CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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4.1.3 SCHEDULING AND ACCESS TO CARE PROCEDURE	Attachments: Yes ☒ No ☐

I. PROCEDURE OVERVIEW

This procedure describes the systems and processes which California Correctional Health Care Services (CCHCS) staff shall utilize to optimize access to care and maintain an effective and efficient scheduling system to reduce wait-times. This includes a flexible appointment system that accommodates various encounter appointment types, visit lengths, same-day visits, and scheduled follow-ups as well as strategies to increase efficiency, such as consolidated appointments. This procedure also specifies roles and responsibilities for key staff involved in the scheduling system.

II. DEFINITIONS

Backlog: An undesirable condition that occurs when today's work (both the planned work and work that is unplanned, but needs to be accomplished by today) is not completed today.

Bundling: When a patient has multiple pending appointments, setting appointments sequentially on the same day so that a patient need only be seen in one encounter for multiple purposes. Bundling helps increase clinic efficiency, meet mandated timeframes, and limit the need for custody escorts, lessening redundant work for custody and health care staff as well as making appointments more convenient for the patient.

Care Team: An interdisciplinary group of health care professionals who combine their expertise and resources to provide care for a panel of patients.

Ducat: A common term for a CDC 129, Inmate Pass. There are two types of ducats, "Priority" and "Non-Priority." Priority ducats are embossed with the word "Priority" and are used for scheduled health care appointments. Non-Priority ducats are printed on plain white paper and are used for unscheduled appointments and/or unescorted movement from one location to another.

Interventions: Centers on the execution of the specific care management activities that are necessary for accomplishing the goals set forth in the patient's treatment plan, linking the patient to the services needed to optimize health.

Non-Business Days: Saturdays, Sundays and State holidays.

Normal Business Hours: A minimum of eight hours per business day. These hours may vary by institution, but are generally between the hours of 0700 and 1800.

Open Access: A scheduling strategy that involves "doing today's work today" and seeing patients as soon as possible after they request care, and on the same day if appropriate. Open access slots are appointment times or blocks that are left open and unscheduled until one to two days prior to that date, allowing the Care Team to accommodate walk-in patients, patients with urgent health needs, and patients with routine health needs that would benefit from expedited services.

Scheduling Support Staff: The member of the Care Team who ensures that all patients are appropriately scheduled and that Care Team members have the information they need for planned patient encounters. This is usually administrative support staff.

Superusers: Individuals designated as superusers in the scheduling system have additional permissions within the system, including the ability to add or change providers or locations.

III. RESPONSIBILITIES

A. Statewide

California Department of Corrections and Rehabilitation (CDCR) and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available to ensure the scheduling system is successfully implemented and maintained.

B. Regional

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

C. Institutional

1. The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the scheduling system at the institution and patient panel level. The CEO delegates decision-making authority to the Chief Nurse Executive (CNE) for daily operations of the scheduling system and ensures adequate resources are deployed to support the system including, but not limited to the following:
    a. Ensuring access to and utilization of equipment, supplies, health information systems, Master Registries, Patient Summaries, and evidence-based guidelines.
    b. Assigning patients to a Care Team.
    c. Maintaining a list of the core members of each Care Team, which shall be available to all institutional staff. Patients shall be informed of their assigned Care Team members at intake and/or upon request.
    d. Ensuring consistent Care Team staffing with a back-up system for core members.
    e. Providing Care Team members with the information they need during huddles (e.g., communication of on-call information).
    f. Ensuring protected time for Care Teams to hold daily huddles.
    g. Documenting and tracking huddle actions and attendance.
    h. Ensuring that at least monthly, each Care Team conducts a Population Management Working Session utilizing tools such as Dashboards, Master Registries, and Patient Summaries to address concerns related to potential gaps in care and improved patient outcomes including, but not limited to:
        - High risk patients.
        - Contract Management.
        - Patient safety alert.
        - Trends in access to care.
        - Surveillance of communicable disease.
        - Patient risk stratification.
    i. Adequately preparing new Care Team members to assume team roles and responsibilities.
    j. Assessing competence of existing Care Team members.
    k. Updating procedures, roles and responsibilities as new tools and technology become available.

