CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 4: MEDICAL SERVICES	Effective Date: 07/2017
CHAPTER 1: COMPLETE CARE MODEL	Revision Date:
4.1.6: COMPLETE CARE MODEL PROCEDURE: COMPLETE CARE OVERSIGHT TEAM	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

California Correctional Health Care Services (CCHCS) shall maintain a Complete Care Oversight Team (CCOT) committee to oversee statewide implementation of the Complete Care Model (CCM) for delivery of patient health care services. This committee is responsible for leading, coordinating and communicating health care initiatives including the appropriate design and deployment of technical tools and systems (e.g., the Electronic Health Record System) to support safe, timely, and cost-effective patient care.

II. STATEWIDE COMPLETE CARE OVERSIGHT TEAM

A. Committee Functions

The CCOT ensures full implementation of the CCM at all California Department of Corrections and Rehabilitation adult institutions by performing the following functions:

1. Strategic Direction
   a. Ensure the organization's approach to health care services delivery applies the foundational principles and requirements set forth in the CCM policy.
   b. Establish standards for the CCM and add new or modify standards based on new information or technology, best practices, or changes in evidence-based practices.
   c. Plan and prioritize CCM implementation and improvement strategies in alignment with organizational goals and priorities.
   d. Provide input to system-wide performance improvement objectives in the CCHCS Performance Improvement Plan.
2. Evaluation and Improvement
   a. Review the Health Care Services Dashboard and other data and information to monitor delivery system performance.
   b. Develop performance metrics and assessment tools.
   c. Design and implement statewide initiatives, collaboratives, and other improvement activities to fully implement the CCM.
   d. Use community literature, industry standards, and evidence-based strategies to standardize and integrate health care delivery processes.
   e. Identify and redesign processes that pose safety risks to patients and staff or impede full implementation of the CCM.
   f. Develop change packages promoting the use of improvement tools and techniques and decision support, such as workflows, forms, user guides, implementation plans, checklists and more.
   g. Identify and disseminate CCM best practices.
   h. Evaluate resources supporting CCM implementation including, but not limited to:
      - Staffing
      - Equipment and supplies

- Information technology
- Physical plant
- Policies, laws and regulations, etc.

i. Recommend changes to relevant programs and stakeholders to resolve barriers to successful implementation.

3. Communication and Coordination
   a. Ensure there is a mechanism for communicating the progress of CCM implementation and system performance to all levels of organization.
   b. Use existing forums at institutions, regional offices, and headquarters to share lessons learned including best practices.
   c. Partner with committees, workgroups, and program areas at all levels of the organization to redesign health care processes and facilitate CCM implementation and improvements.
   d. Refer CCM issues and concerns to other policy-making bodies and relevant committees as appropriate to support policy changes and inform resource management decisions.
   e. Report progress of the CCM implementation and delivery system performance to the CCHCS Quality Management Committee (QMC) at least quarterly.
4. Orientation and Training
   a. Develop and implement training and staff development programs to help health care staff become oriented to and maintain up-to-date knowledge of the CCM principles and associated systems and processes.
   b. Establish a structure for ongoing technical assistance by health care staff at headquarters and regional levels.
   c. Provide regular feedback to institutions on their progress towards successful implementation of the CCM.
   d. Promote a high performance culture of teamwork and continuous learning, improvement, and innovation.

B. Membership and Meetings

1. Chairperson(s): One or more CCOT members shall be selected to serve as chairperson(s) from the current CCOT membership for a period of at least 12 months. The chairperson(s) responsibilities are to ensure the following:
   - CCOT meetings occur regularly;
   - Meeting agendas reflect the responsibilities and actions described in this procedure;
   - Decisions are documented and communicated to relevant stakeholders as appropriate including agenda topics, discussion, conclusions/resolutions, and actions;
   - New CCOT members receive orientation to their new role and responsibilities; and
   - Each voting member chooses a designee to serve in their stead when necessary.
2. Voting Members: Regional Health Care Executives shall serve as voting members of CCOT as well as Deputy Directors from the following CCHCS programs:
   - Business Services
   - Corrections Services
   - Dental Program

- Information Technology Services
- CCHCS Office of Legal Affairs
- Medical Services
- Mental Health Program
- Nursing Services
- Pharmacy Services
- Policy and Risk Management Services
- Quality Management Program
- Resource Management

3. Non-voting Members, Designees, and Other Participants: Non-voting members, such as Subject Matter Experts, presenters, and guests may attend as appropriate and as approved by the CCOT Chairperson.
4. Voting and Quorum: Each member has one vote and a quorum shall exist when a simple majority of the voting membership is present.
5. Meeting Frequency: The CCOT shall meet as often as necessary to cover the responsibilities and actions described in this procedure, but no less frequently than monthly.
6. CCOT Subcommittees and Workgroups: The CCOT shall establish standing subcommittees and ad hoc workgoups to plan and develop or modify existing clinical program policies and processes; opine on resource requirements; and to coordinate and oversee changes or new designs in decision support and documentation within the Electronic Health Records System and reports used to manage patient populations, clinical operations and organizational performance.

III. REFERENCES

- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 1: Complete Care Model Policy
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 3, Chapter 1: Quality Management Program
  - 1.1 Quality Management Program Overview
  - 1.2 Quality Management Program, Statewide Governance
  - 1.3 Quality Management Program, Institution
- California Correctional Health Care Services, Performance Improvement Plan, http://lifeline/HealthCareOperations/QualityManagement/Documents
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.pcmh.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
- Commonwealth Fund – Safety Net Medical Home Initiative, http://www.commonwealthfund.org/interactives-and-data/multimedia/videos/2011/safety-net-medical-home-initiative

- Improving Chronic Illness Care – The Chronic Care Model, http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
- Improving Chronic Illness Care – Reducing Care Fragmentation, http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf