance to make decisions and mediate funeral arrangements. Volunteers often supplement professional caregivers.

While in the example above Patient Bill is housed in the Hospice Unit, hospice and palliative care can be provided to patients throughout the facility. This is accomplished by hospice personnel working across settings and utilizing the Social Work Care Coordinator to ensure communication among providers.

7.6.4 Patient Goals

1. To decrease distress and pain associated with a terminal condition
2. To be assisted with ADLs during their physical decline
3. To be supported in the closure of life
4. To maintain dignity during the dying process
5. To connect with family and friends

PART VIII: DENTAL SERVICES

8.1 Population Served

The dental program provides services to the entire patient population within each CPHCF.

8.2 Levels of Care

Services are mainly the delivery of basic dental treatments (e.g. exams, fillings, extractions, dentures, and cleanings), but may also consist of specialty and consultative dental services of medical necessity.

8.3 Dental Program Description

The dental program includes regular examinations by a dentist, and provides a range of basic treatment services − oral surgery, restorative (fillings), periodontal (gum disease), removable prosthetics (dentures), and some limited endodontic treatment (root canal therapy). Essential to the program is the patient's ability to maintain his oral health through self-care (e.g. brushing and flossing).

Therefore, the dental program model is characterized as three-fold: prevention, treatment and maintenance. Prevention is emphasized through patient education and self-care. Treatment focuses on the resolution of oral disease at the earliest stage of disease progression. Lastly, the program supports the ongoing maintenance of acceptable oral health.

Care may depend on length of time remaining on a patient's sentence and oral hygiene status. Care is prioritized with emergent and urgent conditions treated before routine conditions.

8.4 Program Goals

1. The dental program is designed to promote, stabilize, and maintain the oral health of all patients within the CDCR.

PART IX: PHYSICAL MEDICINE AND REHABILITATION

9.1 Population Served

Physical medicine and rehabilitation in correctional health facilities encompasses a broad array of services. All inmates may, at some time or another, utilize physical rehabilitation services to treat neurological and musculoskeletal ailments including joint pain, soft tissue sprains and strains, post surgical weakness, and post traumatic complications, to name a few. However, the population groups within California's prisons that will benefit the most from PM&R include disabled inmates, aging inmates, and inmates with medical conditions that are referred to physical rehabilitation specialists. The following are several examples of common instances when inmates require PM&R services:

- Determining the proper shoes for a diabetic inmate
- Providing therapeutic exercises for inmates with chronic conditions such as cardiovascular disease or diabetes
- Training for use of a prosthetic leg for an inmate that allows him to live in the general population, instead of the prison infirmary, and to participate more fully in the programs and activities available for inmates
- Prescribing a specialized wheelchair for an inmate with paraplegia, quadriplegia or mobility impairment
- Determining appropriate aids and services for an inmate with a hearing or sight disability to participate in programming required for release
- Providing consultation and fall-risk reduction strategies for frail elderly inmates

According to "Aging Inmates: Challenges for Healthcare and Custody,"[43] elderly inmates face a number of potentially disabling conditions including vision and hearing impairments, incontinence, difficulties in performing activities of daily living, falling, pain, and contractures, among others. Most of these conditions can be improved through careful administration and coordination of physical rehabilitation concepts. Additionally, improving the health of inmates through physical medicine has added benefits in terms of preventing or slowing chronic disease and minimizing the burden of care on the inmate's custodians.

9.2 Physical Medicine and Rehabilitation Program Description

Patients access PM&R programs when referred by their Primary Care Physician for an individualized assessment from a Physiatrist, Physical or Occupational Therapist, Speech/Language Pathologist or Audiologist. Following the assessment, care plans are written with measurable goals and objectives that are based on the individual patient's social, cognitive, physical and emotional needs.

9.3 Skilled Therapies

Approximately 25 percent of all therapy provided in the health care facilities is to High Acuity medical patients who often require skilled therapy. Skilled therapy evaluations and treatments are provided by Licensed Physical or Occupational Therapists, or Speech Language Pathologists. According to Medicare Guidelines[44] there are three conditions that must be met in order to qualify as skilled therapy:

1. The services provided are of such a level of complexity and sophistication, or the patient's condition must be such, that the services required can be safely and effectively performed only by a qualified Therapist.
2. If the expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, the therapy would not be considered reasonable and necessary.

3. Expectations exist that the patient's condition will improve significantly and materially in a reasonable and generally predictable period of time or the services were necessary to establish a maintenance program required in connection with a specific disease state.

9.4 Restorative Care

Therapeutic Activity plays a key role in the physical rehabilitation of patients in both medical and mental health programs in the CDCR. In the context of physical medicine and rehabilitation, Therapeutic Activity programs are designed according to the needs of patients for carryover and follow-through of skilled therapy treatment. These programs are developed and monitored and implemented by Rehabilitation professionals.

The majority of patients receiving PM&R services – about 75 percent – will be provided therapeutic recreation in the form of restorative care. This type of care focuses on maintaining the functional capacity of the patient through routine exercise programs or programs that emphasize adaptive activities of daily living.

Examples of restorative care include helping an individual maintain his ability to walk with an assistive device, providing cueing for eating for a patient with swallowing difficulties, or providing daily range of motion for a patient with abnormal muscle tone due to a stroke. Planning for such programs is initiated either by a Nurse or a Licensed Therapist (such as a Physical, Occupational, or Speech Therapist). Programs are typically rendered at the unit level, although some patients might require specialized equipment that can best be provided at a central location (e.g., standing frames, parallel bars, aerobic training equipment). The prescribed activities usually take 15-30 minutes to perform and can also be provided to groups of up to four patients.

9.5 Specialty Services and Clinics

In addition to skilled therapies, a long-term care facility requires a number of specialty services and clinics, including: audiology evaluation and treatment, low-vision evaluation and treatment, wheelchair prescription and modification, and orthotics/prosthetics prescription and modification.

9.5.1 Audiology Evaluation and Treatment

According to the Abt Needs Assessment Report[45] six percent of the sampled population had known hearing loss. Onsite audiological testing at the new facilities will assure that all inmates with hearing impairments will have access to resources that can minimize the deleterious effects of hearing loss.

9.5.2 Low Vision Evaluation and Treatment

Fourteen percent of the sample inmate population in the Abt Report had significant visual impairments. This program provides adaptive reading devices, training in compensatory strategies and staff education.

9.5.3 Wheelchair Prescription and Modification

Up to 29% of the inmate sample in the Abt Report were noted to use wheelchairs as a primary means of locomotion. In a 1,500 bed health care facility, this means a minimum of 435 wheelchairs that require individual fitting, maintenance, cleaning, and repair. In addition, there is a segment of this population that requires specialized seating adaptations and prescription of electric wheelchairs.

9.5.4 Orthotic/Prosthetics Prescription and Modification

Many individuals in long-term care require either orthotics or prosthetics to augment functional capacity. Orthotics are either off the shelf or custom shaped devices that can support joints or limb parts. A typical example of an orthotic is a plastic molded ankle-foot orthosis that stabilizes the ankle in cases where there is a foot drop or loss of ankle stability. Prosthetics are used to provide an artificial body part in cases of amputation.

PART X: MENTAL HEALTH SERVICES

In the mental health program at the new facilities, patients have access to medical and dental services and participate in rehabilitation programs when feasible. Medical and nursing staff conduct patient rounds and also participate on mental health focused Interdisciplinary Treatment Teams as described in Section 3.1. Treatment is provided to patients in the Treatment Mall, the Diagnostic and Treatment Center or on the housing unit, as medically indicated.

10.1 Population Served

The CDCR Mental Health Program Guide specifies the population of inmates to receive treatment and/or monitoring in the mental health services delivery system within California's prisons. These include inmates with a serious mental disorder (e.g., schizophrenia, bipolar disorder, major depressive disorder) and inmates who have been diagnosed with or suspected of having a mental disorder that requires mental health intervention to protect life or treat significant disability or dysfunction.[46]

Inmates with these diagnoses and/or dysfunctions are eligible to become patients of the new health care facilities.

10.2 Treatment Programs

The guidelines for psychiatric services in correctional institutions, as developed by the American Psychiatric Association (APA)[47], define mental health treatment as the use of a variety of mental health therapies, biological as well as psychological, to alleviate symptoms of mental disorders that significantly interfere with an inmate's ability to function in a particular criminal justice environment. Generally accepted mental health practices and institutional requirements provide the structure for treatment, which is best approached in an interdisciplinary manner.

Guidelines include the following components:

- A crisis intervention program in a licensed Correctional Treatment Center bed for short-term treatment with 24/7 nursing staff coverage (usually less than 10 days)
- An acute care program with 24/7 nursing staff coverage
- An intermediate treatment program with 24/7 nursing staff coverage
- A residential outpatient program with separate housing, within the correctional setting, for inmates with chronic mental illness who may or may not require inpatient treatment but who do require a therapeutic milieu due to their inability to function adequately within the general population
- Outpatient treatment services
- Consultation services and training for non-mental health staff
- Reentry/transfer planning, including services for inmates in need of further treatment at the time of transfer to another facility or discharged to the community[48]

The following levels of care are consistent with the CDCR Mental Health Program Guide, which provide guidance regarding criteria for the following levels of care:

1. Correctional Clinical Case Management System (CCCMS)
2. Enhanced Outpatient Program (EOP)
3. MHCB (Mental Health Crisis Beds)
4. Inpatient care
    a. Acute
    b. Intermediate

How these levels of care are provided to patients is significantly influenced by their custody levels, which also often have an impact on staffing levels.

The course of a major mental illness in any clinical population is variable. This applies to correctional populations, as many patients stabilize relatively quickly following a psychotic episode, while others remain in partial remission for extended periods of time, while still others are chronically more symptomatic, requiring specialized environments throughout their incarceration. Fortunately, the majority entering MHCBs and inpatient treatment respond positively to psychotropic medication and psychological treatments and can successfully transfer to lower levels of care.

Many patients who are served in outpatient programs have less severe mental health problems, including psychotic, anxiety and mood disorders, which may be effectively managed with medication and monitoring. Others receive treatment at inpatient programs episodically due to their psychotic, behavioral, cognitive, and functional symptoms. With pharmacological, psychotherapy and structured clinical treatment, their symptoms can often be attenuated to the degree that they can function in EOP or CCCMS levels of care.

It is important to recognize the severity of the psychiatric disorders in patients who are referred to the in-patient levels of care, and to consider the range of medical, cognitive, and behavioral disorders which characterize this population, the majority of whom will eventually return to less restrictive levels of care.

