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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

REBUTTAL DECLARATION OF SOPHIE HART IN SUPPORT OF PLAINTIFFS' REPLY TO RESPONSES TO ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION (ECF No. 3647)

I, Sophie Hart, declare:

1. I am an attorney licensed to practice before the courts of the State of California and admitted in the Northern District of California. I am a staff attorney at the Prison Law Office, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify.

2. As counsel for Plaintiffs in this action, I have access to the CCHCS COVID-19 Patient Vaccination Registry, which, among other things, reports a "COVID-19 Weighted Risk Score" for each patient in CDCR custody. I previously used this Registry to calculate the number of patients with a COVID-19 weighted risk score of 3 or higher who were incarcerated in a housing facility covered by the August 19 California Department of Public Health (CDPH) Order and August 23 CDCR/CCHCS implementing directive. *See* ECF No. 3663-1 at 5-9 ¶ 6. I included all patients incarcerated at the California Health Care Facility, Stockton (CHCF) and the California Medical Facility (CMF), as well as those patients in Correctional Treatment Center (CTC), Mental Health Crisis Bed (MCB), Outpatient Housing Unit (OHU), or Psychiatric Inpatient Program (PIP) units at all other prisons. *See id.* However, in a declaration in support of Defendants' Response to the Order to Show Cause, Dr. Diana Toche, Undersecretary of Health Care Services for CDCR, stated that the vaccine directive would also apply to staff working in Enhanced Outpatient (EOP), Intermediate Care Facility (ICF), and Psychiatric Segregated Housing (PSU) units. *See* ECF No. 3662 at 7 ¶ 19. I therefore recalculated the number of patients covered by the directive on September 6, 2021, to include patients housed in those units. I did this by downloading, for each prison, a report from the Vaccine Registry with the following parameters: Facility: All; Building: All; Care Team: All; Vaccine Status: All; Patient Filters: COVID Risk Score 3+; COVID Filters: All; Job Category: All; Health Care Beds: All. For CHCF and CMF, I then sorted that report by "Bed Type," and excluded all patients who

were listed as being housed in a county jail or hospital. I included all others. For all other prisons, I sorted the report by "Bed Type," and included all patients with Bed Types listed as CTC, EOP, ICF, MCB, OHU, PIP, or PSU. The following table displays my results:

Prison	Total Patients with a COVID-19 Risk Score of 3 or Higher	Patients in Units **Covered** by CDPH Order and CDCR/CCHCS Memo	Patients in Units **Not Covered** by CDPH Order and CDCR/CCHCS Memo
Avenal State Prison (ASP)	166	5 (all OHU)	161
California City Correctional Facility (CAC)	111	0	111
Calipatria State Prison (CAL)	92	8 (all OHU)	84
California Correctional Center (CCC)	80	2 (both OHU)	78
California Correctional Institution (CCI)	278	2 (both OHU)	276
Central California Women's Facility (CCWF)	434	41 (20 CTC; 19 EOP; 2 MCB)	393
California State Prison, Centinela (CEN)	150	7 (all CTC)	143
California Health Care Facility (CHCF), Stockton	1,394	1,394 (entire prison)	0
California Institution for Men (CIM)	1,133	43 (4 MCB; 39 OHU)	1,090

California Institution for Women (CIW)	273	26 (1 CTC; 12 EOP; 3 MCB; 6 OHU; 3 PIP; 1 PSU)	247
California Men's Colony (CMC)	924	148 (19 CTC; 123 EOP; 3 MCB; 3 PIP)	776
California Medical Facility (CMF)	890	890 (entire prison)	0
California State Prison, Corcoran (COR)	507	78 (27 CTC; 36 EOP; 3 MCB; 12 OHU)	429
California Rehabilitation Center (CRC)	250	3 (all OHU)	247
Correctional Training Facility (CTF)	951	7 (all OHU)	944
Chuckawalla Valley State Prison (CVSP)	303	4 (all OHU)	299
Folsom State Prison (FSP)	417	0	417
High Desert State Prison (HDSP)	246	13 (12 CTC; 1 MCB)	233
Ironwood State Prison (ISP)	164	0	164
Kern Valley State Prison (KVSP)	302	25 (2 CTC; 23 EOP)	277
California State Prison, Los Angeles County (LAC)	736	125 (1 CTC; 123 EOP; 1 MCB)	611

Mule Creek State Prison (MCSP)	1,629	198 (all EOP)	1,431
North Kern State Prison (NKSP)	214	4 (3 CTC; 1 MCB)	210
Pelican Bay State Prison (PBSP)	206	1 (CTC)	205
Pleasant Valley State Prison (PVSP)	56	0	56
Richard J. Donovan Correctional Facility (RJD)	1,266	275 (14 CTC; 257 EOP; 4 MCB)	991
California State Prison, Sacramento (SAC)	348	138 (2 CTC; 110 EOP; 3 MCB; 23 PSU)	210
Substance Abuse Treatment Facility and State Prison, Corcoran (SATF)	797	89 (12 CTC; 76 EOP; 1 MCB)	708
Sierra Conservation Center (SCC)	169	0	169
California State Prison, Solano (SOL)	907	5 (all CTC)	902
San Quentin State Prison (SQ)	1,041	37 (8 CTC; 23 EOP; 6 PIP)	1,004
Salinas Valley State Prison (SVSP)	451	119 (11 CTC; 60 EOP; 40 ICF; 4 MCB; 4 PIP)	332

Valley State Prison (VSP)	702	65 (49 EOP; 16 OHU)	637
Wasco State Prison (WSP)	184	2 (both CTC)	182
TOTAL	17,771	3,754	14,017

3. At least weekly, staff at each prison completes and uploads an "Outbreak Management Tool" (OMT) to a server accessible by Plaintiffs' counsel. A true and correct copy of the August 31, 2021 OMT for COR is attached hereto as **Exhibit 1**, which I have redacted to protect patient confidentiality.

4. A true and correct copy of the August 31, 2021 OMT for CVSP is attached hereto as **Exhibit 2**.

5. A true and correct copy of the September 8, 2021 OMT for PBSP is attached hereto as **Exhibit 3**.

6. A true and correct copy of the September 7, 2021 OMT for MCSP is attached hereto as **Exhibit 4**, which I have redacted to protect patient confidentiality.

7. On August 25, 2021, my colleague, Rana Anabtawi, emailed a document titled "Prison Law Office Prison-specific COVID-19 questions for week of August 23, 2021" to CDCR/CCHCS, which included questions and concerns about COVID-19 protocols at several prisons. I was copied on that email. On September 2, 2021, CCHCS emailed Ms. Anabtawi two documents responding to these questions. I was also copied on those emails. True and correct copies of these documents are attached hereto as **Exhibit 5**, which I have redacted to protect patient confidentiality.

8. On September 2, 2021, Ms. Anabtawi emailed a document titled "Prison Law Office Prison-specific COVID-19 questions for week of August 30, 2021" to CDCR/CCHCS, which included questions and concerns about COVID-19 protocols at

several prisons. I was copied on that email. On September 10, 2021, CCHCS emailed Ms. Anabtawi a document responding to these questions. I was also copied on this email. A true and correct copy of this document is attached hereto as **Exhibit 6**, which I have redacted to protect patient confidentiality.

9. As counsel for Plaintiffs, I also receive weekly emails from CCHCS, reporting, among other things, the total number of staff working in CDCR prisons and the rates of vaccination for staff. A true and correct copy of the update I received on September 10, 2021 is attached hereto as **Exhibit 7**. As of that date, CCHCS reported there were 55,659 staff members working in CDCR prisons. Of those, 30,897 (56%) had been administered at least one dose of vaccine.

10. On August 31, 2021, counsel for Defendants emailed counsel for Plaintiffs an Executive Summary and Summary of Performance Measures for CDCR's inspection and evaluation of the prisons' housing unit ventilation systems. *See* ECF No. 3640 (Joint Notice Regarding Resolution of Discovery Dispute). True and correct copies of these documents are attached hereto as **Exhibit 8**.

11. On April 10, 2020, the Receiver issued a memorandum, directing CDCR to create 8-person housing cohorts in the dormitories. On April 27, 2021, the Receiver issued a memorandum rescinding that directive. True and correct copies of both memorandums are attached hereto as **Exhibit 9**. I received these memorandums via email from counsel for CCHCS, on April 10, 2020 and April 27, 2021

12. Attached hereto as **Exhibit 10** is screenshot of CCHCS/CDCR's COVID-19 Tracker, downloaded on September 8, 2021, from https://www.cdcr.ca.gov/covid19/population-status-tracking. According to that tracker, as of September 8, 2021, 49,924 incarcerated patients in CDCR had been infected with COVID-19 and 240 had died.

13. Attached hereto as **Exhibit 11** is a true and correct copy of a Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, titled "Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020," dated December 11, 2020, and available at: https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6949e2-H.pdf.