l. Reviewing/comparing institution Care Team performance, including the overall quality of services, health outcomes, assignment of consistent and adequate resources, utilization of Dashboards, Master Registries, Patient Summaries, and decision support tools and address issues as necessary.
m. Providing Care Team members with adequate resources, including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
n. Working with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment.
o. Ensuring, in collaboration with the Warden, that the institution establishes a Local Operating Procedure by which priority health care ducats are issued and delivery by custody staff is verified and documented.
p. Requiring institution leadership to establish a back-up system to ensure that scheduling queues are managed when Scheduling Support staff are on leave or otherwise unable to meet daily monitoring requirements.

2. The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork across disciplines.
3. The CNE is responsible for:
   a. The overall daily operations of the scheduling system for medical care.
   b. The coordination of health care between health care scheduling systems.
   c. Oversight and management of the scheduling processes and resources, including personnel.
   d. Ensuring that the institution has a designated lead scheduling supervisor to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
   e. Ensuring that Scheduling Support staff is available for all clinical areas.
4. The Chief Medical Executive (CME) is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.
5. The Supervising Registered Nurse and Chief Physician and Surgeon shall meet to review the Care Teams' performance, including the overall quality of services, health outcomes, level of care utilization and shall utilize Dashboards, Master Registries, Patient Summaries, and decision support tools to address or elevate issues as necessary.

IV. GENERAL SCHEDULING CONCEPTS

A. Standardized Scheduling System

All institutions shall use the standardized statewide scheduling system.

B. Scope of the Scheduling Process

The scheduling process shall begin upon a patient's arrival at CDCR and continue throughout the patient's stay.

C. Scheduling System User Designations and Accessibility

Institutions shall designate two to three staff members as superusers in the scheduling system. During clinic hours, at least one superuser shall be available to assist the scheduler to add a provider or location.

V. ACCESS TO HEALTH CARE SERVICES

A. Hours of Access

1. All CDCR inmates shall have access to medically necessary health care services seven days per week, 24 hours per day.
   a. RNs shall be onsite at the institution seven days per week, 24 hours per day.
   b. Medical, mental health, and dental services shall be available at any time.
2. Each institution shall establish hours of operation for Primary Care Clinics, generally at least eight hours per day, Monday through Friday, excluding State holidays.

B. Methods of Access

1. Licensed Health Care Initiated Appointments.
   a. Access to care includes planned health care encounters, scheduled over time at appropriate intervals and initiated by licensed health care staff as part of ongoing treatment planning and care management to address health care needs.
2. Patient Request for Services:
   a. Access to care also includes episodic encounters requested by patients either through written request or verbal report or demonstration of urgent/emergent health care needs.
   b. At any time, patients with health care needs may submit a CDC 7362, Health Care Services Request Form. Patients with urgent health care needs may complete a CDC 7362 or notify any correctional staff or any other institutional staff member for assistance. Patients with life-threatening conditions shall receive immediate medical attention.
   c. If a patient is unable to complete a CDC 7362, health care staff shall complete the form on behalf of the patient. Health care staff shall document the complaint and the reason the patient did not personally complete the CDC 7362 and shall sign and date the CDC 7362.
   d. Institutions shall ensure the CDC 7362 is available to patients in the housing units, clinics and Reception Centers. Housing unit staff and health care staff shall make the CDC 7362 available upon request. Each institution shall have at least one locked box on each yard/facility designated for depositing the CDC 7362 by patients.
3. Initial Review and Triage of a CDC 7362
   a. On normal business days:
      1) A designated health care staff member shall collect the CDC 7362s from the designated areas, document the date and time of pickup and deliver the forms to the Primary Care RN for review.
      2) The Primary Care RN shall review each CDC 7362 and identify those that describe symptoms of a medical, mental health, or dental condition. The Primary Care RN shall determine whether the patient requires urgent/emergent or routine care. The RN shall immediately refer urgent/emergent medical, mental health, and dental needs to the appropriate clinician for evaluation consistent with established program guidelines.
      3) All CDC 7362s that describe symptoms shall be seen by the Primary Care RN within one business day.