10.3 Maintenance vs. Recovery

There are individuals with mental health care needs who, because of low functional status, cognitive impairments, poor symptom control, behavioral issues, etc., are able to make only minimal progress in treatment. The potential for these individuals to progress into lower levels of care, such as CCCMS, will be limited. While the goal of recovery is to assist them to maximize their level of functioning, they will likely require treatment modalities that are long term and supportive in nature.

10.4 Models of Care

10.4.1 The Community Mental Health Center Model

Thompson, Griffith and Leaf [49]provide an excellent review of the Madison Model of Community Care. The initial version of this model was based on the hypothesis that the community was a better place than the hospital for treatment of patients “difficult to discharge” from the hospital because the community was more likely to demand appropriate behavior, to contain healthy role models, and to allow skills training to be specifically targeted to patients’ day-to-day problems. The treatment model they developed centered on the following guidelines: teaching patients necessary skills for coping in the community; virtually abstaining from re-hospitalization; working with families and significant others to break pathologically dependent relationships; relating to patients as responsible individuals who were exposed as much as possible to the contingencies of community living; establishing close working relationships with a variety of community agencies; and assertively striving to keep patients from dropping out of treatment.[50]

After experiencing success with this model for the difficult-to-discharge population, the Madison model was later expanded to provide early, ongoing community-based care. Many of the treatment guidelines subsequently developed as the model evolved have been incorporated into the Recovery Model referenced in Section 10.4.4.

10.4.2 The Medical/Biopsychosocial Model

The medical model has evolved to include the biopsychosocial model. The biopsychosocial approach is interdisciplinary in composition, taking into account the patient's physical and mental health and social issues. The goal of this approach is to have the patient assume increasing responsibility for their recovery, moving from dependence to independence. In the biopsychosocial approach, treatment is facilitated by an IDTT comprised of clinical and non-clinical members involved in the care of the patient. This team, with the patient as a participant, identifies the patient's strengths and challenges for his recovery and proposes treatment goals, objectives, and interventions.

10.4.3 The Wellness and Recovery Philosophy

The wellness and recovery philosophy is a conceptual framework for understanding mental illness and provides a system of care that supports opportunities for personal development. Recovery emphasizes patients' ability to have control over their lives, even when they may not be able to have control over their symptoms. Recovery enables patients to recognize their strengths, talents, knowledge, skills and experience to improve the quality of their lives.

The road to recovery is a comprehensive one. Upon admission into the health care facility, the individual is assessed for patient-centered, interdisciplinary treatment services. Staff works to assist the patient in accepting responsibility for his own wellness in a strength-based manner that builds a person's self-sufficiency. The individual moves through the various treatment programs based on a series of re-assessments by staff conducting treatment plan reviews that identify relevant issues and interventions. Patients are encouraged to actively participate in their treatment planning as well as their actual treatment.

Accepting responsibility for his life is not only in the best interest of the patient, but also that of the society they will eventually re-enter. Preparing a patient for this transition is an important element of the Correctional Recovery Model (CRM) and a test of the system's ability to provide a comprehensive continuum of care.

Under the recovery philosophy in mental health, the health care provider's role is to assist individuals in reaching their goals towards recovery of effective functioning in the community through individualized treatment, symptom and medication education, coping skills development, and self-determination.

10.4.4 The Correctional Recovery Model

The Correctional Recovery Model (CRM) to be implemented in the new health care facilities incorporates many aspects of the community mental health center model, the medical/biopsychosocial model and most of the recovery philosophy. The CRM aims to address the individualized health care and rehabilitative needs of the patient in a recovery-focused, patient-centered program that is rehabilitative, safe and humane. The goals are to:

- Foster a milieu that is effective in addressing an individual's medical, mental health and rehabilitative needs
- Facilitate relapse prevention and re-entry services through the integration of service programs that include medical/mental health assessment, individual and group therapies/activities, education/training
- Enable return to the least restrictive environment consistent with custody classification if still incarcerated or successful community re-integration

It should be noted that a patient's recovery is rarely a linear process that allows clinicians and patients to simply move from one treatment model to the next. The level of mental health care may periodically be increased or decreased based on the patient's clinical needs. An individual may become more aware, self-sufficient, and involved in his own recovery; however, the need for medication often remains, as does the need to monitor the patient's physical and mental health status.

10.4.5 Program Structure

10.4.5.1 Interdisciplinary Treatment Team (IDTT)

The IDTT is a key component of the CRM within the mental health continuum of care. The composition of the IDTT is determined by the level of care (LOC) being received by the patient. IDTTs are comprised of multiple clinical and non-clinical members involved in the care of the patient, which may include the patient, Psychiatrist, Nurse, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Psychiatric Technician, Teacher, Correctional Officer, and other disciplines. Each person in the IDTT is responsible for assessing and analyzing any information gathered for his respective area of expertise and communicating that information to the whole IDTT and documenting the results in the patient's chart. The result is an individualized treatment plan that is based on the diagnosis, the patient's strengths and challenges, relevant history, symptoms, and goals of the patient and the IDTT for the patient.

The membership of the IDTT is based on the individual patient's needs, and is specifically configured as the patient moves through various levels of mental health treatment. Clinicians who have had responsibility for the patient are responsible to communicate with members of the subsequent IDTT to ensure that the patient receives consistent and appropriate care.

The Social Work Care Coordinator (see Section 2.4.2) follows the patient through all levels of medical and mental health care, and is a consistent member of the patient's IDTTs throughout that patient's stay in the facility.

A patient's programming is a critical component of his treatment plan. The programming offered in the inpatient units is more intensive than the programming required in the outpatient programs, which will have a strong rehabilitative and recovery focus.

10.4.5.2 Continuum of Care

The following principles are fundamental to the overall continuum of care:

- Incorporate the Wellness/Recovery philosophy as the foundation of service delivery
- Use components of the medical, biopsychosocial and community care models depending on level of acuity
- Employ consistent treatment programs across the continuum of care to provide for continuity of programming throughout all levels of care
- Employ consistent medication management
- Use an integrated case management protocol that provides for continuity across the continuum of care
- Have a uniform confidentiality protocol that meets legal and ethical standards

- Incorporate evidence-based, consistent psychological assessment/testing protocols that inform the individualized treatment plan and the IDTT
- Define treatment, rehabilitation and enrichment programs consistently across the continuum of care realizing differences in delivery based on acuity (this may assist with understanding staffing differences)
- Consistently apply criteria for placement into a general population or high custody setting based on recent behavior and clinical needs

10.5 Correctional Clinical Case Management System (CCCMS)

CCCMS is the lowest level of care provided to mental health patients. Clinical case management facilitates care by linking patients to needed services and providing sustained support. Clinical case management adds a clinical component based on a therapeutic working relationship between patient and Primary Clinician (PC) to the usual functions of traditional case management.

10.5.1 CCCMS Patients

In the new health care facilities, the target population for CCCMS is patients admitted for medical reasons, who additionally require mental health services. Medical treatment is provided as described in section 7.2.

Mental health treatment services are tailored to adequately meet the clinical needs of each individual patient considering the functional level, readiness for treatment, insight into mental illness, and motivation for treatment. A patient qualifies for these services if he has been diagnosed, perhaps provisionally, with a serious mental health disorder as described in the CDCR Mental Health Program Guide. In addition, patients meeting "medical necessity" criteria also qualify. Treatment under the medical necessity criteria is continued as needed, after review by an IDTT, for all patients for whom mental health intervention is necessary to protect life and/or treat significant disability or dysfunction in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT.

10.5.2 Patient Carlos

Carlos is 24 year old Hispanic man with uncontrolled Type II diabetes and renal problems who is serving a 13 year term on a first time Armed Robbery. He completed up to 7th grade in school and for several years received services from special education and Alta Regional Centers. He is considered to be a "slow learner," showing deficiencies in writing and reading skills, resulting in low TABE (Test of Basic Adult Education) scores at approximately the fifth grade level. He is functionally illiterate and has cognitive processing problems. While in the community, because of Carlos' medical conditions, he received Supplemental Security Income. He is good with his hands, i.e., fixing things, but has not been able to maintain employment either in prison or in the community due to his cognitive limitations. He has repeated episodes of "depressed moods" but not lasting longer than two days. He is currently receiving mental health services within the CCCMS level of care due to a diagnosis of Cognitive Disorder NOS and Mood disorder NOS on Axis I and Mild Mental Retardation on Axis II.

During Carlos's first two years of incarceration, he is consistently in trouble with staff due to his inability to follow instructions, arriving late to appointments and work, and also is bullied by other inmates. He has received rules violations for disobeying staff and mutual combat. He has spent much of his incarceration either in single cell, Administrative Segregation, or in Protective Custody housing.

Approximately three months prior to his release, Carlos experiences renal failure and requires ongoing dialysis treatment. He is referred and accepted for SGP housing at one of the new health care facilities. He has become wheelchair bound following the diabetes related amputation of his left leg. The referral requests that Carlos receive parole planning services and continued skill development related to his cognitive processing difficulties.

Prior to his transport date, clinical staff from the sending institution scheduled a continuity of care videoconference with the clinical staff at the new health care facility with Carlos present. At the videoconference, staff at the sending institution are able to present Carlos to staff at the new health care facility, discuss medical, mental health, parole needs, and identify his strengths and challenges. The sending institution also informs staff of any pending appointments and treatment services for Carlos and follows up with any requested documentation. The reasons for referral and requested outcomes are identified and documented. Orientation to the new facility is provided verbally to Carlos and documented.

Upon arrival at the new health care facility, Carlos is seen by a Physician for a medical assessment, given a brief mental health assessment by a clinician and is cleared for placement within the facility at the SGP level of care. Orientation to the facility is provided again verbally to Carlos and documented. Carlos is escorted to his new housing by a Correctional Counselor and a Social Work Care Coordinator.

At the new housing unit for SGP patients, Carlos is placed in a single room with the expectation he will be able to be re-assessed by the IDTT at a later date for possible inclusion into a double room or a four man dormitory. The SGP IDTT convenes to determine a preliminary individualized treatment plan. Rehabilitation services meets with Carlos within a short period of time after arrival to assess him for rehabilitation and re-entry services to address treatment goals related to his successful re-integration into society. During Carlos' stay, he is followed on a regular basis by the SGP IDTT and Social Work Care Coordinator along with the Rehabilitation Correctional Counselor in order to facilitate his individualized treatment plan for mental health, rehabilitation, and re-entry goals.

10.5.3 CCCMS Program Model

While the structure of correctional settings is conducive to facilitating clinical case management responsibilities, other factors including safety concerns that are inherent in correctional settings pose special problems for clinical practice. Treatment of patients with serious mental disorders is often complicated by dual diagnoses and behavior problems. Further, security considerations have to be appropriately considered in treatment plans and service delivery methods.