14. Attached hereto as **Exhibit 12** is a true and correct copy of a memorandum from CDCR and CCHCS, titled "EMPLOYEE CASE MANAGEMENT PROCEDURES TEMPORARILY PLACED ON HOLD," and dated August 25, 2021. I received this memorandum via email from CCHCS on September 2, 2021.

15. Attached hereto as **Exhibit 13** is a true and correct copy of a memorandum from CDCR and CCHCS, titled "EXTENSION OF ROUTINE SURVEILLANCE COVID TESTING EXEMPTION IN JUNE FOR THOSE EMPLOYEES AND PATIENTS WHO ARE FULLY VACCINATED," and dated May 26, 2021. I received this memorandum via email from CCHCS on May 28, 2021.

16. As counsel for Plaintiffs in this action, I also have access to electronic health records for all patients in CDCR. On September 6, 2021 reviewed the medical records of several patients who were listed in the COVID-19 Vaccine Registry on that date as having a COVID-19 weighted risk score of 5, and who were housed in units not covered by the current staff vaccine mandate. I identified the following patients:

- An 83-year-old patient at CIM diagnosed with asthma.
- An 83-year-old patient at CMC diagnosed with paroxysmal atrial fibrillation/flutter and hypertension.
- An 84-year-old patient at CIM diagnosed with stage 3 chronic kidney disease.
- A 64-year-old patient at MCSP diagnosed with COPD, hypertension, and advanced liver disease.

- A 62-year-old patient at SATF who is a fulltime wheelchair user, and is diagnosed with COPD with asthma, morbid obesity, and hypertension.
- A 61-year-old patient at SATF who is a fulltime wheelchair user, and is diagnosed with cardiomyopathy, diabetes mellitus, type 2, hypertension, and obesity.
- A 63-year-old patient at SATF who is a fulltime wheelchair user, has a developmental disability, and is diagnosed with hepatocellular carcinoma, hepatitis C, hypertension, and advanced liver disease.

17. Attached hereto as **Exhibit 14** are select provisions from the CCHCS Health Care Department Operations Manual regarding custody staff's responsibilities to perform services related to the delivery of medical health care; these are available at: https://cchcs.ca.gov/hcdom/. The following table summarizes these provisions:

Title	Section	Provision
Patient Safety Program: Heat Alert Medications	1.2.9(e)(2)(A)	"Designated health care and custody staff shall obtain a Heat Medication Report of all patients currently prescribed a Heat Alert Medication . . . ."
Health Care Ethics Committee	1.3.3(c)(1)(B)(1)(e)	Custody is encouraged to appoint a member to the Ethics Committee.
Effective Communication Documentation	2.1.2(e)(2)(C)(3)	"In locked units . . . during daily Psychiatric Technician rounds, if sign language interpretation is accomplished via video remote, custody staff shall escort patients to a private setting . . . ."
Over-the-Counter Products	2.1.3(d)(4)	"[P]atient access to OTC products shall only be restricted on an individual, case-by-case basis by health care or custody staff . . . ."

Scope of Patient Care Services	3.1.2(b)(3)(D)(3)	"The CEO and all members of the institution leadership team shall . . . [w]ork with custody staff to minimize unnecessary patient movement and ensure appropriate escort and transport."
Care Teams and Patient Panels	3.1.3(b)(3)(A)(14) & (15)	CEO delegates decision-making authority to the CNE for certain daily operations, including: "Working with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment." "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."
	3.1.3(c)(2)(A)(2)	"The range of possible Care Team members includes, but is not limited to, custody staff, pharmacy staff, dietitians, specialists, specialty nursing staff, laboratory or imaging staff, and therapists . . . ."
	3.1.3(c)(4)(A)(3)	"The Care Team shall convene each business day in a Care Team Huddle to . . . [m]anage day-to-day clinic operations, including preparation for that day's encounters, conferring with custody, addressing security or construction impacts to clinic processes, and planning coverage of clinic services while staff are on leave."

	Appendix 1, duty f	Duties of Supervising Registered Nurse (SRN) II include: "Coordinate with custody to mitigate barriers affecting access to health care."
Patient Education	3.1.4(e)(5)(C)(1)	"The institution CNE shall coordinate with the Community Resource Manager . . . and collaborate with medical, mental health, dental, and custody staff to create a Master Schedule of Groups offered within the institution"
	3.1.4(e)(6)(C)(F)	"Each institution shall coordinate with institutional custody leadership to establish a sufficient number of paid [Inmate Peer Mentor] positions to meet the identified needs of the institution."
Scheduling and Access to Care	3.1.5(b)(3)(A)(15)	Mirrors 3.1.3(b)(3)(A) above, outlining duties of CEO, including: "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."
	3.1.5(c)(3)(C)(1)(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 encounter."
	3.1.5(c)(3)(C)(1)(b)	"Each institution shall establish a procedure by which health care

		ducats are issued as priority ducats and delivery by custody is verified/documented."
	3.1.5(c)(3)(C)(1)(d)	"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." [Regarding patients in the Developmental Disability Program/Disability Placement Program]
	3.1.5(c)(3)(C)(2)	"Custody staff shall ensure delivery of priority health care ducats to patients prior to their scheduled appointment."
	3.1.5(c)(3)(C)(3)(b)	In event of missed appointment, "[c]ustody 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."
	3.1.5(c)(3)(D)(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 . . . ."
	3.1.5(c)(3)(E)(3)(b)	"Health care staff may ask custody staff to leave the room if they are comfortable with the patient and custody staff shall respect the request of health care staff and leave the

		room."
	3.1.5(c)(3)(E)(3)(c)	"If health care staff asks custody staff to exit the room and leave the door propped open, custody staff shall be in control of the door to remain in compliance with State Fire Marshall requirements."
	3.1.5(c)(3)(E)(5)	"When health care staff are in housing units or on the tiers, custody staff shall maintain visual surveillance."
Health Care Transfer	3.1.9(c)(3)(E)(5)	"Custody staff shall ensure that the following occurs after the record review by the care team: a. The patient has all of their KOP medications in possession by verifying against the count provided by the care team. b. The patient is in possession of required DME and medical supplies. c. The care team has provided a sealed envelope containing the Patient's Summary Sheet and NA/DOT medication, if applicable."
Outpatient Specialty Services	3.1.11(b)(3)(A)(9)	CEO duties include "[c]ollaborating with the Warden to ensure that custody staff are available to provide timely, safe, and efficient escort and transportation of patients to specialty appointments."
Outpatient Dietary Intervention	3.1.12(d)(3)(C)(2)	"Orders for nourishments . . . shall be stored and distributed by institution food services and custody staff . . . ."

Medication Administration	3.2.4(c)(2)(C)	"Custody staff shall be present at the medication window to directly observe the medication process, maintain order, and provide assistance if necessary."
	3.2.4(c)(3)(A)	"Custody staff shall accompany licensed health care staff on medication administration rounds to facilitate opening of the food port or the cell door, if necessary, for administration of medications."
	3.2.4(c)(5)(A)(2)(e)	"Licensed health care staff, with assistance from custody as needed, shall verify that the patient swallowed the medications by completing a visual mouth check, viewing the empty cup, and other checks as indicated."
Handling of Confiscated Medications	3.5.14(c)(2)(A)	"When medications are confiscated . . . custody staff shall place the medication in an unsealed envelope . . . , label the envelope as 'confiscated medication,' and deliver to nursing staff."
Durable Medical Equipment/Supplies and Accommodations	3.6.1(b)(2)	Purpose of section is to ensure that "[i]nstitution safety and security is maintained by working with and advising custody staff regarding the distribution and maintenance of DME."
	3.6.1(e)(9)(C)	"All DME shall be inspected by custody staff . . . minimally, during required cell inspections."
	3.6.1(e)(9)(E)	"Custody staff shall conduct and log safety and security inspections on all

		wheelchairs on at least a monthly basis."
Emergency Medical Response System	3.7.1(d)(3)(B)	"All correctional peace officers (custody) shall, within the previous two years, have successfully completed a course in CPR that is consistent with AHA guidelines. Custody staff shall maintain a system to manage and track correctional peace officers CPR requirements."
	3.7.1(g)(2)(B)(1)	"All peace officers who respond to a medical emergency shall provide immediate life support until medical staff arrives to continue life support measures. All peace officers must carry a personal CPR mouth shield at all times."
Emergency Medical Response Training Drill Nursing Skills Lab	3.7.2(d)(1)	Emergency training drills "shall address responses to medical emergencies in all areas of the institution and include participation of health care and custody staff."
Tuberculosis Surveillance Program	3.8.7(b)(1)	"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 TB Surveillance Program is successfully implemented and maintained."
Communicating Precautions from Health Care Staff to	3.8.8(a)(1)-(3)	"Health care staff shall communicate to custody the appropriate form of precautions to be used when dealing

Custody Staff		with a single patient or a small cluster of patients who have contracted certain communicable diseases. Staff shall use either the correctional standard precautions or the transmission-based precautions." "When a patient has an infectious disease that is easily transmitted person-to-person but transmission-based precautions are not required (e.g., norovirus or Staphylococcus aureus infections), health care staff shall communicate the need for correctional standard precautions to custody staff." "When a patient needs transmission-based precautions (in addition to correctional standard precautions), health care staff shall communicate the need for transmission-based precautions to custody staff."
Foreign Body Examination	4.1.4(d)(1)(B)	"CDCR custody officers shall escort the patient to the local Medical Imaging Services department."