4) The Primary Care RN shall separately address CDC 7362s that do not include symptoms, such as requests for eyeglasses or medication renewals, routing them to appropriate health care staff for follow up.
5) CDC 7362s that do not describe symptoms shall be delivered the same day to the designated program representative on normal business days. A CDC 7362 requesting services from more than one area (e.g., medical and dental) shall be copied and delivered to the requested service area by the RN reviewing the CDC 7362.

b. On non-business days:
1) All CDC 7362s shall be sent to the Triage and Treatment Area (TTA) RN for triage. Upon receipt of the collected forms, the TTA RN shall review, initial and date each CDC 7362. The TTA RN shall ensure that the routine CDC 7362s are delivered to the Primary Care RN that is assigned to that patient by the beginning of the next business day.
2) The TTA RN shall determine whether the patient requires urgent/emergent or routine care, and shall take direct action to coordinate care for patients with emergency or urgent conditions. The TTA RN shall immediately refer urgent/emergent medical, mental health, and dental needs to the appropriate clinician for evaluation consistent with established program guidelines.

4. Emergency Care Required
   a. Patients with life-threatening medical symptoms shall receive immediate medical attention (Refer to Inmate Medical Services Policies and Procedures [IMSP&P], Volume 4, Chapter 12.1, Emergency Medical Response System Policy).
   b. For patients with a potential mental health and/or dental urgent/emergent condition, during normal business hours, the Primary Care RN shall immediately assess the patient and communicate findings directly with designated mental health and/or dental staff.
   c. The Primary Care RN shall ensure immediate transportation of the patients to the designated area for evaluation and treatment. When a patient is referred to the mental health program, the CDC 7362 shall be accompanied by a CDCR 128-MH5, Mental Health Referral Chrono.
   d. Patients with a potential mental health emergency must remain under continuous observation until the patient is evaluated by a mental health clinician or by TTA medical staff.
5. Urgent Care Required
   a. Patients with urgent medical symptoms shall be scheduled for a same day face-to-face visit with the Primary Care RN and other members of the Care Team as indicated by symptoms.
   b. For patients with urgent symptoms involving more than one clinical discipline, the Primary Care RN shall ensure any urgent medical, dental, and/or mental health conditions are evaluated as described above.
   c. When the patient requests services from more than one clinical discipline (e.g., medical and dental) on the CDC 7362, health care staff shall copy and forward the request to the other clinical discipline as soon as possible. The original shall be forwarded to the first requested service area.

VI. SCHEDULING STRATEGIES

CCHCS staff shall use strategies such as open access, bundling, co-consultation, and collaborative planning of the clinic schedule to optimize access to services.

A. Services that Require Appointments

1. All health care encounters shall be considered appointments and shall be entered into the Scheduling System including, but not limited to, the following:
   - Receiving and Release screenings and assessments.
   - Episodic care encounters, including Primary Care RN visit and provider referrals.
   - Well patient visits.
   - Chronic care encounters.
   - TTA encounters.
   - Laboratory and radiology services.
   - High priority Specialty services.
   - Other Specialty services as indicated.
   - Care management encounters.
   - Inter-disciplinary treatment planning sessions.
   - Recurring patient monitoring or follow-up appointments, such as dressing changes and blood pressure checks.
   - Injection appointments.
   - Public health screening and treatments.
   - Patient education and non-adherence counseling.
   - Special situations, such as hunger strike evaluations and monitoring.
   - Follow up after return from higher level of care.
   - Health care appeals.
2. The Care Team shall ensure that existing health care appointments, including specialty referrals, are rescheduled at the receiving institution, as indicated. All members of the Care Team shall ensure that follow-up appointments are entered into the "To Be Scheduled" queue within the Scheduling System including, but not limited to, the following:
   - TTA encounters.
   - Receiving and Release intake.
   - Discharge from a higher level of care.