Psychiatrists, Clinical Social Workers (CSW), and Psychologists can function as Primary Clinicians (PC). Correctional Counselors (CC) provide case management for institutional programming with which CCCMS interfaces. In effect, each CCCMS patient will have both a PC and a CC working within the scope of their designated duties, as members of an IDTT to coordinate and deliver services.

Individualized treatment plans specify measurable treatment goals and objectives, address problems, prescribe intervention modalities including treatment frequency/duration, and identify the staff member responsible for providing services.

For less symptomatic CCCMS patients, tracking and monitoring of behavior and medication is often sufficient to meet this population's clinical needs. They are the group most likely to benefit from active involvement in institutional programming and require minimal contact with the PC. The primary clinical focus is on symptom management and medication monitoring.

For patients with significant psychological impairment, CCCMS provides more focused monitoring contacts with the PC, treating psychiatrist, and custody and correctional counseling staff to promote symptom management and prevent clinical deterioration. Individual and group psychotherapy and other supportive services are provided as clinically indicated.

Although scheduled at different intervals according to clinical needs, CCCMS patient monitoring entails regular assessments and treatment plan updates.

The goal of the CCCMS is to maintain and/or improve adequate functioning of mentally ill patients in the least restrictive treatment setting possible within each correctional setting. Doing so enables CCCMS to prevent the use of more expensive, intensive levels of treatment services. The CCCMS also helps maintain adequate functioning among the general population by providing crisis intervention to those experiencing situational crises.

CCCMS relies on both mental health staff and custody staff, as members of an IDTT working within the scope of their credentials and job descriptions, to provide the prescribed services to a patient suffering from a serious mental disorder. The CCCMS treatment philosophy supports the concept that patients with mental illnesses need comprehensive services to maintain adequate functioning in the general population. In addition to mental health treatment, services such as academic and vocational education programs are therapeutic and integral elements in a comprehensive treatment plan for CCCMS patients. This correctional-clinical model of case management requires custody and clinical staff to work in tandem, from the beginning, to assess the treatment and programming needs of seriously mentally ill patients and to ensure they receive the mental health and other services specified in their treatment plans.

10.5.4 Treatment Modalities for CCCMS Patients

Based on identified needs, in addition to prescribed medical treatments, mental health treatment modalities may include:

- Orientation and supportive counseling for institutional adjustment
- Medication review and monitoring
- Individual counseling and crisis intervention
- Group therapy such as anger management and relapse prevention
- Social skills training
- Consultation services, such as to education and work programs

- Clinical discharge and/or clinical pre-release planning

10.6 Enhanced Outpatient Program (EOP)

The EOP provides the most intensive level of outpatient mental health care within the Mental Health Services Delivery System (MHSDS). This program provides structured activities for mentally ill patients who, because of their illness, experience adjustment difficulties in a General Population (GP) setting, yet are not so impaired as to require 24-hour inpatient care. Although referred to as "outpatient," the program is characterized as residential treatment and is provided in a separate housing unit.

Some key critical components of this program include:

- A comprehensive array of mental health services delivered within the framework of an IDTT, which is composed of representatives from a cross-section of clinical disciplines as well as custody and rehabilitation staff

  Services include management of activities of daily living, group and individual psychotherapy, medication management, recreational therapy, and clinical pre-release planning.

- A designated housing unit with restricted access and alternative educational, work, and recreational opportunities

- Active interface with custodial staff, including Correctional Counselors (CC), which enhances the assessment and treatment process and optimizes patient functioning

10.6.1 EOP Patients

A patient qualifies for EOP services if he has a current symptom or requires treatment for a diagnosed Axis I serious mental health disorder (as delineated in the current Diagnostic and Statistical Manual, DSM-IV-R) or medical necessity related to mental illness.

An inmate must also meet the following specific treatment criteria to receive treatment at the EOP level of care:

1. Acute onset or significant decompensation of a serious mental disorder characterized by symptoms such as increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment; and/or

2. Inability to function in general population based upon one of the following three characteristics:

   a. A demonstrated inability to function in work or educational assignments, or other correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder

b. The presence of dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of a serious mental disorder

c. An impairment in the activities of daily living including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of a serious mental disorder

These conditions usually result in Global Assessment Functioning (GAF) scores of less than 50.

10.6.2 Patient Wayne

Wayne is a 31 year old male of Vietnamese decent committed to the California Department of Corrections and Rehabilitation (CDCR) for armed robbery from Los Angeles County. While this is his first incarceration as an adult, Wayne has spent half of the last 10 years in and out of Los Angeles County jail and mental health facilities. Most of his crimes, including his recent armed robbery, were committed to support a long-standing methamphetamine habit.

Wayne was born in Pasadena, California to a hard working, middle class family. He is the youngest in a family that includes three sisters and a brother. His parents, both born in Vietnam, came to the United States shortly before the war ended with the fall of Saigon. Wayne's father, who suffers from posttraumatic stress syndrome, was a Major in the South Vietnamese Army. When coming to this country, the parents worked in low paying jobs until they were able to start what is now a successful janitorial service.

The parents were strict with their children, pushing them hard to succeed in all their endeavors. Wayne's siblings all graduated from college; his oldest sister and brother obtained graduate degrees from the University of Southern California (USC). Wayne was an honor student throughout high school, as well as ranked among the top ten tennis players in California for boys 18 years of age and younger. His academic and athletic achievements earned him a four-year scholarship to the University of California at Los Angeles (UCLA). It was during his sophomore year at UCLA that his professors, tennis coach and family started noticing a drastic change in Wayne's behavior. He went from a dedicated student athlete, to someone who was quick to anger, socially isolated and routinely missed class and tennis practices. He eventually lost his scholarship and was terminated from UCLA before finishing his sophomore year.

Wayne's parents, with the help of his sisters and brother, sought to get him mental health treatment. By the time he was referred to county mental health, he was starting to hear voices and experimenting with drugs. He readily admitted that his drug of choice was methamphetamine. The county clinician was able to ascertain that Wayne's symptoms started some eight months earlier, shortly after finishing his freshman year at UCLA. The initial diagnosis was Schizophrenia, Paranoid type. His parents decided to have him placed in a private mental health facility in Pasadena.

Over the next ten years or so, Wayne's drug use increased dramatically, as did his stays in mental facilities and the LA County Jail. Until the recent armed robbery, he supported his drug habit by committing petty crimes, including shoplifting and selling stolen property. On two occasions he stole electronic equipment from his parents, selling the items for a fraction of the actual value.

He was arrested in Redondo Beach for trying to rob a pharmacy with a large butcher knife. Because he resisted arrest, the Redondo Beach PD had to employ a taser to subdue him. Wayne was ultimately found competent to stand trial and sentenced to 15 years in state prison.

Upon arriving at the North Kern State Prison (NKSP) Reception Center, Wayne was quickly diagnosed as having a co-occurring disorder of Schizophrenia and substance abuse. It was also determined that his daily use of methamphetamines resulted in what is commonly referred to as "Meth mouth." Wayne was at NKSP for before being transferred to the recently constructed new California Prison Health Care Facility (CPHCF) as an Enhanced Outpatient Program (EOP) patient. His medications, started at NKSP, have been continued at the CPHCF, as has his extensive dental care.

Wayne typically starts his day at 7:00 a.m. He takes about 45 minutes to take care of his personal hygiene needs. While he avoids large groups of people, he is willing to eat breakfast with other patients from his unit. After breakfast he takes his medications and attends group therapy at 8:30 a.m. in the Treatment Mall, along with three other patients from his unit. He has to be encouraged to participate and even then his responses are short and to the point; however, this is an improvement over his initial non-participation.

Every Tuesday at 10:00 a.m. he goes to a dental appointment. Although he has had several teeth extracted, most of his teeth were saved. He remains stoic during the dental procedures, seldom complaining of discomfort. His dental work will continue for at least another six months.

At noon Wayne eats lunch, followed by an hour or so of watching television. He enjoys watching sports, especially tennis, and cartoons. He has to be reminded that on Monday, Wednesday and Friday at 1400 hours he is to attend an arts and crafts class in the mall. He and several other patients are escorted to the class. Wayne likes to work with his hands, especially with clay. Recently he has shown an increased willingness to interact with other patients in this class.

On Tuesday and Thursday at 2:00 p.m. Wayne attends substance abuse counseling. He usually remains quiet in the session, but on more than one occasion has indicated that meth made the voices in his head.

If weather and time permit, Wayne will spend a half hour or so outdoors enjoying the fresh air. He will then be escorted back to his unit for dinner, which he eats promptly at 6:00 pm.. He has a healthy appetite and has put on about five pounds since coming to the CPHCF.

He watches television in the evenings or participates in board games. His social skills have definitely improved.

Once a week he participates in a Narcotics Anonymous meeting hosted by a community volunteer. As in his counseling sessions, Wayne remains relatively quiet during the NA meeting. On a monthly basis Wayne meets with his Interdisciplinary Treatment Team (IDTT). While he is in the early stages of his recovery, the members of the IDTT are encouraged by the progress he has made. He occasionally has hallucinations, but seems to understand they are a manifestation of his illness. The members of the IDTT have also been impressed with his medication adherence.

Wayne goes to bed at around 9:00 p.m.

10.6.3 EOP Program Model

EOP provides focused evaluation and treatment of mental health conditions that limit a patient's ability to adjust to a general population placement. The overall objective is to provide clinical intervention to return the individual to the least restrictive clinical and custodial environment. Some objectives of this program are to:

1. Provide short-to-intermediate term focused care (a range of three to 12 months in many cases) for patients who do not require 24-hour inpatient care

   Short-term treatment goals are primarily directed at developing constructive coping mechanisms, achieving treatment compliance, and further stabilization of psychiatric symptoms that are necessary for transition to the CCCMS level of care.

2. Provide longer-term placement for patients with chronic mental illness whose symptoms have stabilized, but whose level of functioning is insufficient to allow GP placement

   Supportive care, assistance with activities of daily living, recreational therapy, anger management, reality therapy, and programs related to symptom management and clinical pre-release planning are offered.

3. Provide short-term secure custodial placements with clinical resources that address behavioral problems for mentally ill EOP patients who are transitioning from Security Housing Units or Psychiatric Services Units (PSU)

   Treatment for these patients focuses on achieving behavioral control and the development of socially acceptable behavior.

10.6.4 Program Structure

The EOP patient has an individualized treatment plan that provides for treatment consistent with his clinical needs. Each patient is offered at least 10 hours per week of scheduled, structured therapeutic activities as approved by the IDTT. For some patients, 10 hours a week may be clinically contraindicated. For patients scheduled for less than 10 hours a week of treatment services, the Primary Clinician presents the case and recommended treatment

program to the IDTT for approval. The treatment plan must include a detailed description of the diagnosis, problems, level of functioning, medication compliance, and rationale for scheduling less than 10 hours. For these patients, the IDTT meets at least monthly and is responsible to review and increase the treatment activities or refer to a higher level of care if clinically indicated.

10.6.5 Treatment Modalities

Treatment activities that patients participate in are varied and include the following:

1. Group therapy and psycho-educational groups, provides patients with an opportunity to express, explore, and resolve issues with the assistance of clinical staff and other patient group participants who have similar problems or experiences. Psycho-educational groups focus on cognitive/behavioral skill building as a means of improving patient interpersonal skills and problem solving abilities.

2. Individual therapy provides patients with the opportunity to discuss personal problems that may not be adequately, or appropriately, addressed in a group setting.

3. Recreational and occupational therapies provide patients with supervised recreational activities or exercise programs designed to reduce stress, improve self-esteem and physical health, foster positive interpersonal interactions, and promote the constructive use of leisure time. Occupational or recreational therapy is counted as structured activity only if an appropriate clinician (an Occupational Therapist, Recreational Therapist, Licensed Psychiatric Technician, or other qualified professional) is present and supervising the activity. Unsupervised routine exercise should be available for all patients and is not counted as a therapeutic activity.

4. Work and educational programs may provide rehabilitative services through programming designed to help patients improve vocational and educational functioning. The treatment plan must indicate how it is believed the patient benefits from particular vocational and/or educational activities.

10.6.6 Treatment Activities

The EOP program may offer some or all of the following treatment activities, depending on the needs of the patient population and the resources available: Daily Living Skills, Medication Education, Symptom Management, Specific Mental Health Issues, Social Skills/Communication, Anger Management, Stress Management, Substance Abuse Group, Health Issues, Offense Specific Therapy, Rational Behavior/Reality and Decision-making, Family Issues, Therapeutic Community Meeting, and Clinical Pre-Release Group.

10.7 Enhanced Outpatient Program High Custody – High (EOP-H)

Enhanced Outpatient Program High Custody – High (EOP-H) is intended to provide services to individuals currently housed in CDCR Psychiatric Services unit (PSU) who require EOP level of care and also to inmates who require EOP level of care housed in CDCR Administrative Segregation Units (ASU) awaiting disposition of pending charges.

10.7.1 EOP-High Patients

Title 15 of the California Code of Regulations (CCR), Section 33359(a) states, "When an inmate's presence in an institution's general inmate population presents an immediate threat to the safety of the inmate or others, endangers institutional security or jeopardizes the integrity of an investigation of an alleged serious misconduct or criminal activity, the inmate shall be immediately removed from general population and be placed in administrative segregation."

EOP-High (EOP-H) was developed to deliver mental health services to individuals diagnosed as having a serious mental disorder and are serving a Security Housing Unit (SHU) term. The purpose of the EOP-H is to assure the effective delivery of EOP services to patients in a maximum-security setting.

10.7.2 EOP-High Program Model

The EOP-H provides a more secure environment than provided for patients in the regular EOP. Like regular EOP patients, the patients in the EOP-H are generally characterized by significant signs and symptoms of a serious mental illness; however, unlike their counterparts in the regular EOP setting, the EOP-H patients' behavior may manifest as anger, poor frustration tolerance, dysfunctional and/or disruptive social interaction, difficulty attending to, processing or following up on information presented, significant depression or mood changes, impulsivity, loss of control and poor judgment which may result in violent acting out and/or impairment of activities of daily living. For these reasons, programs must be tailored to meet their needs by taking into account patient and staff safety in the therapeutic setting.

The EOP-H housing unit is made up of two single-bed pods. Two or more EOP-H units form a cluster supported with treatment and support space. Most of the services provided to EOP-H patients take place in either their unit or cluster. Access to the Diagnostic and Treatment Center is determined on an individual basis. In all instances, EOP-H patient movement is under custody escort.

The EOP-H will provide a more controlled housing environment and programming for those patients who have demonstrated difficulty participating in treatment and who, due to behavioral issues, cannot be managed in a treatment program without increased security and behavior management techniques.

10.7.3 Treatment Modalities

Treatment modalities are similar to those described for EOP patients. However, while this population has the same treatment goals and objectives as the regular EOP patients, the program must take into account patient and staff safety. It is recognized this challenging population will require increased security and behavior management techniques.

10.8 Mental Health Crisis Evaluation and Stabilization (MHCB)

The MHCB is a licensed acute inpatient program that operates 24 hours a day, seven days a week. A patient admitted to the MHCB for mental health treatment may have acute symptoms of a serious mental disorder or may be suffering from a significant or life threatening disability. The length of stay is up to 10 days, with an average length of stay of eight days.

10.8.1 Patient Ed

Ed is a 60-year-old Caucasian man with Bipolar Disorder and is HIV+. Ed has been diagnosed with Bipolar Disorder, Mixed Episodes, for approximately 20 years and does well when he takes his psychotropic medication on a regular basis. Approximately 10 years ago he was diagnosed as HIV+ resulting from sharing needles during intravenous Heroin use. He is incarcerated as a result of a First Degree Burglary, after breaking into his parent's home 10 years ago. Since this was his third conviction of a serious felony, he is currently serving a life sentence. Even though his parents were the victims of his crimes, they have been supportive to Ed while he has been incarcerated.

Recently, his last living relative has passed away and he no longer has any family in the community and no support outside prison. Ed stopped taking his medications approximately six months ago and has been getting worse. He is currently deeply depressed, not taking any of his HIV medications and has expressed an interest to other inmates in no longer living and has stopped eating for the last two days. He continues to drink water, but only at the insistence of staff. Staff has referred Ed to the new health care facilities to the MHCB for assessment and stabilization of his psychiatric symptoms. He has been accepted for treatment by the new health care facility staff

Prior to Ed's transport date, clinical staff from the sending institution scheduled a continuity of care videoconference with the clinical staff at the new health care facility with Ed present. At the videoconference, staff at the sending institution presents Ed to staff at the new health care facility, discuss medical, mental health, substance abuse issues and identifies his strengths and challenges. The sending institution also informs staff of any pending appointments and treatment services for Ed and follows up with any requested documentation. The reasons for referral and requested outcomes are identified and documented. Orientation to the new facility is provided verbally to Ed and documented.

Upon arrival at the new health care facility, Ed is seen by a Physician for a brief medical assessment. Once he is medically cleared, he is placed into a MHCB designated for male patients. Upon admission, before Ed is taken to his housing, the psychiatrist, along with the

Nurse, takes vital signs, and completes an assessment for suicide and psychotropic medication. Within 24 hours, the IDTT, including Ed, convenes to provide a preliminary assessment for suicidal ideation and behaviors, mood disorder and co-occurring substance abuse treatment goals, and develops an individualized treatment plan to address his medical and mental health issues. Nursing staff develop a Nursing Care Plan to address Ed's medical and mental health issues. Ed is placed in a single room with a safety smock, along with appropriate suicide precautions.

After Ed spends eight days in the MHCB, the IDTT determines that he would benefit from further assessment, evaluation and stabilization of his medical and mental health needs and is referred to the APP. A member of the MHCB IDTT meets with a member of the APP IDTT prior to admission to provide continuity of care for Ed. Upon admission to the APP, Ed is assessed by the APP psychiatrist and nursing staff. Ed is seen within 72 hours by the APP IDTT and an individualized treatment plan is developed for him to address mental health and co-occurring substance abuse, medical, social, and rehabilitation services during his stay within the APP. The APP IDTT also provides information to the health care facility's Social Work Care Coordinator to facilitate communication and consistency in treatment planning.

The MHCB provides evaluation, stabilization and referral services for patients who show marked impairment and dysfunction requiring 24-hour nursing care and/or are a danger to self or others as a consequence of a serious mental disorder.

10.8.2 MHCB Program Model

The Clinical Director or designee is responsible for the prompt care and treatment of patients admitted to the MHCB, development and implementation of a treatment plan, completeness and accuracy of the health record, necessary special instructions, and transmitting reports of the patient's condition consistent with CCR, Title XXII, Division 5, Chapter 12. A patient admitted to the MHCB will be provided the following services and treatment:

- Medication Evaluation and Management
- Nursing Care
- Crisis Therapy and Counseling
- Rehabilitation Therapy
- Aftercare Planning and Referral

Because the MHCB length of stay is for up to ten days, planning for follow-up services begins shortly after the patient is admitted. A patient who is stabilized typically is returned to a lower level of care. A patient who clearly requires longer-term care may be referred and transferred to an inpatient acute care hospital.

Studies show that 75 percent of MHCB patients stabilize and return to a lower level of care, and that 25 percent of the patients require transfer to a higher level care. The goal in the new facilities is to maintain or improve upon these percentages.

10.8.3 Program Structure

The MHCB is a component of the Correctional Treatment Center (CTC) license as defined in Title XXII, Division 5, Chapter 12. The MHCB within the CPHCF will operate 24 hours a day, seven days a week. The specific objectives of the MHCB are (1) to observe, monitor and provide continuous nursing assistance to patients whose conditions require around the clock services to achieve stabilization; (2) to assess the patient's symptoms, formulate a provisional or differential diagnosis and develop the initial treatment plan; (3) to control symptoms of serious mental disorders, using medication as needed; (4) to alleviate psychiatric distress with appropriate therapy or counseling; (5) to refer the patient for placement in the appropriate level of care; and (6) to provide an alternative to long-term hospitalization for patients whose condition allows placement within 10 days to a less intensive level of care.

PART XI: INPATIENT MENTAL HEALTH SERVICES

11.1 Intermediate Care

11.1.1 Intermediate Care Facility (ICF) Program

The Intermediate Care Programs (ICP) will be delivered in two facilities with inpatient care available for males and females. Both of these programs will be licensed under the respective health care facilities. An intermediate care facility operates and has nursing staff available 24 hours a day, seven days a week. A patient admitted to intermediate care for mental health treatment will have chronic and severe symptoms of a serious mental disorder, may be suffering from poor or non-existent coping skills, exhibit poor self-care as related to the patient's mental illness, and have repeated acute hospitalizations. The ICF is the lowest inpatient level of care, and is intended for patients who need longer and more comprehensive psychiatric, habilitative and rehabilitative treatment for chronic serious mental disorders. The average length of stay is from six to eight months.

11.1.2 Intermediate Care Facility Patients

The Intermediate Care Facility provides evaluation, treatment and referral services for patients who show psychiatric impairment and dysfunction requiring 24-hour nursing care as a consequence of a serious mental disorder. Intermediate care patients are those who are psychiatrically stabilized and capable of a more comprehensive treatment program.