18. Attached hereto as **Exhibit 15** are select provisions from the CDCR Department Operations Manual regarding custody staff's responsibilities to perform services related to the delivery of medical health care, which are available at: https://www.cdcr.ca.gov/regulations/cdcr-regulations/dom-toc/. The following table summarizes these provisions:

Title	Section	Provision
Possible Death	51070.3	"An employee discovering a possible inmate/parolee death shall immediately summon

		medical assistance. Pending arrival of medical assistance, the employee shall make every effort to preserve life. "This may include first-aid, Cardio Pulmonary Resuscitation (CPR), and other life-saving measures for which the employee is trained. Life support measures shall be continued until the medical personnel arrive."
Lockdown Movement – Medical Appointments or Care	52020.8.8	"Inmates who require medical care, or have scheduled medical appointments, shall be under direct staff supervision and/or escort."

19. In my declaration in support of Plaintiffs' Response to the Order to Show Cause, I listed jurisdictions that had mandated the COVID-19 vaccination as a condition of employment for those working in correctional facilities. *See* ECF No. 3663-1 at 16 ¶ 34. Since we filed that declaration, two additional jurisdictions have mandated the COVID-19 vaccine as a condition of employment for government employees, including for those working in the:

a. **Federal Bureau of Prisons**: Attached hereto as **Exhibit 16** is a true and correct copy of an Executive Order from President Joseph R. Biden, Jr., dated September 9, 2021, and available at https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees.

b. **Orange County Jails**: Attached hereto as **Exhibit 17** is a true and correct copy of a Memorandum from Orange County Sheriff Don Barnes, dated September 7, 2021, and available at https://voiceofoc.org/wp-

content/uploads/2021/09/OC-Sheriff-Memo-on-Updated-State-Public-Health-Order-Requirements-Sept-7-2021.pdf.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at Berkeley, California this 10th day of September, 2021.

DATED: September 10, 2021

/s/ Sophie Hart
Sophie Hart

INDEX OF EXHIBITS

TO DECLARATION OF SOPHIE HART

Exhibit Number	Description
1	Outbreak Management Tool (OMT) for COR (dated August 31, 2021)
2	OMT for CVSP (dated August 31, 2021)
3	OMT for PBSP (dated September 8, 2021)
4	OMT for MCSP (dated September 7, 2021)
5	CCHCS responses to Prison Law Office Prison-specific COVID-19 questions for week of August 23, 2021 (redacted) (received September 2, 2021)
6	CCHCS responses to Prison Law Office Prison-specific COVID-19 questions for week of August 30, 2021 (redacted) (received September 10, 2021)
7	Email from CCHCS reporting rates of staff vaccination (September 10, 2021)
8	CDCR Executive Summary and Summary of Performance Measures for CDCR's inspection and evaluation of ventilation systems (received August 31, 2021)
9	Memorandums from the Receiver regarding social distancing in the dormitories (dated April 10, 2020 and April 27, 2021)
10	Screenshot of CCHCS/CDCR's COVID-19 Tracker (downloaded on September 8, 2021)
11	Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, titled "Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020" (dated December 11, 2020)

12	CCHCS/CDCR Memorandum titled "EMPLOYEE CASE MANAGEMENT PROCEDURES TEMPORARILY PLACED ON HOLD" (dated August 25, 2021)
13	CCHCS/CDCR Memorandum titled "EXTENSION OF ROUTINE SURVEILLANCE COVID TESTING EXEMPTION IN JUNE FOR THOSE EMPLOYEES AND PATIENTS WHO ARE FULLY VACCINATED" (dated May 26, 2021)
14	Select provisions from the CCHCS Health Care Department Operations Manual
15	Select provisions from the CDCR Department Operations Manual
16	Executive Order from President Joseph R. Biden, Jr. (dated September 9, 2021)
17	Memorandum from Orange County Sheriff Don Barnes (dated September 7, 2021)

EXHIBIT 1

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

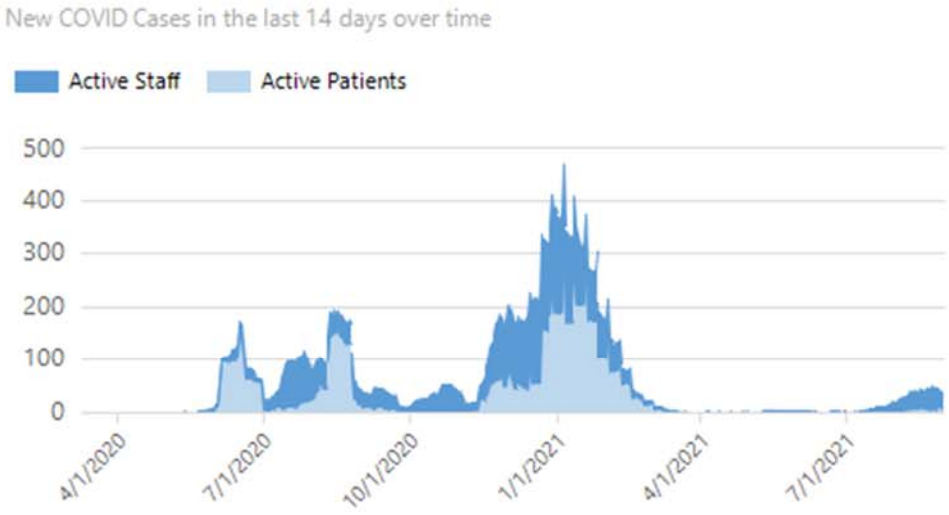
Recent Changes

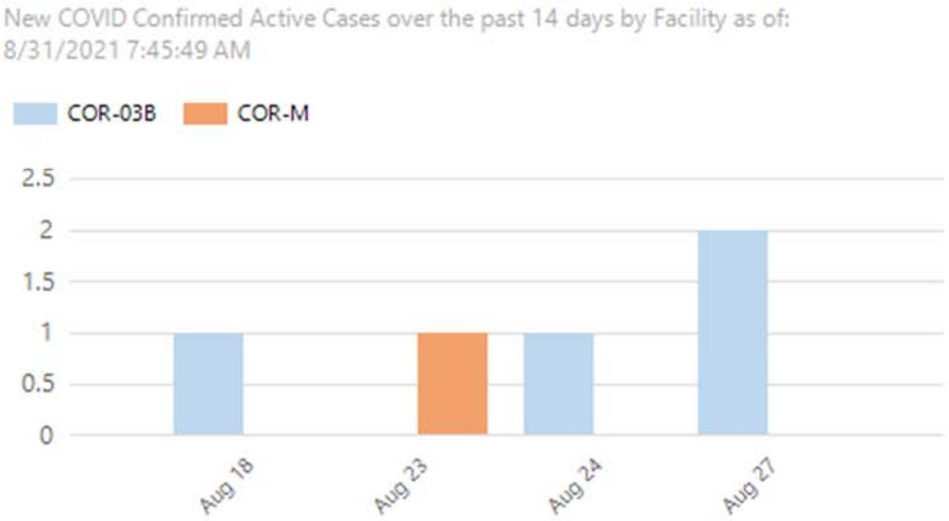
Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined





COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
28	28	5	5

Facility	COR-03A	COR-03B	COR-03C	COR-04A	COR-04B	COR-M	COR-S	COR-Z	Offsite	Total
Confirmed Active	0	0	0	5	0	0	0	0	0	5
Isolation	0	0	0	10	0	0	1	0	0	11
Quarantine	11	179	14	8	52	0	8	12	0	284
Susceptible	654	735	749	255	770	50	69	65	0	3347

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Status of COVID Patients and Isolation/Quarantine Housing, cont.

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

2. Isolation and Quarantine Housing

To look up patients' quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order", click View Report button at right top of report to activate filters. You can also filter by housing unit and building.

Isolation Housing

DATA PULLED @8/31/2021 7:45:33 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
4A1L Section A, 180 Design, Solid Door	40	1	39		N	Designated Isolation Positive - EOP/CCCMS
4A1R Section A, 180 Design, Solid Door	40	4	36	0	N	Designated Isolation Positive - EOP Max Custody
4A3L Section B, 180 Design, Solid Door	40	0	35	5	N	Designated Isolation Negative- GP/CCCMS
INF B, solid door		1			N	I/P cells do not share air space. Not designated isolation housing
TOTALS	**120**	**6**	**110**	**5**		**Available Isolation Beds**

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

Are any patients refusing to move to designated ISO areas?	N	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	7	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Y

Quarantine Housing

DATA PULLED @8/31/2021 7:45:33 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
3A02, 270 design, solid door	200	1		0	N	PQT
3A03, 270 design, solid door	200	6		3	N	PQT
3A04, 270 design, solid door	200	1			Y	Refused to move to designated housing s/p possible exposure (not confirmed).
3B01, 270 design, solid door	200	133			N	Entire building on post exposure quarantine due to MH EOP level of care.