B. Translation Services

Translation services (including sign language) shall be made available to patients as necessary, via certified bilingual health care staff, certified bilingual CDCR staff, or by utilizing a certified interpretation service. Each institution shall maintain a contract for certified interpretation services. (Refer to IMSP&P, Volume 1, Chapters 28.1 and 28.2, Effective Communication Policy and Procedure).

C. Scheduling

1. General Requirements
   a. Health care staff shall ensure that lists for scheduled appointments are communicated to custody staff no later than one business day prior to the scheduled visit.

b. Each institution shall establish a procedure by which health care ducats shall be issued as priority ducats and delivery by custody is verified/documented. This procedure shall include the following:
   - The method by which priority health care ducats are delivered to each patient.
   - The individual responsible for issuing priority health care ducats.
   - Verification by custody staff that the priority health care ducats were issued to the patient.
   - A method of re-routing priority health care ducats to patients.

c. The patient is responsible to report to the health care appointment at the time indicated on the priority health care ducat.

d. Developmental Disability Program/Disability Placement Program designated patients shall be provided specific instruction regarding the time and location of their scheduled appointment. The custody staff delivering the priority health care ducats shall communicate effectively and appropriately based upon the patient's ability to understand to ensure that the patient(s) arrives at the designated appointment location.

2. Custody staff shall ensure delivery of priority health care ducats to patients prior to his/her scheduled appointment.
3. Failure to Report for a Medical and/or Dental Appointment
   a. If the patient (including patients who are in the Mental Health Services Delivery System) fails to report to a scheduled Medical and/or Dental appointment, the assigned health care access clinic officer shall immediately contact the designated housing unit or work/program assignment to locate the patient and have him/her escorted or have the patient report to the scheduled Medical and/or Dental appointment.
   b. Custody staff shall locate the patient and escort the patient to the appointment or direct the patient to report to the scheduled Medical and/or Dental appointment. If necessary, custody staff shall order the patient to comply with the instructions on the priority ducat.
      1) If the patient continues to refuse, custody staff shall advise the patient that he/she is in violation of Title 15, Section 3014, Calls and Passes, which states "Inmates must respond promptly to notices given in writing, announced over the public address system, or by any other authorized means."
      2) If the reason the patient did not report as ducated was beyond the patient's control (e.g., out to court), custody staff shall advise health care staff of this fact.
      3) If the reason the patient did not report as ducated was due to the patient refusing to report as directed, custody staff shall escort the patient to the health care area for health care staff to discuss the implications of refusing health care treatment. Licensed health care staff shall counsel the patient and have the patient sign the CDC 7225, Refusal of Examination and/or Treatment, if he/she continues to refuse treatment after the counseling. The CDC 7225 shall be filed in the health record.
      4) Patients who are insistent in their refusing to report shall not be subject to cell extraction or use of force to gain compliance with the priority health care ducat. In these instances, licensed health care staff must respond to the patient's

housing unit to provide the necessary patient education regarding the refusal. Custody staff cannot accept refusals on behalf of the patient, nor can refusals be taken over the phone.

5) The reason for the failure to report shall be documented by health care staff on an Interdisciplinary Progress Note and filed in the health record.
6) Custody staff shall be responsible to document the patient's refusal to report to the priority health care ducat on a CDC 115, Rules Violation Report.

c. Medical and/or Dental appointments shall be rescheduled as clinically indicated.

4. Failure to Report for a Mental Health Appointment
   a. If a patient in the Mental Health Services Delivery System refuses to report for a Mental Health appointment in person, custody staff shall not complete a CDC 115 or a Counseling Only Rules Violation Report (formerly known as a CDCR 128A, Custodial Counseling Chrono).
   b. Refer to the CDCR Mental Health Services Delivery Systems Program Guide, 2009 Revision, for additional procedures regarding Mental Health appointment refusals.

D. Lockdown and Other Security Concerns

1. Health care services shall continue to be provided during alarms/incidents not occurring on the clinic yard. For alarms/incidents occurring on the clinic yard, clinic services shall resume as soon as safely possible during and following the alarms/incidents.
2. During a facility or prison lockdown, health care staff shall coordinate with custody staff to facilitate continuity of care. Custody personnel shall escort patients to scheduled clinic appointments; lockdown shall not prevent the completion of scheduled medical appointments.
3. In restricted housing units and facilities/housing units on lockdown status, a system shall be maintained to provide patient access to health care services. Access to health care services shall be accomplished via daily cell front rounds by health care staff for the collection of the CDC 7362. The rounds and collection of the CDC 7362 shall be documented by nursing staff in the housing unit logbook.

E. Clinic Closure / Cancellation of Scheduled Appointments

Any modification of clinic hours, clinic closure, and cancellation or rescheduling of scheduled appointments requires the approval of the CEO or a designated clinical executive.

F. Timeframes

1. Under the Complete Care Model, the goal of all Care Teams is to provide timely access to care and whenever possible "complete today's work today" to allow immediate access to necessary services.
   a. To ensure that patients are not exceeding acceptable thresholds for timely care, the timeframes should be viewed as the latest possible time that a patient may be seen and not as a guideline for scheduling.
   b. Scheduling Support staff shall set appointments several days in advance of the acceptable threshold.
2. Attachment B, Access Timeframes, provides a list of all applicable scheduling timeframes as well as suggested scheduling windows to ensure that appointments are within the applicable timeframes.

G. Duration of Appointments

Attachment C, Appointment Time Duration Template, shall be used as a guideline for appointment durations. Appointments shall be created with differing appointment lengths (in five minute increments) to accommodate the needs of the patient. A "one size fits all" schedule where each patient is given the same 15, 20, or 30-minute appointment duration is not appropriate.

H. Scheduling Queues and Building the Clinic Schedule

Health care staff shall place appointments that need to be scheduled in the "to be scheduled" queue in the scheduling system. Scheduling Support staff are responsible for monitoring the "to be scheduled" queue for each Care Team and clinic location daily with particular focus on scheduling appointments for patients within several days of the relevant threshold date.

I. Increasing Patient Show Rates and Clinic Efficiency

When scheduling patients, health care staff shall consider patient preferences regarding access, such as providing appointment times that do not interfere with the patient's work shifts or classes.

J. Recurring Appointments

Scheduling Support staff shall use the recurring appointment function when a provider or clinician's order will result in a series of appointments with a specified frequency.

K. Rescheduling

Scheduled appointments must be rescheduled if the appointment date or priority of the appointment changes.

L. Cancelling Appointments

Health care staff are prohibited from deleting appointments from the scheduling system.

M. Tracking "Reasons Not Seen"

Health care staff shall record and track reasons that patients are not seen as scheduled. Health care staff shall use the standard "Reasons Not Seen" as listed in the scheduling system.

N. Closing Appointments

Scheduling Support Staff shall obtain the required information from the Care Team to close out appointments. The Primary Care Scheduler, or designee, is responsible to contact members of the Care Team to obtain any missing information or address discrepancies. Required information may include, but is not limited to, the following:

- Clinic Log.
- CDC 7362 review.
- Physician's Orders Form.
- TTA Log.
- Ducat List.

O. Open Access

1. Institutions shall use open access slots to ensure that patients are seen in an efficient manner, in a clinically appropriate setting, and within all mandated timeframes. Approximately 20 percent of Primary Care Clinic appointment slots shall remain open and available for same-day or next-day urgent clinical issues or appointments with short mandated timeframes.
2. Primary Care Clinics shall designate specific times each day as open access times for the Care Team.

3. During daily huddles, the Care Team shall identify patients that need to be scheduled into the same-day or next-day open access times and ensure that this information is communicated to the Scheduling Support staff if he or she is not present at the huddle.
4. Appointments that may be appropriate for open access slots include, but are not limited to, the following:
   - Follow-up on abnormal diagnostic results or other critical abnormal clinical findings.
   - Community hospital discharges.
   - Urgent TTA follow-up.
   - High priority specialty referral follow-up.
   - High-risk/complex patients new to the Care Team.
   - Patients whose condition has become clinically complex.
   - Other urgent referrals.
5. If open access slots remain available even after all urgent follow-ups are addressed, these slots may be used to schedule other routine appointments.
6. With the exception of certain clinics (e.g., Administrative Segregation) where need and coverage may vary, clinic schedules shall be booked at least three to seven calendar days ahead of time (except for "Open Access" slots).