The typical patient's clinical picture is one of an inadequate, poorly coping, functionally compromised and vulnerable population with varying degrees of psychotic acuity (the preponderance being at the chronic level). As described by the California Prison Receiver's mental health subject matter expert, Roger Smith, Ph.D.:

> "A typical IP admitted to these programs has an Axis I major mental illness, a co-occurring Axis I Substance Abuse Disorder, an Axis II Personality Disorder, a history of suicidality, violence, sexual offending, and prior sexual abuse, a history of self-injurious

behavior, indications of neurological injury, and significant cognitive deficits which endangers them and others in a general population environment. The majority of these are single, increasing numbers of them are incarcerated for murder, and the number of 'Lifers' has increased since the 2005 survey from 11% to 35%."[51]

ICF patients' social skills and social adaptation behaviors are underdeveloped. Chronic impairment in areas of reasoning, decision-making, accurate reality testing, self-care, and appropriate choices are common in this population, as is susceptibility to stress and environmental change. Abilities and rates of adaptation are compromised. Based on these characteristics, the ICF provides treatment modalities focusing on:

- A structured environment with comprehensive clinical staffing levels
- Psychotropic medication adjustment and maintenance
- Psycho-educational therapy modalities, including, but not limited to, Relapse Prevention, Symptom Management, and Coping Skill Development

  These include therapies facilitating development of an understanding of mental illness and the symptoms of decompensation, including precursors and warning signs specific to the individual patients. The program also includes modalities aimed at developing and monitoring implementation of adaptive patterns of social behavior.
- Psycho-educational modalities to enhance the patients' capabilities in maintaining psychiatric stabilization and maximizing functioning

  These include understanding the need for medication and possible side effects as well as effective use of clinical resources and supportive services available outside an inpatient setting.
- Therapy focusing on understanding and modifying substance abuse behaviors

  Ideally, these incorporate psycho-educational, mutually supportive/directive, and relapse prevention approaches.
- Ancillary and supportive therapies aimed at acquiring skills in adaptive living such as those provided by the rehabilitative therapies

  These include recreational, art, music, and occupational therapies.
- Academic instruction, which includes remedial literacy programs, designed to increase the patient's reading and writing skill
- Discharge planning

  By statute all patients return to CDCR from DMH, with some of those patients returning to the community. Discharge planning will need to address both options. This will require therapy and planning at the group and the individual levels.

11.1.3 ICF Program Model

The DMH Program Medical Director or designee is responsible for the prompt care and treatment of each patient admitted to the ICF, development and implementation of a treatment plan, completeness and accuracy of the inpatient record, necessary special instructions, and transmitting reports of the patient's condition consistent with California Code of Regulations (CCR), Title XXII, Division 5, Chapter 2 (or 12). A patient admitted to ICF is provided the following services and treatment as determined by the Interdisciplinary Treatment Team (IDTT): Licensed Clinical Assessment, Medication Evaluation and Management; Nursing Care; Therapy and Counseling; Rehabilitation Therapy; Psychological Assessment, Positive Behavioral Support Services, and Aftercare Planning and Referral.

The ICF is guided by the biopsychosocial rehabilitation model and recovery philosophy. This model recognizes the interrelationship of factors that contribute to mental illness, including brain impairment, intrapsychic abnormalities, and environmental, situational and social factors. The treatment approach is designed to address each of these areas, through psychopharmacology, group and individual therapy, and the program's structure and milieu. The theoretical framework of non-pharmological treatment interventions is primarily cognitive-behavioral.

Treatment is provided through the use of an IDTT typically consisting of a Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Nurse, and Custody staff.

Both programs will offer many hours of therapeutic/rehabilitative, assisted daily living, and enrichment programs. The average amount of therapeutic programming offered to a patient ranges from seven to eight hours per day with at least two to three different types of programs each hour. On the weekends, patients are offered primarily ADL and Enrichment types of therapeutic programming. The total number of planned therapeutic programs amounts to approximately 35-40 hours each week. The goal is to provide 25-30 hours of therapeutic and rehabilitative programming per week. As a result of inevitable interruptions of the scheduled program, i.e., lockdown, admissions, refusals, emergencies, etc., the program hours scheduled must be at least 25 percent more per week than the target goal in order to assure a minimum level of hours actually provided to each patient. Therefore, in order to achieve the goal of 25-30 hours, approximately 35-40 hours each week must be scheduled.

11.2 Acute Inpatient Psychiatric Evaluation and Stabilization Program (APP)

The APP is a licensed acute inpatient program, operating 24 hours a day, seven days a week. The APP provides acute mental health care to all patients admitted and is the highest level of care for patients who need longer and more comprehensive evaluation and treatment for serious mental disorders.

A patient admitted to APP for mental health treatment will have acute symptoms of a serious mental disorder or will be suffering from a significant or life threatening disability. Patients admitted to the APP are anticipated to be stabilized and referred within 45-60 days to a lower level of care.

11.2.1 Acute Psychiatric Program (APP) Patients

The APP provides evaluation, stabilization and referral services for patients who show marked impairment and dysfunction requiring 24-hour nursing care and/or a danger to self or others as a consequence of a serious mental disorder. Generally, the majority of acute psychiatric patients have not been stabilized within a ten-day length of stay in the MHCB program.

11.2.2 APP Program Model

The Medical Director or designee has overall responsibility for the prompt care and treatment of each patient admitted to the APP. This includes the development and implementation of a treatment plan, completeness and accuracy of the inpatient record, necessary special instructions, and transmitting reports of the patient's condition consistent with CCR, Title XXII, Division 5, Chapter 2 (or 12). A patient admitted to APP is provided the following services and treatment as clinically appropriate:

- Licensed clinical assessment including medication evaluation and management
- Nursing care
- Psychological testing
- Therapy and counseling
- Rehabilitation therapy
- Positive behavioral support services
- Aftercare planning and referral

Planning for discharge begins at admission. A patient who is psychiatrically stabilized is assessed for referral to an Intermediate Treatment Program as determined by the IDTT, and if not found clinically appropriate, discharged to the most appropriate level of care, which in most cases is the EOP.

11.2.3 APP Program Structure

It is anticipated that the APP program in the new facilities will be developed based on best practices in the correctional setting and the experience of current APP treatment within CDCR. Currently, DMH provides licensed acute inpatient psychiatric services under contract to CDCR at the California Medical Facility. Patients are referred to APP from the 33 prisons within the CDCR, county jails, and state hospitals for evaluation, stabilization and treatment of serious mental disorders.

In the State of California, because an APP is an acute inpatient psychiatric treatment program it must meet the licensing standards set forth in the CCR, Title 22, Division 5, Chapter 2 (or 12). These standards are reflected in the policies and procedures outlined in the CDCR Mental Health Program Guide, which includes an acute level of care as part of the continuum of care.

Each patient admitted to the APP receives an individualized evaluation and treatment plan developed by the IDTT within 72 hours of admission. Discharge planning for movement to a lower level of care also begins with the 72-hour treatment team conference and is included in the treatment plan.

The treatment plan and the patient's progress are reviewed at ten days after admission and updated every thirty days thereafter, or at any time there is a change in the patient's condition or treatment needs. The patient's progress is documented in the medical record. Patients, who have been clinically discharged, but not yet transferred, continue to receive all services appropriate to their clinical needs until they transfer out of the program.

11.2.4 Program Goal

The overall goal of the APP is to fully remit or significantly reduce the symptoms of a presenting psychiatric illness, while providing education and guidance in developing basic coping skills. The primary goal of the APP is to identify and provide a successful transition to the most appropriate level of care for the patient. A particular emphasis is placed on diagnosis and evaluation, including thorough psychiatric and internal medicine examinations, psychological and neuropsychological testing, nursing assessment, social history evaluation and rehabilitation therapy evaluation. Diagnosis and evaluation is an ongoing process that continues throughout the patient's hospitalization. Positive Behavioral Support (PBS) services are provided to all patients identified by the IDTT as needing reinforcement in adopting positive pro-social and healthy behaviors. Any patient who is identified by the IDTT as a candidate for PBS receives intensive assessment in order to determine optimum functioning levels and appropriate incentives for change.

11.2.5 Treatment Approach

The APP is guided by the biopsychosocial rehabilitation model and the recovery philosophy. This model recognizes the interrelationship of factors that contribute to mental illness, including brain impairment, intrapsychic abnormalities, and environmental, situational and social factors. The treatment approach is designed to address each of these areas, through pharmacotherapy, group and individual therapy, and the program's structure and milieu. The theoretical framework of non-pharmological treatment interventions is primarily cognitive-behavioral.

PART XII: CORRECTIONAL REHABILITATION

Rehabilitation Services is responsible for providing evidenced-based rehabilitation program opportunities for patient-inmates in the new health care facilities. State mandated rehabilitation programs developed for the facilities will be designed to improve outcomes, reduce recidivism, and will be based on the individual patient's needs. Program designs and delivery systems will be created consistent with the core program values. Elements of the new rehabilitation model will include an evidenced-based risk and needs assessment completed for

each patient upon entry into the facility. The specific programs offered will target the patient's criminogenic needs and include vocational training, education, substance abuse treatment, life skills, faith-based programs, re-entry preparation and transition services. Rehabilitation programs will also support the patient's pro-social development and provide recreational activities that support the wellness and recovery of the patient.

All patients at the health care facilities are eligible for participation in rehabilitation programming. However, each patient's physical and mental abilities and individual needs and treatment plan will determine participation.

As noted in Section 2.4.1, a Rehabilitation Correctional Counselor is assigned to a patient upon entry into the facility.

The primary role of the Rehabilitation Correctional Counselor is to complete the traditional duties related to classification, custody, re-entry. In addition the Correctional Counselor prepares a custody a risk and needs assessment and, along with other members of the IDTT, monitors the patient's Individualized Treatment and Rehabilitation Plan (ITRP).[52] The Rehabilitation Correctional Counselor also works with the Social Worker Care Coordinator related to the patient's re-entry and release planning and support.

The Correctional Rehabilitation Program includes Academic and Vocational Education, Substance Abuse, Case Management and Reentry, Visiting, Library and Law Library, Physical Activity and Art/Hobby Programs. National research has shown that adult basic education programs can reduce recidivism by 9%, post secondary education by 13%, and vocational education by 9%. Additionally, in-custody substance abuse programs with community aftercare can reduce recidivism by 5.7%. It is anticipated that the Rehabilitation Programs offered at the new facilities will meet or exceed these national averages, and that across all rehabilitation programs, recidivism will be reduced by 10 percent for those patients who will parole. All of the Rehabilitation Programs offered are evidence-based programs that either reduce recidivism and/or improve patient behaviors, support pro-social development and reduce the likelihood of patient violence. All rehabilitation programs will be delivered in a manner that supports the core values and mission of the facility.

Each program is described below.

12.1 Education: Academic and Vocational

Penal Code (PC) 2053.1 requires an inmate literacy level of 9th grade or greater and required CDCR to have programs available to 60 percent of eligible inmates by January 1, 1996. The facility's educational programs will meet this PC requirement.

The education delivery model is a patient-centered, distributed education delivery system incorporating both direct instruction in traditional classroom settings as well as in the housing unit, clusters and e-learning zones. Delivery methods include asynchronous (structured learning over a single transmission line to a single site or terminal), synchronous (simultaneous instruction to multiple sites) and computer-aided instruction. This distributed education model

will allow the various specialized populations, not all of which are able to receive instruction in a traditional classroom setting because of physical, mental or behavioral limitations, to participate and benefit from the programs offered.

Assessments will determine individual patient needs and measure critical grade-level gains in student proficiency. The goal is to ensure a minimum of 60 percent of the eligible population is offered literacy programs, and the remaining population is offered other academic and vocational programs that address their criminogenic rehabilitative needs as identified in their assessment and meet statutory requirements and national standards.

12.1.1 Program Structure

The educational model will employ multiple methods of course delivery, all designed to meet the needs of the specialized populations that will be housed at the health care facilities, which include patients with both medical and mental health issues. Secondary education specific assessments will be administered to patients that measure their educational needs. The educational model provides three shifts for academic programs, a morning, afternoon, and evening program, and two shifts, morning and afternoon, for vocational programs, which will accommodate other aspects of the patients' health care needs and individual treatment plans. This strategy has the added benefit of increasing capacity. In their February 2008 report[53], the California Legislative Analyst Office reported that the single most significant way to increase capacity at little or no cost was to place inmates in education programs for half days. E-learning zones will also be offered on-unit in the housing and quiet room areas. Education Services will also be offered in the housing cluster and at bedside for those patients who cannot travel to the Treatment Mall.

The model will also include an evaluation component to evaluate the program's efficacy and measure the outcomes to ensure program fidelity.

12.1.2 Delivery Methods

Direct Instruction

Core academic and vocational courses delivered in classrooms within the Diagnostic and Treatment Center by fully certified and licensed teachers and vocational instructors and instructional aides. Core Academic classes will also be offered at the bedside or on the unit/cluster for the EOP High and High Acuity Patients.

Asynchronous

Instructional delivery over a single transmission line to a single receive site or terminal, designed to be delivered both in classrooms and in on-unit learning zones. Learning in this modality is structured, individualized, and can be both diagnostic and prescriptive.

Synchronous

Simultaneous instruction from a single point within the technology infrastructure of the facilities, to one or multiple other facilities with guided discussions in real time. This delivery method will include satellite (students participate in live or recorded broadcasts together), videoconferencing (each room has a camera, a large-screen monitor/TV, and push-to-talk microphones; camera and voice transmission switches to the room or area currently speaking automatically unless otherwise dictated), and/or web-based platforms (independent learning simultaneously taking place with other students).

Computer-Aided Instruction

Options for on-unit learning zones include using stand-alone computers with DVD libraries and/or networked labs that deliver a range of educational services using products such as Aztec, PLATO, NovaNET, WebCT, and other types of software or delivery solutions.

12.1.3 Patient Goals

Assembly Bill 900 adds Government Code Section 15819.40(a)(1)(B)(2) which requires that any new beds constructed pursuant to AB 900 be supported by rehabilitative programming for inmates, including, but not limited to, education, vocational programs, substance abuse treatment programs, employment programs and prerelease planning. While the new facilities are not constructed pursuant to AB 900, the Receivership has determined that rehabilitative programming consistent with the requirements of AB 900 will be offered at the new facilities and created a Rehabilitation Services Advisory Council to provide expert advice on the design and development of rehabilitative programming including substance abuse treatment. AB 900 further adds Penal Code 2054.2 requiring CDCR to determine and implement a system of incentives to increase inmate participation in, and completion of, academic and vocational education, consistent with the inmate's needs as identified in an assessment.

The goal is to ensure a minimum of 60 percent of the eligible population is offered literacy programs - Adult Basic Education, High School, GED, Post Secondary - and the remaining population is offered Life Skills, English as a Second Language, and vocational programs that meet these standards. Additional goals include increasing literacy levels to support community transition and a reduction in recidivism.

12.2 Law Library

Patients have a right to have access to use law libraries and legal resources to prepare petitions to the court. Therefore, an appropriate law library and other supplies and services related to legal matters will be provided. The law library includes, at a minimum, relevant and up-to-date constitutional, statutory, and case law materials, applicable court rules, and practice treatises. When an inmate is unable to make meaningful use of the law library on his or her own, the additional assistance necessary for effective use is provided.

12.2.1 Program Structure

The model includes an electronic law library. Technology exists that allows patients, even those with no computer experience, to research every type of legal data that must be available to inmates. For those patients who are bed-ridden and unable to access the on-unit terminals or the central electronic law library, a Library Technical Aid can provide assistance. The law library is available eight hours a day, seven days a week.

12.2.2 Patient Goals

1. To provide all patients access to law library materials
2. To ensure the constitutional right to access to the courts is supported by an exemplary law library access program

12.3 General Library

Libraries are an effective tool for patient management, provide valuable recreational activity and an incentive to learn, provide information to aid patients in rehabilitation efforts, and provide teachers and students with materials and instruction on their use.

The general library will be used by patients to prepare for return to the community, succeed in GED and vocational classes; apprenticeships; take college courses; attend special programs and book discussion groups to encourage pro-social behavior; check out books for recreational reading; get information for decision making for self and family; and, keep up-to-date on current events. Specialized library materials and equipment will be available to accommodate the needs of patients with disabilities.

12.3.1 Program Structure

Patients will access library services by either visiting the physical location on the Treatment Mall, or by use of an ordering system for patients who are not ambulatory. Additionally, book carts will be available on the housing units. The library will be structured in accordance with American Correctional Association Guidelines which recommend comprehensive library services that include, but are not limited to, a reference collection containing general and specialized materials, and planned and continuous acquisition of materials to meet the needs of staff and inmates.

Materials will be available that support patient recovery programs, the rehabilitation programs offered in the facilities, as well as information on community resources, parenting skills, occupations, job opportunities, resume writing, interviewing skills, educational and vocational training opportunities on the outside, housing, welfare, banking skills, etc.; and materials that support basic health information on common diseases, conditions and health concerns, and faith-based program materials.

12.3.2 Patient Goals

1. To meet the educational, informational and recreational needs of the patient population through the provision of well-balanced collections of library resources

12.4 Physical Activity and Arts/Hobby Program

The primary purpose of Physical Activity services is to restore, remediate or rehabilitate in order to improve patients' functioning and independence as well as reduce or eliminate the effects of illness or disability.[54]

Physical Activity channels a patient's energy therapeutically; energy which if left undirected might otherwise result in more destructive activities, thus enhancing the safety and security of all. In addition, structured leisure and socialization training assist in maintaining cognitive engagement and in rebuilding basic social skills often impaired by serious mental illness, which are required for successful functioning in community and general population settings. This program is available for medical and mental health patients who are interested in participation in recreational programs and are physically and mentally able to participate.

12.4.1 Program Structure

The program provides physical activity and leisure activities designed to meet the social, physical, psychological, and overall activity needs of the patient population and is available seven days a week. The model includes agility-appropriate sports, games, arts and hobbies.

Consistent with the model of patient centered care, each patient referred by the IDTT for a physical therapy assessment will receive an individualized assessment. Staff will be responsible for developing individualized care plans with objective and measurable outcomes. Physical Activity staff are an integral part of the interdisciplinary team and will be expected to contribute towards the overall Rehabilitation Plan.

12.4.2 Patient Goals

1. To encourage patients to make constructive and socially responsible use of leisure time by providing all patients access to a range of recreational activities

12.5 Faith Based Program

California Penal Code Section 5009 provides that all state prison inmates shall be afforded reasonable opportunities to exercise religious freedom. The California Department of Corrections and Rehabilitation (CDCR) is responsible for making reasonable efforts to ensure that the religious and spiritual needs of the inmate population are met (Title 15, California Department of Corrections and Rehabilitation, Section 3210, Establishment of Religious Programs).

The opportunity to practice a faith is paramount to the development of spiritual strength and viability; the practice of faith in a group setting also helps to break down and alleviate the racial divide that is so common within the correctional setting. The opportunity to engage in a holistic worship experience offers the patients a vehicle to move beyond the areas of incarceration that may have caused them to be confined in the correctional facility. The proper practice and embrace of the worship experience can and may lead to the breaking of the cycles of spiritual, emotional, moral and generational incarceration. As these bonds of incarceration are broken, we find the recovery becoming visually and inherently evident in the lives of the patient-inmate population.

While inmates often worship as individuals, they also frequently do so within the structure provided by the programs of religious groups and denominations tending to the incarcerated. Nearly all correctional facilities provide support for at least the Abrahamic religions: Christianity, Islam and Judaism. Chaplains, volunteers and other representatives of these groups may organize religious services as often as daily in large prisons, while also providing pastoral care to inmates and staff.[55] Faith based staff will include Protestant, Jewish, Muslim, and Catholic Chaplains and a Native American Spiritual Leader.

It is anticipated that all patients in the new facilities will be given the opportunity to participate in Faith Based services, although it is understood that a portion of the population will not be able to attend formal Chapel programs.

12.5.1 Program Structure

Upon entering the facility, each patient will be given a Faith Preference Handbook. In this handbook, each patient will be given a Faith Preference Survey. The handbook will describe the Faith Based Eclectic Community, the schedule of programs, how to sign up for services, and the resources that are available to them. Based on the findings of the patient survey, the patient will then request to be added to the list of participants of their desired worship experience.

The Chapel Program will be available at the chapel for ambulatory patients and in groups on the housing units for non-ambulatory and high custody patients. Patients needing hospice or dementia care will receive ministerial visits on an individualized basis. Services will consist of reading scriptural text to the patients, the loaning of worship music and teaching material, both audio and printed.

12.5.2 Program Goals

1. To provide a spiritual environment for patients within the framework of a new patient-centered, holistic model
2. To build a community that is conductive to the development of an environment of healing
3. To provide patients with access to a variety of faith-based programs
4. To afford all patients the opportunity for communal religious and spiritual services; and

the development of an eclectic community of worship

12.6 Visiting

An analysis of the effects of visitation on two-year recidivism rates, using information on 7,000 Florida Department of Corrections inmates, found that "visitation and the amount of visitation reduce recidivism. Specifically, among inmates who were visited, the odds of recidivism were 30.7 percent lower than the odds for those who were not visited. The amount of visitation was also associated with reduced recidivism: For each additional visit an inmate received, the odds of recidivism declined by 3.8 percent."[56]

All patients of the new facilities with families and friends who wish to visit will be able to do so. The visiting model will employ a variety of visiting options in order to ensure maximum flexibility and the most opportunities for family reunification for the specialized populations. This patient-centered model allows the various specialized populations, not all of which would be able to receive visits in a traditional visiting room setting because of physical, mental or behavioral limitations, to participate and benefit from family reunification. Contact and video visiting options will be available at all of the facilities.

12.6.1 Program Structure

Onsite visiting is available three days a week in rooms equipped with audio/visual surveillance for monitoring and recording visits.

On-unit visiting is available to those patients too ill to move to the general visiting area, such as hospice, high acuity and dementia patients. Appointments will be made on a case-by-case basis. Hospice visiting will be available seven days per week.

Online Visits can be prescheduled using an automated, self service system that allows potential visitors to register and schedule visits online and will be available 24 hours a day, seven days a week.

Non-Contact Video Visiting is only available for patients with medical issues requiring isolation, and patients with severe mental illness and/or behavioral problems. To facilitate video visiting, video-visiting terminals will be available on each housing unit as part of the e-learning zones.

Transportation Services for the families of the female patients will be provided to the facility housing women patients in order to facilitate visiting for this population, which will only be housed in one location in the State.

The Offsite Visitor Center will provide assistance with transportation between public transit terminals and prisons, child care for visitors' children, emergency clothing, information on visiting regulations and processes, referral to other agencies and services, and a sheltered area outside of the security perimeter for waiting before or after visits. Visitor Center services will be shared where facilities are co-located with existing CDCR institutions.

12.6.2 Patient Goals

1. To provide ample visiting opportunities to strengthen patients' community and family ties
2. To diminish the likelihood of recidivism through stronger connections to people in the community

12.7 Substance Abuse Treatment and Prevention

Substance abuse is a serious problem for inmates in California's prisons. According to the Department of Corrections and Rehabilitation, more than 36,000 of the state's 172,500 inmates—21 percent of the adult prison population—are serving prison terms for drug offenses. A recent University of California study estimated that 42 percent of California inmates have a "high need" for alcohol treatment and 56 percent have a high need for drug treatment.[57] The California Office of the Inspector General issued a report in 2007 stating that "Effective in-prison substance abuse treatment and aftercare may represent one of the State's best hopes of reducing criminal behavior, decreasing recidivism, helping relieve the State's prison overcrowding crisis and lessening the cost to society of criminal activity related to drug use and addiction."[58]

12.7.1 Patient Javier

Javier is a 43-year-old Hispanic male, a parole violator committed with a new term, serving 18 months for possession of a controlled substance with intent to sell. He has been transferred from a CDCR prison due to a prescribed lengthy wound recovery and physical rehabilitation period from an amputation, a byproduct of his chronic diabetes. Due to his medical condition, his level of care in the facility will be Low Acuity. Upon arrival at the CPHCF, an initial medical, mental health, dental and rehabilitation screening are done. He is introduced to his assigned Rehabilitation Correctional Counselor I and Social Worker Care Coordinator, who escort him to his assigned housing unit in the Low Acuity housing cluster. Within the next 48 hours, he will meet again with his Rehabilitation Correctional Counselor, who will use Motivational Interviewing Techniques to administer the Men's In-prison COMPAS Risk and Needs Assessment, an update to the existing COMPAS assessment performed at the CDCR institution where he last resided.

The assessment will gauge his educational and vocational needs, including reading, writing, communication, and arithmetic skills, health care needs, mental health needs, substance abuse needs, and trauma-treatment needs. The initial assessment will include projections for Javier's academic, vocational, health care, mental health, and substance abuse treatment needs. These needs will be identified and addressed by the Interdisciplinary Treatment Team, with Javier as an active participant, to develop the Individualized Treatment and Rehabilitation Plan (ITRP).

The assessment identifies that Javier has a long history of substance abuse, has a sixth grade education, and that he needs employable work skills. He will most likely parole directly from the facility due to his medical condition and therefore requires reentry planning to ensure a

successful transition into the community. The Team and Javier agree to an ITRP that accommodates his medical needs and includes attending substance abuse treatment, literacy and GED courses, followed by a vocational program to gain an employable skill.

The assigned Social Worker Case Manager will work with the Rehabilitation Correctional Counselor I to ensure that Javier's medical care are coordinated, and that he is linked to the appropriate rehabilitation programs as specified in his ITRP. Javier spends the next two months attending medical and physical rehabilitation treatments in the mornings, followed by GED and literacy classes in the afternoons, and substance abuse treatment twice a week. After two months his wound has sufficiently healed and he is transferred to the Specialized General Population level of care where he will continue to receive occasional physical therapy and regular treatment for diabetes.

After a year, Javier has successfully completed a GED and all phases of his substance abuse treatment. He has also become very involved in one of the Faith Based Programs, serving as a volunteer to the Catholic Priest most evenings and leading small group discussions as well as assisting in Chapel services regularly. He attends NA/AA meetings weekly and volunteers for occasional fund raising events for Victims Rights Groups. His Rehabilitation Correctional Counselor I has updated his assessment and ITRP by administering the Men's Reentry COMPAS assessment tool, and his ITRP has been adjusted to address his reentry needs. His Social Worker Care Coordinator continues to ensure he is linked to his medical care plan, but is now also working on his reentry plan, linking him to pre-release classes and placing him into a Vocational Program to learn a job skill. Over the final six months of Javier's stay in the facility, he will successfully complete a Certified Vocational Program, complete pre-release course work, and get linked to community job opportunities through his Rehabilitation Correctional Counselor and the self-help job kiosk located in his housing unit. The Social Worker Care Coordinator will also ensure Javier is signed up for benefits prior to leaving the facility and assist him in obtaining a California ID Card.

Javier is now ready to parole with a stabilized medical condition, his post release housing confirmed, and will report to his new job within one week of his parole. This patient's story represents the success that can be achieved by effective risk and needs assessment, case management, and rehabilitative programming delivered within an integrated care model.

12.7.2 Population Served

The population to be provided substance abuse treatment will be identified by the Risk and Needs Instrument evaluation, and for those appropriate, a secondary substance abuse assessment instrument. Patient participation will be determined by the patient's individual treatment and rehabilitation plan. In general, Substance Abuse Programming will be delivered to patients serving long-term sentences as well as those that will parole. Decreasing long-term patient substance usage will reduce illegal in-facility drug usage and contraband and assist paroling patients with their recovery, which will aid in their successful re-entry into society.

12.7.3 Substance Abuse Treatment and Prevention Program Structure: Modified Therapeutic Community with Aftercare

Substance abuse treatment services will be provided in a Modified Therapeutic Community (MTC) environment with community aftercare for patients who parole. The MTC recognizes that the core mission of the facility is therapeutic in nature and will accommodate the specialized medical and severe mental health needs of the patients. The MTC will offer increased flexibility and individualization for patients and will incorporate medical and mental health therapies to address the physical and emotional aspects of the patient's addiction as follows:

- Therapy for dually diagnosed mental health patients provided by mental health clinicians (with IDTT approval mental health patients can participate in counseling and 12 step programs delivered by the Rehabilitation Program)
- Medical treatment to alleviate substance abuse addictions provided by medical staff
- Counseling and 12 step programs provided to non-mental health patients within the Rehabilitation Program by specially trained staff

Mental health, medical and rehabilitation-bases treatment services will be closely coordinated to ensure the physical, emotional and social aspects of the patient's addiction are all addressed.

The modification to the MTC model will include self-help sponsors who lead a 12-Step program such as Alcoholic Anonymous (AA) and Narcotic Anonymous (NA) classes. The 12-Step program will supplement the rehabilitation, clinical mental health and medical strategies. The AA and NA sponsors will also assist with creating a community linkage and support network for those patients who will parole.

Half-day treatment schedules will be established to ensure the patient's physical and mental abilities will be matched to program duration. Additionally this doubles the capacity of patients able to participate in programming.

The program will include an evaluation component to evaluate the program's efficacy and measure the outcomes to ensure program fidelity.

12.7.4 Patient Goals

1. To lessen relapse
2. To improve patient behavior
3. To decrease recidivism

PART XIII: FACILITY GOVERNANCE

A Chief Executive Officer/Executive Director will be responsible for directing health care services at each of at the new facilities, the facility itself and facility operations.

13.1 Chief Executive Officer (CEO)/Executive Director (ED) and Leadership Team

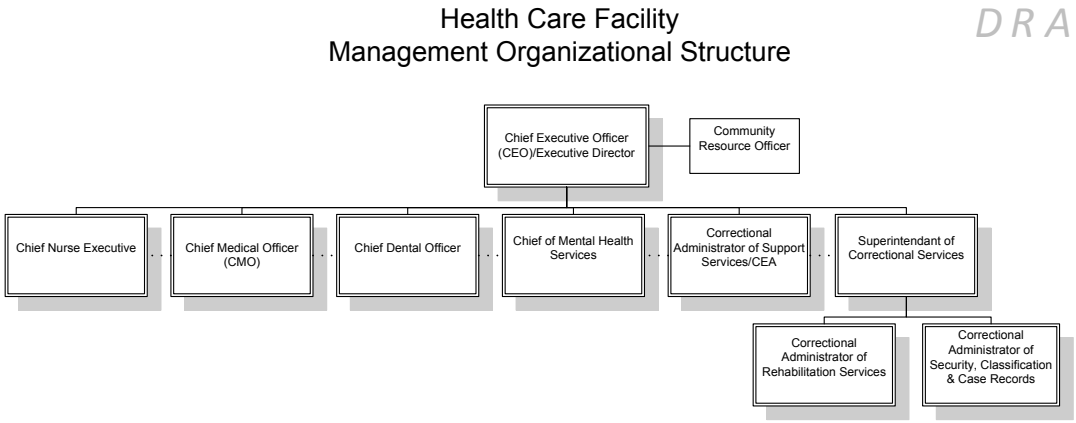
A CEO/ED-led organization at the facility conforms to the organizational structure described in the paper on *Team-based Care: Best Practices to Meet the Needs of CDCR's Patients.*[59] A team consisting of the Chief Medical Officer, Chief Nursing Executive, Chief of Mental Health Officer, Chief Dental Officer, Superintendent of Correctional Services, Correctional Administrator of Support Services/CEA, support the CEO/ED.

The system of leadership will guide, sustain and motivate the organization. It will also provide a system of governance, and maintain a commitment to excellence and legal and ethical behavior. Three primary aspects of this system of leadership are:[60]

1. CEO/ED chain of command
2. Clinical chain of command
3. Performance reporting and feedback to assess results

Data collection and mechanisms for performance reporting and feedback in the new health care facilities will mirror the processes being established by CPHCS Administration for health care in the existing 33 prisons.

The chain of command can be viewed in the draft organizational chart of a new health care facility below:



13.2 Departmental Organizational Charts

Draft organizational structures of the departments can be found in Appendix G.