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

3B02, 270 design, solid door	200	46	154	0	N	Designated Quarantine
3C01, 270 design, solid door	200	2			Y	[redacted] refused to move to designated quarantine area.
3C02, 270 design, solid door	200	2			Y	[redacted] refused to move to designated quarantine area.
3C03, 270 design, solid door	200	5	195	0	N	Designated Quarantine (Facility 3C only)
3C04, 270 design, solid door	200	1			Y	[redacted] refused to move to designated quarantine area.
3C05, 270 design, solid door	200	4			Y	[redacted] refused to move to designated quarantine area.
4A1L Section C, 180 design, solid door	48	1			Y	Currently located in Alternative Housing Unit pending evaluation for MHCB.
4A2L Section A, 180 design, solid door	40	0	39	1	N	Designated Quarantine: HLOC Returns - Max Custody
4A2L Section B, 180 design, solid door	40	0	39	1	N	Designated Quarantine: HLOC Returns
4A3R Section A, 180 design, solid door	40	1		0	N	AD-SEG
4A3R Section B, 180 design, solid door	40	2		0	N	AD-SEG
4A3R Section C, 180 design, solid door	48	1		0	N	AD-SEG
4A4L Section B, 180 design, solid door	40	1		0	N	AD-SEG
4B4R Section A, 180 design, solid door	40	17	20	3	N	Designated Post Transfer Quarantine - New Arrivals
4B4R Section B, 180 design, solid door	40	9	24	7	N	Designated Post Transfer Quarantine - New Arrivals

COVID OUTBREAK MANAGEMENT REPORT

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Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

4B4R Section C, 180 design, solid door	48	16	32	0	N	Designated Post Transfer Quarantine - New Arrivals
ASU-STRH	200	7		5	N	Precautionary quarantine (pre transfer quarantined in place)
INF A, solid door	24			1	N	
INF B, solid door	26	5		1	N	
INF C, solid door	14			1	N	
TOTALS	**2688**	**262**	**503**	**22**		**Available Quarantine Beds**

Are any patients refusing to move to designated Quarantine areas?	Y	If so, where are they housed? (Location & # of patients)	3A04: 01, 3C01: 02, 3C02: 02, 3C04: 01, 3C05: 04
How many new Quarantine cases since last report?	32	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Y

ADA Accommodations

To look up Armstrong Class members and their quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order" and under Patient Filters select "Armstrong Class Members", click View Report button at right top of report to activate filters.

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	N	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
338	2 (Both Vaccinated)	105	0

3. Clinical Management of COVID Patients - *Click on any underlined header to access the COVID Monitoring Registry (Clinical) and patient lists for all indicators below*

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	47	0

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0		6

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Testing and Movement Plan

5. Vaccination of Patients and Staff – *Click on any underlined header to access a list of staff or patients affiliated with that category*

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
2187	45	983	*Coming Soon!*	3388	66	2626	713

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)
b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)
c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

Next scheduled surveillance testing will be Tuesday, September 7th.

POC and Serial testing for both transfer and exposure related patients.

Pre Visit POC

Thursdays: POC for Friday & Saturday visits

Saturdays: POC for Sunday & Monday visits

Post Visit PCR

Tuesdays: Post visit PCR for Friday & Saturday visits

7. COVID Test Turnaround Time (Days) – Patients *(See Medical Weekly Report)*

COR	Statewide Average
3-5 Days	Unavailable

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
3347	1765	0	0	1765	0.33%

9. Staff Testing Plan

a. Required frequency per protocol, *and* b. Upcoming testing activity

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

a. Required frequency per protocol
Staff testing completed weekly, currently on Round 60.
- Per HQ memo 7/28/2021, fully vaccinated staff are not required to weekly test until further notice.
- Effective 8/20/2021, weekly staff testing will be extended from 5 to 7 days per week. All unvaccinated staff will be required to test weekly.

b. Upcoming testing activity

c. Staff testing by EHW related to outbreak areas

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

10. COVID Test Turnaround Time – Staff

COR	1-2 Days	SW Average	Unavailable	

11. Anticipated Movement

Scheduled movement as outlined by statewide bus schedule.

12. Movement Matrix Adherence - *Click on the words "Pre-Transfer" and "Post-Transfer" below to open either registry in a new window.*

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	86		25	72	73	1
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	269	10	23	177	208	0

Supplies and Equipment Plan - *For PPE and KN95 supplies contact DOC DOCCOVID19@cdcr.ca.gov. Contact HQ for medical supplies and pharmacy for medications and fluids. For public health consultation contact the Local Health Department and CCHCS Public Health CDCRCCHCSPublicHealthBranch@cdcr.ca.gov.*

13. COVID Test Kits *(See Weekly Medical Services Report)*

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply

14. N95 Masks

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

Current Inventory	67,500
Who uses N95 masks and in which locations?	Medical and Custody staff in Unit A, Unit B, Unit C and D in CTC

15. Resource Requests

16. PPE Inventory Report - *Click here to open the CDCR/CCHCS Personal Protective Equipment Statewide Inventory and Usage Report*

Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	512,059	1,298	392	6/22/2022
Gloves	1,289,930	4,246	112	9/15/2021
KN95 Masks	31,500	N/A	N/A	N/A
N95 Masks	67,500	50	1351	2/2/2025
Eye Protection	16,487	16	1001	2/21/2024
Gowns	33,830	48	707	4/30/2023
Cloth Masks	1,000	N/A	N/A	N/A
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)	27,728	7	3961	1/24/2032

Staffing Plan - *Describe deficiencies in resources and plan to remedy. Include discussion of specific registry orders, etc.. Consider need to cohort staff so that those working with cases or contacts of cases do not engage with other populations.*

17. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership)*

9 nursing staff out COVID

18. Custody

13 custody staff out due to COVID

19. Providers

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

No provider issues

20. Administrative / Other Staff

2 CDCR non custody, 2 CCHCS medical staff, 1 CCHCS non-medical staff and 1 PIA out due to COVID related issues.

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing: current physical distancing directives in place. Signs posted, floors marked for social distancing.
- Disinfection/Cleaning: Daily sanitation of high contact surfaces in all areas, cleaning scheduled in place. Deep cleaning PIA laundry
- Environment Controls: Implemented N95 masks for all staff in all isolation and quarantine areas.
- Feeding / showers / phones / canteen / programming / ventilation: Cell feeding and no yard activities

22. Education/Communication Plan

- Staff vaccination clinic open on Wednesday's with EHP.
- COVID Vaccine education provided to I/P population via broadcasting channel, flyers, and during clinical encounters with patients.
- Signage posted outside of buildings, PPE donning and doffing stations in place, education information on weekly testing playing on inmate information television

23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

Effectiveness: Dental department has been directed to POC test before all dental encounters effective 2/17/21. Dental, nursing, and custody collaborated to ensure that POC testing is done in an outdoor area to limit potential exposure from aerosol generated procedures.

24. Other

- 37 Patients identified as IMMUNOCOMPROMISED and eligible for 3rd dose recommendation for COVID vaccine booster. All 37 initially identified have been offered and vaccinated for those who accepted.
- How are CPAP patients being managed?
  We follow the aerosol generating procedures from HQs. CPAPS are tracked by housing to ensure single cell status.

# of Patients with CPAP Equipment	85	

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

Recent Changes

Date: 8/31/2021 7:45:49 AM **Institution:** (COR)

TOPICS FOR DISCUSSION

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

26. RHE/AD Comments

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*
- *Questions about this report? Contact QMStaff@CDCR.ca.gov*

EXHIBIT 2

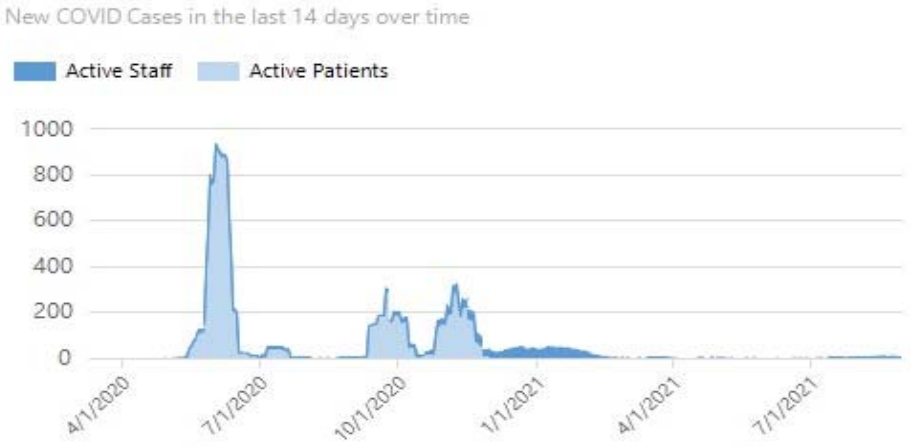
COVID OUTBREAK MANAGEMENT REPORT

Date: 8/31/21 9:51 AM **Institution:** Chuckawalla Valley State Prison (CVSP)

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation / Quarantine Housing

1. Current Active Cases / Isolated / Quarantined



COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
10	10	0	0

Facility	CVSP-A	CVSP-B	CVSP-C	CVSP-D	CVSP-M	CVSP-S	Offsite	Total
Confirmed Active	See comments to the right							
Isolation								
Quarantine								
Susceptible	513	650	624	371	99	10	0	2267

Notes:

650

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Status of COVID Patients and Isolation / Quarantine Housing, cont.

2. Isolation and Quarantine Housing

To look up patients' quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order", click View Report button at right top of report to activate filters. You can also filter by housing unit and building.

Isolation Housing

DATA PULLED @8/31/2021 9:50:14 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design e.g.*(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
D11 (Dorm)	192	0	192	N/A	N/A	
Community Hospitals (without EHRS isolation order	N/A	0	N/A	N/A	N/A	85

Are any patients refusing to move to designated ISO areas?	N/A	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	0	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

Quarantine Housing

DATA PULLED @8/31/2021 9:50:14 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design e.g.*(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Isolation	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
A3	200	87	113	30	N	
OHU	24	2	22	N/A	N/A	

Are any patients refusing to move to designated Quarantine areas?	N	If so, where are they housed? (Location & # of patients)	N/A

How many new Quarantine cases since last report?	N	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

ADA Accommodations

To look up Armstrong Class members and their quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order" and under Patient Filters select "Armstrong Class Members", click View Report button at right top of report to activate filters.

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	N	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
52	49	12	12

3. Clinical Management of COVID Patients - *Click on any underlined header to access the COVID Monitoring Registry (Clinical) and patient lists for all indicators below*

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours

0	2	0

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0		9

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	No updates at this time

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Testing and Movement Plan

5. Vaccination of Patients and Staff – *Click on any underlined header to access a list of staff or patients affiliated with that category*

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
893	27	434	*Coming Soon!*	2278	57	1918	299

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)
b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour.)
c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

a. Testing Plan for the week of: **08/30/2021 - 09/05/2021**

1. Continue testing all post-visiting (in person) patients. Continue testing all COVID-19 naive patients and critical areas inmate workers who are not fully vaccinated. Continue testing all post-Family visiting patients within 72-96 hours. Continue testing quarantined patients. Continue testing patients within 7 days of their parole date. Continue testing pre-transfer patients within 5 days of their transfer date. Continue testing all new arrivals; out to medical returns; and Higher Level of Care returns on day 5 and day 12. Continue testing patient as needed.

b. POC Antigen testing plan:

Continue testing all pre-transfer inmate/patients within 24 hours prior the transfer. Continue testing all pre-visiting patients (in-person and Family visiting), who are not fully vaccinated, within 3 days prior to their scheduled visit. Continue testing all out to medical and higher level of Care returns on day 5 after they return to the institution. Continue testing patient as needed.

c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

CVSP is on track in meeting testing requirements per the testing schedule.

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2267	1052	96	1	956	0.00%

9. Staff Testing Plan

a. Required frequency per protocol, *and* b. Upcoming testing activity

COVID-19 testing will be held in the Personnel Kitchen (PK) Monday through Friday every week. All staff are to test weekly unless they are on extended leave for various reasons, or they have tested positive within the last 12 weeks. 2021-NO ROUTINE COVID-19 TESTING IN MAY, JUNE, JULY and AUGUST FOR THOSE WHO ARE FULLY VACCINATED. Unless staff is experiencing symptoms or are identified as a closes contact to an active case.

10. Staff Testing Results

Testing for Week	Total Civil Service Staff	Staff Tested	% Staff Tested	Positive Staff	Positivity Rate
08/09/2021-08/13/2021	775	521	67.23%	5	0.96%
08/02/2021-08/06/2021	791	491	62.07%	5	1.02%

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

11. COVID Test Turnaround Time – Staff

CVSP	1-2 days from MiraDX	SW Average	N/A	

12. Anticipated Movement

Paroles Tomorrow:	Positive Paroles:	Parolees for Project Hope:	Expedited Transfers:	Anticipated Transfers from Institution:	Anticipated to Received	Notes:
1	0	0	Reviewed; Treat in Place	Week of 08/23/2021: 5	Week of 08/30/2021: 27	Medical Chronos were reviewed prior to transfers. Send and Intake for week of 9/6/21 will be received on 9/1/21.

13. Movement Matrix Adherence

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	47		3	43	43	3

POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	156	7	1	98	104	91

Supplies and Equipment Plan - *For PPE and KN95 supplies contact DOC DOCCOVID19@cdcr.ca.gov . Contact HQ for medical supplies and pharmacy for medications and fluids. For public health consultation contact the Local Health Department and CCHCS Public Health CDCRCCHCSPublicHealthBranch@cdcr.ca.gov .*

14. COVID Test Kits *(See Weekly Medical Services Report)*

Inventory as of Noon		Ordered as of 2 PM	Available Test Kit Supply
Quest Red Top Swab Kits	207		
SOPHIA-2	225		
VCM tubes for influenza	4,581		
Valencia Swab Kits	1,500		
Binax Cards	600		

Notes: REDTOP ON BACKORDER FROM QUEST, USING VCM AS BACKUP IF NEEDED

15. N95 Masks

	HEALTHCARE:		CUSTODY:	
Current Inventory	**3M:**	16,659	**3M:**	21,572
	BYD:	24,880	**BYD:**	245,858
Who uses N95 masks and in which locations?	**HEALTHCARE:**		**CUSTODY:**	
	No distribution for week of AUG 24		**3M:** 8/5/21 HFM FIT TESTING 80 8/6/21 MSF 5	**BYD:** 8/10/21 100 Transportation 8/13/21 2 Canteen 8/125/21 200 Control/Trns bags

a. KN95 Masks

	HEALTHCARE:	CUSTODY:
Current Inventory	33,000	173,430
Who uses KN95 masks and in which locations?	**HEALTHCARE:**	**CUSTODY:**
	Not in use	Zero Masks Issued in August

16. Resource Requests

HEALTHCARE:

None at this time

CUSTODY:

None at this time

17. PPE Inventory Report - *Click here to open the CDCR/CCHCS Personal Protective Equipment Statewide Inventory and Usage Report*
Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

HEALTHCARE:				
Equipment	Inventory	One Week Usage	Projected Run-Out Date	Projected Weeks Until Out
Goggles (Each)	58	0	N/A	N/A
PPE/Spill Kit (Each)	10	0	N/A	N/A
N95 Masks (Box/20)	44,558	0	N/A	N/A
KN95 Masks (Box/20)	33,000	0	N/A	N/A
Surgical Masks (Each)	293,784	0	N/A	N/A
Face Shields (Each)	22,605	0	N/A	N/A
Gowns (Each)	38,045	40	11/22/2039	951
Nitrile SM Gloves (Box)	41,900	0	N/A	N/A
Nitrile MD Gloves (Box)	876,500	300	6/1/2027	
Nitrile LG Gloves (Box)	568,880	0	N/A	N/A
Nitrile XLG Gloves (Box)	17,400	1,100	12/14/2021	15
Sanicloth Super Wipes (Can)	135	5	3/8/2022	27
Sanicloth Wipes (Pac)	1,374	0	`N/A	N/A
Hand Sanitizer Foam (1200ml)	14	0	N/A	N/A
Hand Sanitizer Foam (45ml)	111	0	N/A	N/A
Hand Sanitizer Gel Cleanse	336	0	N/A	N/A
Germ-X Hand Sanitizer (8 oz)	208	0	N/A	N/A

Notes:

CUSTODY:				
Equipment	Inventory	One Week Usage	Projected Run-Out Date	Projected Weeks Until Out

Goggles (Each)	49,970	0	N/A	N/A
PPE/Spill Kit (Each)	85	0	N/A	N/A
N95 Masks (3M) (Box/20)	21,572	0	N/A	N/A
N95 Masks (BYD) (Box/20)	245,858	0	N/A	N/A
KN95 Masks (Box/20)	173,430	0	N/A	N/A
Surgical Masks (Each)	1,004,750	2,000	4/18/2031	502.38
Face Shields (Each)	278,406	0	N/A	N/A
Gowns (Each)	57,779	0	N/A	N/A
Nitrile SM Gloves (Box)	45	0	N/A	N/A
Nitrile MD Gloves (Box)	265	0	N/A	N/A
Nitrile LG Gloves (Box)	6,084	2	12/19/2079	3042.00
Nitrile XLG Gloves (Box)	6,798	2	10/22/2086	3399.00
Lysol Wipes (Can)	282	0	N/A	N/A
Cavi Wipes (Can)	0	0	N/A	N/A
Hand Sanitizer (Alcohol) (Pump)	1,441	0	N/A	N/A
Hand Sanitizer (Non-Alcohol) (Pump)	687	0	N/A	N/A
Liquid Hand Soap	210	13	12/22/2021	16.15
Foaming Hand Soap (Dispensers)	1,446	6	4/14/2026	241.00
Cell Block 64	664	7	6/26/2023	94.86
Bleach	122	0	N/A	N/A

Staffing Plan - *Describe deficiencies in resources and plan to remedy. Include discussion of specific registry orders, etc.. Consider need to cohort staff so that those working with cases or contacts of cases do not engage with other populations.*

18. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership.)*

8/30/2021 3W:	82%	Vacancies are filled with registry staff, overtime and redirects. No issues at this time with the current process.
8/31/2021 1W:	60%	
8/31/2021 2W:	97%	

19. Custody

8/31/2021	3W:	CO: 12	SGT: 3	LT: 0	With the proposed vacancies mentioned, we do not foresee any issues staffing these vacancies throughout the weekend. The vacancies will be filled either through overtime or the utilization of OP F#53, which is a plan for program adjustment due to vacant posts caused by staff shortages.
9/1/2021	1W:	CO: 0	SGT: 1	LT: 1	
9/1/2021	2W:	CO: 18	SGT: 1	LT: 2	

20. Providers

1 provider scheduled off, all other providers scheduled are present.

21. Administrative / Other Staff

Institution Vacancies (including: Telework, Sick/Family Sick, Vacation, Scheduled Time Off, PLP, PDD, FMLA, Bereavement Leave, Long Term Sick/Worker's Comp)

Accounting:	0	Notes: **Fire House**- 2 on duty, 3 Strike Team, 1 Vacant,
Business Services:	1	
Personnel:	8	
Records:	5	
Procurement:	9	
Food Services:	15	
Plant Operations:	24	
Fire House:	2	

Other Operations/Stakeholders

22. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
    - Feeding / showers / phones / canteen / programming / ventilation

CUSTODY:	1. All facilities have normal program including yard, dayroom, showers, canteen, packages, and phone calls alloweing for social distancing and frequent cleaning. For all facilities, inmates attending DRP, Education, Vocational and ITLAG programs will be allowed from different housing units ensuring social distancing and areas to be cleaned between each session. 2. Cleaning/disinfecting: All housing units will clean and disinfect tables, restrooms, phones and common areas with bleach and water between each use. Dining hall to be disinfected after each building. All DRP, Education, Vocational and ILTAG areas will be cleaned between each session. 3. Weekly Tour Checklist: Completed as scheduled. 4. Weekly Cleaning: Completed as scheduled.
HFM/PIA:	**Any Changes necessary to the following plans to protect staff, patients, or inmate-workers?** All Training will be limited to the number of inmates per session to allow for social distancing, masks are requited, offender workers screened daily for symptoms before allowed into work areas, and all high touch arreas are disinfected daily per COVID cleaning guidelines.

23. Education/Communication Plan

· Residents and Staff

· Community and/or Public Health Outreach

a. Staff:	1. Any Information will be communicated via custody supervisors to staff as needed.
b. Residents:	1. Any information will be communicated to inmates via custody and helath care staff as needed
c. Community Outreach:	No updates at this time
	1. All porters to follow disinfecting procedures as outline in institutional porter training.d. Custody Inmate 2. All inmate workers are required to wear face masks.Workers:
e. HFM Inmate Workers:	• Fit-testing of N95 masks for current Central Health offender workers has been completed and a process has been established for new hires. • All contracted medical areas are on normal cleaning program.

24. Pre-Procedural COVID Testing for Dental Patients

· Effectiveness/challenges of program

No Updates

25. Other

How are CPAP patients being managed?

# of Patients with CPAP Equipment	44	Notes: No updates at this time. Patients w/ CPAP machines are tested at least monthly.

26. Status on Pending Action Items from Previous Meetings

· CEO/Warden Comments

None

27. RHE/AD Comments

None

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred □□Questions about this report? Contact QMStaff@CDCR.ca.gov*

EXHIBIT 3

COVID OUTBREAK MANAGEMENT REPORT

Click Here for Instructions on how to Export to Word

Registry Definition

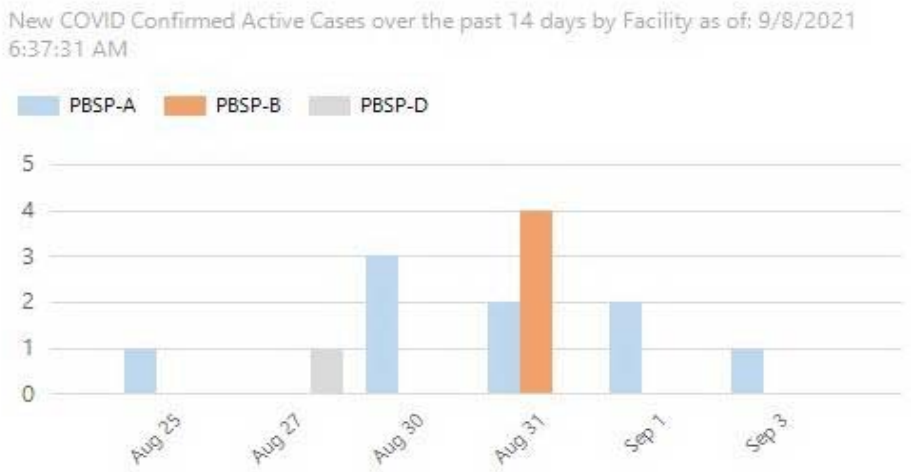
Recent Changes

Date: 9/8/2021 6:37:31 AM

Institution: (PBSP)

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined



COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days
30	30	15	14

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

Date: 9/8/2021 6:37:31 AM

Institution: (PBSP)

Facility	Offsite	PBSP-A	PBSP-B	PBSP-C	PBSP-D	PBSP-M	PBSP-S	PBSP-Z	Total
Confirmed Active	0	0	0	14	0	0	1	0	15
Isolation	0	1	0	15	0	0	1	0	17
Quarantine	1	347	262	5	41	0	1	2	659
Susceptible	0	696	584	205	426	32	6	57	2006

Active patients=14. Numbers generated in this report include a POC positive pending PCR confirmation.

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Status of COVID Patients and Isolation/Quarantine Housing, cont.

2. Isolation and Quarantine Housing

To look up patients' quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order", click View Report button at right top of report to activate filters. You can also filter by housing unit and building.

Isolation Housing

DATA PULLED @9/8/2021 6:35:24 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

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Recent Changes

Date: 9/8/2021 6:37:31 AM

Institution: (PBSP)

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
C1: A-F Pods	96	14	82	2	No	C1: Lexan on cell fronts C6: Not activated, designated and ready for activation for surge overflow.

Are any patients refusing to move to designated ISO areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new COVID positive cases since last report?	0	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

Quarantine Housing

DATA PULLED @9/8/2021 6:35:24 AM

Field Name	Definition
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure
Available Beds	Note the actual amount of available beds in the housing unit.

COVID OUTBREAK MANAGEMENT REPORT

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Recent Changes

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Institution: (PBSP)

Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
A1: C Sections A2: A, B, C Sections A3: C Section C2: F pod Z: Sections B,H,D,E	162	120	31	11	No	A1: Arizona cell doors with Lexan covering A2: Arizona cell doors with Lexan covering Z: ASU; solid cell doors

Are any patients refusing to move to designated Quarantine areas?	No	If so, where are they housed? (Location & # of patients)	N/A
How many new Quarantine cases since last report?	0	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	N/A

ADA Accommodations

To look up Armstrong Class members and their quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order" and under Patient Filters select "Armstrong Class Members", click View Report button at right top of report to activate filters.

COVID OUTBREAK MANAGEMENT REPORT

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Registry Definition

Recent Changes

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Institution: (PBSP)

Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	No	If so, where are they housed? (Location & # of patients)	N/A
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	N/A	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	N/A

COVID High Risk Individuals

COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
157	2	20	0

3. Clinical Management of COVID Patients - *Click on any underlined header to access the COVID Monitoring Registry (Clinical) and patient lists for all indicators below*

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	59	2

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date

COVID OUTBREAK MANAGEMENT REPORT

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Institution: (PBSP)

0	0	0

Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	Community resources are limited, ICU beds at Sutter Coast Hospital support the surrounding communities and the institution. SCH is currently operating under a surge plan, resources have been received from CDPH and OES. If SCH cannot accommodate local patients in need of ICU level of care, a handoff would be coordinated for transport outside of the community. CCHCS has been active in coordinating additional acute care resource facilities should the need arise.

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

Testing and Movement Plan

5. Vaccination of Patients and Staff – *Click on any underlined header to access a list of staff or patients affiliated with that category*

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
1358	34	425	*Coming Soon!*	2107	76	1587	454

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.) b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)

c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

Surveillance testing of patient population and response testing of quarantined housing units at designated intervals.

COVID OUTBREAK MANAGEMENT REPORT

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Institution: (PBSP)

7. COVID Test Turnaround Time (Days) – Patients *(See Medical Weekly Report)*

PBSP	Statewide Average
~3 days	

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
2006	3177	895	40	2282	0.65%

9. Staff Testing Plan

a. Required frequency per protocol, *and* b. Upcoming testing activity

Staff testing strategy, continue mandated twice weekly testing for all staff regardless of vaccination status. Testing available for staff 7 days per week.

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

COVID OUTBREAK MANAGEMENT REPORT

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Recent Changes

Date: 9/8/2021 6:37:31 AM

Institution: (PBSP)

10. COVID Test Turnaround Time – Staff

PBSP	~2 days	SW Average		

11. Anticipated Movement

Movement to resume, per Movement Matrix.

12. Movement Matrix Adherence - *Click on the words "Pre-Transfer" and "Post-Transfer" below to open either registry in a new window.*

PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	50		37	48	48	0
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	52	2	4	37	39	1

COVID OUTBREAK MANAGEMENT REPORT

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Recent Changes

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Institution: (PBSP)

Supplies and Equipment Plan - *For PPE and KN95 supplies contact DOC DOCCOVID19@cdcr.ca.gov . Contact HQ for medical supplies and pharmacy for medications and fluids. For public health consultation contact the Lo cal Health Department and CCHCS Public Health CDCRCCHCSPublicHealthBranch@cdcr.ca.gov .*

13. COVID Test Kits *(See Weekly Medical Services Report)*

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply
5300	3000	

14. N95 Masks

Current Inventory	See PPE numbers from the PowerBI report below.
Who uses N95 masks and in which locations?	N95 are used and deployed in accordance with CDCR/CCHCS PPE Guidance directive; quarantine, isolation areas, and while present during aerosolizing generating procedures.

15. Resource Requests

No pending 213 RR (Resource Requests).

16. PPE Inventory Report - *Click here to open the CDCR/CCHCS Personal Prot ective Equipment Statewide Inventory and Usage Report*

Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks				
Gloves				
KN95 Masks				
N95 Masks				
Eye Protection				
Gowns				
Cloth Masks				

PPE Group	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Cloth Masks	2,208			
Eye Protection	144,623	-31	4,733	8/21/2034
Gloves	907,671	-3,945	230	4/23/2022
Gowns	60,779	-97	626	5/24/2023
KN95 Masks	208,200	-45	4,643	5/23/2034
N95 Masks	330,988	-173	1,909	11/27/2026
Surgical Masks	935,680	-721	1,297	3/25/2025

COVID OUTBREAK MANAGEMENT REPORT

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Institution: (PBSP)

Staffing Plan - *Describe deficiencies in resources and plan to remedy. Include discussion of specific registry orders, etc.. Consider need to cohort staff so that those working with cases or contacts of cases do not engage with other populations.*

17. Nursing *(Review Clinical Operations Reports through Regional or HQ Nursing leadership)*

Continue to operate with critical staff shortages; daily monitoring of operations continues. 8/9/2021, request placed to CCHCS for additional resources to assist during surge. One nurse has been received from CDPH.

18. Custody

Custody staffing resources have been reduced due to positive cases and mandated quarantine. Management continues to evaluate staffing levels for each facility. Programs for impacted facilities may be modified based on staffing resources available.

19. Providers

Sufficient provider resources regarding Covid related conditions are addressed and monitored daily. No additional resources needed at this time. Will continue to evaluate based upon identification of positive cases.

20. Administrative / Other Staff

Staffing resources for Covid related conditions are monitored. No additional resources needed at this time. Will continue evaluate based upon identification of positive or quarantine cases.

Other Operations/Stakeholders

21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
- Feeding / showers / phones / canteen / programming / ventilation

COVID OUTBREAK MANAGEMENT REPORT

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Recent Changes

Date: 9/8/2021 6:37:31 AM

Institution: (PBSP)

Physical distancing, mandated mask wearing, disinfection/cleaning continue to be active and monitored through compliance audits. N95 mask use mandated in A & B Facilities and the CTC building due to outbreak status. A3, A4, B1, B3, B4, B5, B6, D2, operating under a PSR due to modified programs (quarantine-sheltering in place).

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

ICP briefing for external stakeholders conducted 1200 hours, each Friday. Community stakeholders, Public Health, and OES are all invited to participate. Please refer to ICP Notes for attendance and discussions.

23. Pre-Procedural COVID Testing for Dental Patients

□□□□Effectiveness/challenges of program

No challenges encountered. Limited to urgent, emergent dental treatment for units on quarantine or isolation.

24. Other

□ How are CPAP patients being managed?

# of Patients with CPAP Equipment	26

25. Status on Pending Action Items from Previous Meetings

□□CEO/Warden Comments

N/A

26. RHE/AD Comments

N/A

COVID OUTBREAK MANAGEMENT REPORT

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Institution: (PBSP)

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred*

Questions about this report? Contact QMStaff@CDCR.ca.gov

EXHIBIT 4

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Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

DefinitioRecent Changesn

TOPICS FOR DISCUSSION

Status of COVID Patients and Isolation/Quarantine Housing

1. Current Active Cases / Isolated / Quarantined

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

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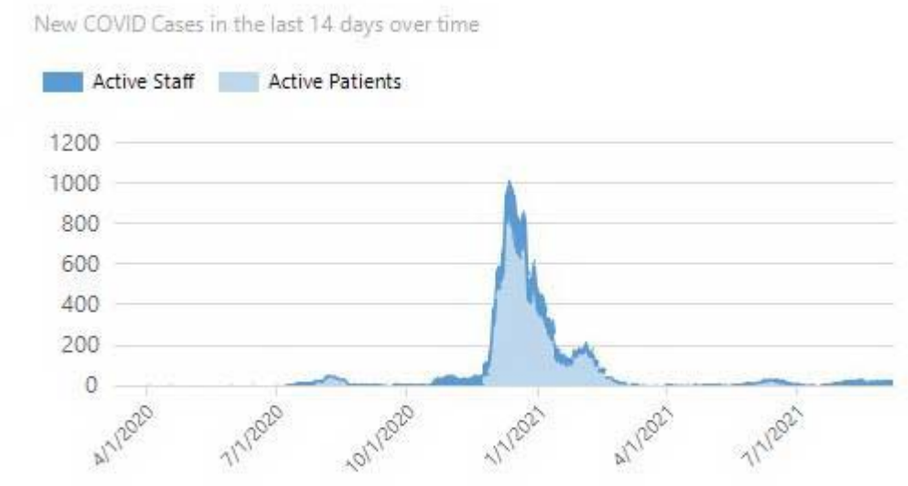

COVID Active Staff Today	New Staff Cases in Last 14 Days	COVID Active Patients Today	New Patient Cases in Last 14 Days

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

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24	24	1	1

Per RTW and Employee Health there are currently 13 staff out on isolation and 1 on extended leave for a total of 14 staff out for COVID related reasons. There were a total of 15 positive staff from last week, 13 via Miradx results and 2 via offsite testing.

As of 8/31/2021 there is a staff outbreak in Building E20 due to 3 linked staff cases (positives from 8/15/2021, 8/16/2021 and 8/22/2021). Staff are required to wear N95s in E20 until approximately 9/8/2021 per EHP

As of 9/2/2021 there is a staff outbreak in IST/Range due to 3 linked staff cases, positive staff worked 8/23/2021 – 8/27/2021. 1 staff was an instructor and 2 were staff going through block and range. Custody will identify staff who attended IST 8/21/2021 – 8/27/2021. Staff are recommended to wear N95s in IST/Range until approximately 9/10/2021.

As of 9/2/2021 there is a staff outbreak in C Clinic due to 3 linked staff cases, positive staff worked 8/22/2021 – 9/1/2021. Staff are required to wear N95s in C Clinic until approximately 9/15/2021.

As of 9/7/2021 there is a staff outbreak in A Clinic due to 3 linked staff cases, last positive on 9/3/2021. Staff are required to wear N95s in A Clinic until approximately 9/17/2021. Per Custody HFM completed a deep clean of A Clinic over the weekend. EHP is completing staff surveillance testing.

TOPICS FOR DISCUSSION

Facility	MCSPA	MCSPB	MCSPC	MCSPD	MCSPE	MCSPM	MCSPS	Offsite	Total
Confirmed Active	0	0	0	0	0	0	1	0	1

Total Positive: 1 Positive. 0 new positive in the last 24 hours.
Total Re-Positive: 0 current Re-Positive. Per the registry 10 re-positive and 10 re-resolved.
Total on Isolation: 4 patients with isolation orders.

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

DefinitioRecent Changesn

Isolation	2	0	1	0	0	0	1	0	4
Quarantine	32	0	10	1	0	0	2	0	45
Susceptible	681	757	770	755	781	57	12	0	3813

Isolation Locations: 1 patient on isolation in MCIC R&R and 3 patients on precautionary isolation in A2.