P. Bundling Appointments

To increase clinic efficiency and timely access, the Scheduling Support staff shall review all pending appointments for possible bundling and discuss with the Care Team at the daily huddle to determine the total time required for the patient.

Q. Co-Consultation

Throughout the day, the Care Team shall look for opportunities to collaborate using co-consultation strategies to resolve in one visit issues that would likely result in a referral to another member of the Care Team, eliminating the need for the patient to return to the clinic for a second time.

R. Chaperones

Chaperones shall be present during all examinations of patients involving genitalia, rectal, or breast examinations.

VII. MANAGEMENT AND SUSTAINABILITY

A. Care Team

1. At least monthly, the Care Team shall evaluate the effectiveness and efficiency of scheduling processes and overall access to care. The Care Team shall consider trends in the following:
   a. Adherence to access timeframes.
   b. Proportion of appointments seen as scheduled and reasons patients were not seen as scheduled.
   c. Episodic Care referral rates to the Primary Care Provider (PCP).
   d. Effectiveness of scheduling strategies, such as bundling and co-consultation.
   e. Design of clinic schedules (e.g., number of open access slots, allotting certain time blocks for different appointment types).
   f. Productivity.
   g. Demand management, including episodic care, chronic care, chronos, medication refusals and other types of non-adherence counseling, appeals, etc.

h. Allocation of work across team members.
i. Clinic closures.
j. Specialty provider network issues.
k. Accuracy of scheduling data.
l. Security and construction impacts to access.
m. Population management health care alerts.

2. Institution leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the scheduling monitoring activities.
3. The Care Team shall take corrective action to resolve and/or elevate concerns identified in the review. The Care Team shall review and corrective action shall be documented and forwarded to the designated committee.

B. The Scheduling Supervisor

1. The Scheduling Supervisor shall review select information daily to identify and immediately address scheduling system problems.
2. The Scheduling Supervisor shall determine whether all Scheduling Support staff, Primary Care RNs, and PCPs are in attendance at their respective clinics that day, and shall verify that appropriate back-up has been provided if any of these staff are unavailable.
3. The Scheduling Supervisor shall review available scheduling management reports on a daily basis, including, but not limited to, the following:
   - Scheduling system data to identify data entry errors.
   - Scheduling queues not managed properly.
   - Duplicate appointments.
   - Unorthodox clinic scheduling practices and other scheduling system problems.
4. The Scheduling Supervisor shall review clinic scheduling strategies to ensure that clinics are optimizing strategies such as open access, bundling, and co-consultation.
5. The Scheduling Supervisor shall work with the CNE to improve communication processes within the Care Team and across health care settings that impact scheduling and access, including daily huddles.
6. The CNE and Scheduling Supervisor are responsible for providing frequent feedback to health care staff involved in the scheduling system on their individual performance based upon findings from daily observation of scheduling processes.

C. System Monitoring

1. The CEO and leadership team shall review institution-wide scheduling and access to care data monthly in the context of Quality Management Committee and subcommittee meetings.
2. To ensure accuracy of scheduling system data, the institutional leadership shall:
   a. Periodically evaluate the reliability of scheduling system data through methods such as comparison with independent data sources, like movement or ducat reports and progress notes, or audits for abnormal or incomplete entries.
   b. Take effective action to remedy unreliable data, including creating or revising decision support, updating desk procedures, and redesigning orientation and training strategies.
   c. Re-validate problematic data monthly until the data reliability issue is resolved.
3. Quality committees shall take action as appropriate to investigate quality problems and develop interventions to improve access.