PART XIV: ANTICIPATED PATIENT AND FACILITY OUTCOMES

14.1 Anticipated Patient Outcomes

Anticipated patient outcomes have been established for all levels of care and services provided at the new health care facilities. Following activation and during the first year of operation, these outcomes will evolve further, and baselines will be established through generation, monitoring, aggregation and analysis of data in critical areas of service provision and delivery systems. These refined outcomes and baselines will provide the measures to be used in year two of operations, and will support planned, incremental improvement in patient care outcomes. In addition, program fidelity will be measured 12 months after start-up. Changes to the programs will be made as needed.

Medical Services	**Anticipated Outcomes**
Patients of All Medical Services	▪ Limit pneumococcal diseases, influenza and public health diseases by immunizing 80% of the SGP population ▪ Reduce adverse drug events below national outpatient averages through monthly Physician or Nurse Practitioner review of medication lists ▪ Length of stay within limits established by the IDTT ▪ 100% patient admissions will have an interdisciplinary treatment plan, including anticipated discharge date, within 7 days of admit date.
Specialized General Population (Ambulatory)	▪ Patient initiated requests for health care attention requiring a primary care appointment will be met within seven days.
Low Acuity (Assisted Living)	▪ 50% of the Low Acuity patients will not lose functionality in Activities of Daily Living (ADL) from admission baseline. ▪ 25% of patients in Low Acuity will be transferred to a lower level of care. ▪ 10 % of patients in Low Acuity will be transferred to a higher level of care.
High Acuity (Skilled Nursing)	▪ Exceed state and national norms documented in NH Compare for quality indicators utilized by CMS to determine quality in “The Five-Star Nursing Home Quality Rating System.”

Dementia	▪ Use of physical restraints will be below NH Compare[61] levels for California. ▪ All patients will have designated someone to make health care decisions on their behalf. ▪ All patients will have advance directives discussed. ▪ 90% of patients will have advance directives in place.
Hospice	▪ All patients will have someone designated to make health care decisions on their behalf. ▪ 90% of patients will have advance directives in place.
Mental Health Services	**Anticipated Outcomes**
	▪ Critical Incidents - Reduce the number of critical incidents by 15% within the first year of operation, as measured by decreases in self-injurious behavior and documentation of serious rule infractions ▪ Treatment Adherence - Improve treatment adherence by 15% the first year of operation, as measured by increased attendance in group treatment sessions, participation in recreation treatment activities and involvement in the IDTT process ▪ Changes in Patient Psychiatric Symptoms - Implement a symptom-severity measure (example: Brief Psychiatric Rating Scale) with 90% of all patients admitted to the Mental Health Program ▪ Medication Adherence - Medication adherence outcome measures to be developed after the establishment of benchmarks determined by the medication management tool to be piloted at CDCR facilities beginning in March 2009
Correctional Rehabilitation Programs	**Anticipated Outcomes[62]** ▪ Overall patient recidivism will be reduced by 10%.

14.2 Anticipated Facility Outcomes

The new health care facilities will be accountable for implementing patient-centered, integrated care; matching resources to needs; establishing efficient systems; using rapid cycle quality improvement processes; meeting financial goals; hiring, training and supporting a competent staff; and ensuring a safe environment for patients, staff and visitors.

A sample of anticipated facility outcomes include:

- Staff overtime will not exceed 10% of total staff costs
- Facility audits for regulatory compliance and risk management procedures will all score above 90%
- Regular patient and staff satisfaction audits regarding availability of care, " art of caring", access to specialty service, and operational/clinical supports available to optimize their job productivity and clinical outcomes
- Through claims data and facility encounter data tracking, unit costs to be less than equivalent community costs
- All specialists and non primary care requests for services to be queried through Interqual or other correctional evidence based systems to verify medical necessity
- Compliance with all preventive health care guidelines, chronic care and pharmacy guidelines > 90%
- Waiting time for outside tests, community physician visits, community hospital and clinic services for urgent conditions less than 48 hours, elective conditions less than 90 days
- Lengths of stay equal to or less than recommended length of stay, as determined by the IDTT
- Health care outcomes improved per functional, mental, medical, and other assessments
- Clear written/electronic communication and documentation received on admission for every patient and discharge planning documentation complete and reliably delivered for every patient
- Clinical rounds, orders, documentation within required timeframes and standards
- Abnormal lab, radiology, potential adverse pharmacy interactions notification process followed
- Active problem list available and up to date
- Health care record up to date, backlog of filing less than one week old
- Appointment backlogs and specialty referral backlogs less than one week

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[4] California Prison Health Care Services, posted at http://www.cprinc.org/about.aspx.
[5] CPS Human Resource Services. *Management Evaluation and Review: California Prison Health Care System*. January 2009.
[6] Northstar Correctional Educational Services LLC. *Education Summary and Recommendations Report*. October 2008.
[7] Within this document, health care refers to medical, dental, mental health, substance abuse and disability related services and programs.
[8] California Department of Corrections and Rehabilitation. *Information Technology Roadmap*, September 22, 2008; CPHCS Project Office Management. *Project Data Sheets.* January 2009.
[9] Individual papers can be found in the Appendix.
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[12] Rehabilitation programming increases public safety when the patient is paroled and reduces recidivism.
[13] Nurses performing this function will be provided special training.
[14] This model is championed by change organizations such as Institute for Healthcare Improvement (IHI).
[15] Chassin et al., 1998; Disch et al., 2001; Palmersheim, 1999.
[16] Timely interventions reduce later, more costly care utilizations.
[17] Quality patient care reduces errors, which, if allowed to occur, harm the patient and drive up the cost of care associated with the treatment of mistake-induced disease.
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[21] Obtained from Kenneth B. Schwartz Center, 2007-2008 Massachusetts General Hospital (Rounds Program 1995), posted at http://www.theschwartzcenter.org/programs/rounds.html, retrieved 03/02/09.
[22] Meade, C., et al. "Effects of nursing rounds: on patients' call light use, satisfaction and safety," 2006 Sep; 106 (9), pg 58-70; American Journal of Nursing.
[23] Ibid.
[24] Meetings may be shorter or longer, as needed.
[25] Obtained from http://www.cmsa.org.au/definition.html, retrieved 11/28/08
[26] Healey, K.M. "*National Institute of Justice, Research in Action. Case Management in the Criminal Justice System*" February 1999. Posted at http://www.hawaii.edu/hivandaids/Case_Management_in_the_Criminal_Justice_System.pdf, retrieved 11/28/08
[27] CDCR's existing Compas Risk and Needs Instrument will be used to ensure consistency for those patients transitioning from and back to CDCR institutions.
[28] The Individual Treatment and Rehabilitation Plan identifies the risks and needs of the offender and the corresponding programs required to address those needs, not only during the offender's period of incarceration and for those who will parole, also through community placement and their time on parole. It includes identification of programs, interventions and services needed to ensure successful reintegration into the community upon parole.
[29] "Research has proven that operating a facility under the principles of direct supervision result in a safe and controlled facility, increased work output from staff, higher staff morale and treatment productivity. Direct supervision can also be accredited to less violence, vandalism, and large scale incidents that drive up operating costs. With continuity of health care the ultimate goal, direct supervision will allow the entire facility to be controlled by staff, allowing all patients to receive a constitutional level of health care." National Institute of Corrections (NIC), *A Comparison of Direct and Indirect Supervision*. 1989. Posted at http://www.nicic.org/pubs/pre/007807.pdf.
[30] See Appendix E for 2004 United States Department of Justice's publication on The Principles of Direct Supervision.
[31] ADLs are Activities of Daily Living such as eating, walking, toileting, bathing, dressing and personal hygiene.
[32] PADLs are Prison Activities of Daily Living such as getting on the top bunk, climbing stairs, getting on the floor for alarms, hear orders from staff, walking to the dining room.
[33] The need to offer inmate-patients rehabilitation opportunities is well established in statute. Penal Code 2053.1 requires that literacy programs be offered to at least 60% of the population that is below the 9th grade reading level. Penal Code 2054.2 requires a system of incentives to increase inmate participation in, and completion of, academic and vocational education programs, including literacy (as specified in Penal Code 2053.1), a high school diploma or equivalent, or a particular vocational job skill. Penal Code 2062 goes even further, requiring the Department of Corrections and Rehabilitation to obtain additional rehabilitation and treatment services for prison inmates and parolees. Penal

Code 3020 requires that assessments of all inmates be done to place inmates in programs that will aid in their reentry to society and that will most likely reduce the inmate's chances of reoffending. Specifically for female inmate-patients, Penal Code 3430 requires a needs-based case and risk management tool designed specifically for female offenders that gauges their educational and vocational needs, including reading, writing, communication, and arithmetic skills, health care needs, mental health needs, substance abuse needs, and trauma-treatment needs, and requires the design and implementation of evidence-based gender specific rehabilitative programs.

[34] Patients may be referred and subsequently moved by mental health or medical staff within the health care system, outside of the facility where they reside, or to another CDCR health care facility.

[35] A health system-wide Assessment Tool is currently in the planning stages under the direction of Dr. Hill.

[36] The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

[37] Activities of Daily Living include bathing, eating, dressing, toileting, transferring in/out of bed or chairs, and walking. Prison Activities of Daily Living include dropping to the floor for alarms, standing for head count, climbing on and off the top bunk, getting to the dining hall for meals and hearing orders from staff.

[38] Based on the New York Heart Association's staging levels of heart failure from Class I to IV. Posted at http://www.abouthf.org/questions_stages.htm retrieved March 9, 2009.

[39] Some patients will be treated for an acute illness from which improvement or recovery will allow for transfer to a lower level of care or discharge back to a CDCR prison.

[40] Physical Medicine and Rehabilitation Services are described fully in Part IX.

[41] Maxor is the contractor providing pharmacy services to CPHCR.

[42] Of note, assisted living in the "free" world serves residents, not patients and, as noted within this report, is a social, not a medical model.

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[50] Ibid.

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[52] The Individualized Treatment and Rehabilitation Plan is comprehensive in that it identifies the risks and needs of the offender and the corresponding programs required to address those needs, not only during the offender's period of incarceration and for those who will parole, also through community placement and their time on parole. It includes identification of programs, interventions and services needed to ensure successful reintegration into the community upon parole.

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[61] http://www.medicare.gov/NHCompare. Information entered by nursing homes in the MDS, risk adjusts some, but not all the data, and puts the information on line for public viewing. It rates every nursing home in the country that takes Medicare money (virtually all) and allows the viewer to look up nursing homes based upon state, city, zip code, name, etc. This is part of CMS' transparency initiative.

[62] Rehabilitation measures and outcomes can be found in Appendix C.8.