D. Training and Decision Support

1. All institution health care staff shall be trained in scheduling and access to care. A system for the orientation, mentoring, and cross-training of all critical positions in the scheduling system shall be maintained.
2. Institutions shall provide all Scheduling Support staff with a desk procedure with guidance on how to accurately and effectively employ the scheduling system, with information tailored to different work locations and scheduling functions. The desk procedure shall be updated as scheduling processes change.
3. Institutions shall develop or adopt decision support tools (e.g., forms, checklists, cards that can be taped to a computer monitor) to prompt health care staff in different roles in the scheduling system to fulfill their roles and responsibilities (Refer to Attachment A, Detailed Scheduling Roles and Responsibilities) including, but not limited to, the following:
   a. Prompting clinic staff to communicate clearly to Scheduling Support staff.
   b. Giving tips on how to enter data in a way that is recognized by the scheduling system.
   c. Reminding Scheduling Support staff and clinic staff of new scheduling procedures.
4. Ongoing Staff Development
   a. Staff involved in the scheduling system shall receive training on changes to scheduling processes and tools as they evolve and periodic refresher training on their particular roles and responsibilities.
   b. At least monthly, the CME and CNE shall review each Primary Care Clinic's schedule plan, utilization of open access time, and the number of additional "add-on" appointments to determine if adjustment needs to be made to the overall clinic schedule plan to meet patient care needs.

VIII. ATTACHMENTS

- Attachment A, Detailed Scheduling Roles and Responsibilities
- Attachment B, Access Timeframes
- Attachment C, Appointment Time Duration Template

IX. REFERENCES

- California Code of Regulations, Title 15, Division 3, Chapter 1, Article 1, Section 3014, Calls and Passes
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 28.1 and 28.2, Effective Communication Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 1.4, Population and Care Management Services Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12.1, Emergency Medical Response System Policy
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.ahrq.gov/

- The Joint Commission Primary Care Medical Home Certification, http://www.jointcommission.org/accreditation/pchi.aspx
- National Committee for Quality Assurance – Patient-Centered Medical Home Recognition, http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

ATTACHMENT A
Detailed Scheduling Roles and Responsibilities

ROLE	RESPONSIBILITIES
CEO	1. Coordinate with the Warden to ensure all scheduled health care appointments are considered a priority ducat. Priority health care ducats shall take priority over all other scheduled institution appointments. 2. Identify access and scheduling as a priority for the institution and communicate that on every level. 3. Monitor scheduling performance on a regular basis through the local Quality Management Committee to help keep the focus on this area and sustain improvements. 4. Ensure that clinic schedules are determined at least 14 days in advance, or more, if possible. 5. Define each primary care clinic's operating hours. 6. Define the number of appointment slots on any given business day, in any given primary care clinic, for each primary care member. 7. Ensure primary care clinics on main yards have consistent providers with reliable schedules. 8. Ensure an "Open Access" scheduling model and that there are mechanisms in place to monitor supply and demand, and adjust short-term appointment supply as needed (i.e., more on Mondays and Fridays or after holidays). 9. Ensure sufficient resources to accomplish the scheduling of care, including training, designated and protected space, staffing, and proper equipment. 10. Ensure that the scheduling system data input is occurring as designed in every location and for all intended processes. 11. Set the expectation that all staff will work to update institution processes as needed to utilize the scheduling system as it was designed. 12. Utilize performance reports produced by the scheduling system for quality evaluation and improvement activities.
CNE	1. Be responsible for the overall daily operations of the scheduling system for medical care. 2. Be responsible for the overall coordination of health care between health care scheduling systems. 3. Be responsible for the oversight and management of the scheduling personnel. 4. Ensure there is an institution contact list for each scheduler. 5. Ensure there is a problem resolution process in place to identify and resolve any problems that occur in the scheduling function. 6. Ensure patients are scheduled efficiently without redundancies (i.e., bundling appointments as indicated). 7. Ensure stratification of appointments (allowing sufficient time for certain types of patients, e.g., high risk intake versus episodic care). 8. Work with the Primary Care Team to schedule appointments, anticipate the patient's needs in advance, and schedule to prevent lapses in care. 9. Ensure appointments are closed out daily.
CLINICAL LEADERS	1. Ensure that all Care Teams participate in daily huddles, and that scheduling issues are included in every huddle discussion. 2. Work with Clinical Staff to develop workable scheduling "rules" and "templates" that are used consistently throughout the institution. 3. Ensure ALL staff demonstrate understanding of scheduling systems and are engaged in closing appointments correctly. 4. Require all clinical providers to work with schedulers to avoid duplicate or redundant appointments (PCP, PCRN, LVN, onsite specialists, etc.) 5. Review scheduling reports on a regular basis to identify and address scheduling system inefficiencies. 6. *For more details see* Scheduling Process Responsibilities – Clinical Leaders
SCHEDULING SUPERVISOR	1. Ensure appointments are closed within 24 hours. 2. Ensure schedulers look at each patient's upcoming "Scheduled" or "To Be Scheduled" appointments before creating a new appointment of the same type. 3. Ensure schedulers are entering appropriate and useful information in the Problem/Symptom field and are editing this field when needed for follow-up appointments spawned. 4. Ensure staff understand and use the correct "Reason Not Seen" when closing an appointment as "NOT Seen as Scheduled." 5. Review scheduling reports on a regular basis to identify and address scheduling system inefficiencies. 6. *For more details see* Scheduling Process Responsibilities – Scheduling Supervisor

ATTACHMENT A
Detailed Scheduling Roles and Responsibilities

ROLE	RESPONSIBILITIES
SCHEDULER	1. “Hard” schedule patients as much as possible. (i.e., Do not leave an appointment “To Be Scheduled” for a long period of time.) 2. Schedule patients prior to the compliance date. 3. Close appointments within 24 hours. 4. Review the “To Be Scheduled” and “Past Due” report several times a week. 5. Maintain a single appointment “String/Tree” for each appointment type.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT B
Access Timeframes

Appointment Type	Timeframe for Completion	Suggested Scheduling Window
New Arrivals (Reception) – *Initial Health Screening*	Seven calendar days	Suggested scheduling window: Three business days before compliance.
Interfacility Transfers	30 calendar days of arrival	Suggested scheduling window: Three business days before compliance. Clinically high risk within seven calendar days. MHSDS patients within timeframes listed in program guide.
Registered Nurse (RN) face-to-face triage *(California Department of Corrections and Rehabilitation (CDC) 7362, Health Care Services Request Form)*	The next business day	Same day if possible.
PCP Urgent Referrals *(from RN FTF triage)*	Within 24 hours	Same day if possible (add-on).
PCP Routine Referrals *(from RN FTF triage)*	14 calendar days	Four business days before compliance.
Chronic Care Follow-Up	Per provider orders, or at least every 180 days	Seven business days before compliance.
High Priority/ Urgent Specialty Returns	Three business days	On day two.
Routine Specialty Returns	14 calendar days	Four business days before compliance.
Return from Higher Level of Care *(Hospitalization, ED Returns, and TTA Follow-Up)*	Five calendar days	On day three or sooner if clinically indicated.
Lab Timeframes – *Lab ordered "Stat"*	Same date ordered	

ATTACHMENT B
Access Timeframes

Appointment Type	Timeframe for Completion	Suggested Scheduling Window
Lab Timeframes – *Lab ordered “Urgent”*	Next day	Same day if possible.
Lab Timeframes – *Lab ordered “Routine”*	14 days from date ordered	Four days before compliance.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Attachment C
Appointment Time Duration Template

Appointment Type	Patient Characteristic: Minutes
Chronic Care Patient New Arrival	• High Risk: 45 Minutes • Medium Risk: 30 Minutes • Low Risk: 15 minutes
Chronic Care Patient Follow-Up	• High Risk: 30 minutes • Medium Risk: 20 minutes • Low Risk: 15 minutes
CDCR 7362 Episodic Care PCP Follow-Up	• Free-standing appointment with simple issue: 15 minutes (longer as requested by PCRN for more complex patient) • If added to related CCP appointment same day: five minutes
High Priority Specialty Follow-Up	• Free-standing appointment: 25 minutes • If added to related CCP appointment same day: ten minutes
Routine Specialty Follow-Up	• Free-standing appointment: 15 minutes • If added to related CCP appointment same day: ten minutes