[redacted] from A3 is a first time positive as of 9/1/2021 via PCR test (results received on 9/2/2021). [redacted] is vaccinated with a second dose on 2/24/2021. Housed in MCIC R&R.

[redacted] placed on precautionary isolation on 9/1/2021 from A3 due to COVID symptoms. [redacted] is vaccinated (J&J), positive 1/26/2021 and POC negative 9/1/2021.

[redacted] out of Building A3 symptoms as of 9/3/2021. PCR negative on 9/3/2021 and vaccinated with last dose 3/14/2021.

[redacted] out of A3 symptoms as of 9/3/2021. PCR negative 8/25/2021, 8/30/2021, 9/1/2021 and POC negative 9/3/2021. Unvaccinated.

Total on Quarantine: 45 patients with quarantine orders per the COVID Monitoring Registry. Building A2 is our designated quarantine units. Per CME and PHN A3 will be removed from quarantine today and the 12 patients who refused testing on 9/3/2021 will have tests reoffered today. If patients refuse testing again they will be placed on quarantine status and moved to A2. A3 patients quarantine orders were not placed previously, although requested, and no need to place at this time as A3 is being removed from quarantine status. .

There are 46 patients on precautionary quarantine or quarantine status at this time, 32 in A2, 11 in ASU, 1 in D18 (DPW) and 2 in CTC.

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

DefinitioRecent Changesn

QMSU staff followed up with the doctors daily on any patients on quarantine or isolation status that do not have a current quarantine or isolation order or patients needing orders discontinued.

At least once per week, check the COVID Population Tracker, Institution View tab to see your institution's new case rate vs. county and state new case rates here.

Per the Population Tracker there is 1 active case and 1 new case in the last 14 days, which match our registries and logs.

Status of COVID Patients and Isolation/Quarantine Housing, cont.

2. Isolation and Quarantine Housing

To look up patients' quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order", click View Report button at right top of report to activate filters. You can also filter by housing unit and building.

Isolation Housing	
DATA PULLED @9/7/2021 7:54:46 AM	
Field Name	**Definition**

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COVID OUTBREAK MANAGEMENT REPORT

Registry

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TOPICS FOR DISCUSSION	
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac.-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for isolation
In Isolation	Number of patients in isolation due to being COVID-19 positive (+)
Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Isolation	Patients on precautionary isolation (includes symptomatic patients without a confirmed COVID-19 test result)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your isolation population? Answer “Y or N”. If “Y”, include plan to move patients if co-located with other populations in the “Comments” section. Do not include “resolved” patients

Housing	Capacity	In Isolation	Available Beds	Precautionary Isolation	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

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MCIC R&R	10	1	9	*	No	[redacted] from A3 is a first time positive as of 9/1/2021 via PCR test (results received on 9/2/2021). [redacted] is vaccinated with a second dose on 2/24/2021. Housed in MCIC R&R.

Date: 9/7/2021 7:55:04 AM **Institution:** (MCSP)

COVID OUTBREAK MANAGEMENT REPORT

Registry

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A2	*	*	*	3	Yes	There are 3 patients on precautionary quarantine in A2 due to COVID symptoms. [redacted] placed on precautionary isolation on 9/1/2021 from A3 due to COVID symptoms. [redacted] is vaccinated (J&J), positive 1/26/2021 and POC & PCR negative on9/1/2021. [redacted] out of Building A3 symptoms as of 9/3/2021. PCR negative on 9/3/2021 and vaccinated with last dose 3/14/2021. [redacted] out of A3 symptoms as of 9/3/2021. PCR negative 8/25/2021, 8/30/2021, 9/1/2021 and POC negative 9/3/2021. Unvaccinated. All single cell, solid closed door housing with at least two vacant cells between quarantined, precautionary quarantine and precautionary isolation patients.
Are any patients refusing to move to designated ISO areas?		N	If so, where are they housed? (Location & # of patients)			

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TOPICS FOR DISCUSSION			
How many new COVID positive cases since last report?	2	Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	Yes, all moves were in timeframes. No pending moves.

Quarantine Housing	
DATA PULLED @9/7/2021 7:54:46 AM	
Field Name	**Definition**
Housing	Facility, Housing Unit, Section, Building and Door Design *e.g.(Fac.-C HU3 A-sec 180 Solid Door)*
Capacity	Building capacity designated for quarantine
In Quarantine	Number of patients in quarantine due to COVID-19 exposure

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Available Beds	Note the actual amount of available beds in the housing unit.
Precautionary Quarantine	Patients on precautionary quarantine due to transfer (includes pre & post transfers)
Patients Co-Located? (Y/N)	Are other than COVID-19+ patients co-located with your quarantine population? Answer "Y or N". If "Y", include plan to move patients if co-located with other populations in the "Comments" section. Do not include "resolved" patients

Housing	Capacity	In Quarantine	Available Beds	Precautionary Quarantine	Patients Co-Located? (Y/N)	Comments (Cell type, Door type - e.g., Single Cell, Solid Door)
CTC	*	*	*	2	Yes	2 patients on precautionary quarantine in CTC due to hospital visits/refusal for testing. Single cell, solid/closed door housing.
A2 New Arrivals/HLOC	*	16 Cell 115, 118 X2, 119 X2, 124, 125, 133, 150, 218, 219, 224, 225, 231, 232, 233	*	16 Cells 126, 127, 128, 129, 131, 132, 145, 226, 227, 234, 235, 239, 240, 242, 243 and 247	Yes	There are 16 patients on quarantine in A2 due to exposure/contact of positive staff and 16 patients on precautionary quarantine due to movement/hospital visits/testing refusals in A2. All single cell, solid/closed door housing with at least two vacant cells between quarantined, precautionary quarantine or isolation patients with the exception of [redacted] and [redacted]

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Returns/ER Admits						[redacted] are both in 118 as positive staff exposures and [redacted] and [redacted] are both in 119 as positive staff
TOPICS FOR DISCUSSION						
						exposures. At this time precautionary isolation, precautionary quarantine and quarantine patients are housed in A2.
A3	*	*	*	*	No	Placed on quarantine on 9/3/2021 due to patient positive. Removed as of today 9/7/2021.

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ASU	*	1 Cell 224	*	10 Cells 110, 114 X2, 120, 134, 137, 147, 235, 239 and 240	Yes	There is 1 patient on quarantine in ASU due to exposure/contact of positive staff. There are 10 patients on precautionary quarantine due to movement/pending movement/hospital visits in ASU with single cell, solid/closed door housing and at least one empty cell between precautionary quarantined, quarantined and non-quarantined patients as space allows. With the exception of [redacted] who are both celled in C12 [redacted] was placed on precautionary quarantine as a pending transfer on 8/30/2021, [redacted] refused to remove from the cell and will be on quarantine status the same length of time as [redacted]. At this time precautionary quarantine, quarantine patients and patients not on quarantine status are housed in ASU.

Click Here for Instructions on how to Export to Word

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D18A	*	1 D18A 103L	5	*	Yes	There is 1 patient on quarantine in D18 due to exposure/contact of a positive staff. [redacted] is DPW. The cell accommodates 6 beds; however, [redacted] is the only one in the cell at this time, single cell/solid closed door housing.

Are any patients refusing to move to designated Quarantine areas?	N	If so, where are they housed? (Location & # of patients)	
How many new Quarantine cases since last report?		Have the new positive cases been moved to appropriate housing units? (Y/N) If moved, what was the approximate timeframe to move? If NOT moved, when will the move take place?	No pending moves.

TOPICS FOR DISCUSSION

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ADA Accommodations			
To look up Armstrong Class members and their quarantine/isolation status, please click here for the COVID Monitoring Registry (Custody). Under COVID Filters at the top of the report, choose "Active Quarantine Order" and "Active Isolation Order" and under Patient Filters select "Armstrong Class Members", click View Report button at right top of report to activate filters.			
Are any Armstrong class members currently housed in non-traditional / non-designated housing for quarantine or isolation purposes?	Y	If so, where are they housed? (Location & # of patients)	Today there are 10 Armstrong Class Members with quarantine orders, 1 in D18 (DPW patient), 1 in ASU and 8 in A2. List provided to Custody. The ADA AW reports on any class members in non-traditional or non-designated housing.
Were all Armstrong class members moved to non-traditional / non-designated housing within the last 24 hours interviewed using 128B checklist?	Y	Coordination with ADAC: What pending actions need to be taken to accommodate Armstrong patients in quarantine and isolation?	The ADA AW ensures 128B interviews are completed within 24 hours and every other week.

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COVID High Risk Individuals			
COVID Risk Score ≥ 3, Never Positive	COVID Risk Score ≥ 3, Never Positive in Dorm	COVID Risk Score ≥ 6, Never Positive	COVID Risk Score ≥ 6, Never Positive in Dorm
811	380	341	203

3. Clinical Management of COVID Patients - *Click on any underlined header to access the COVID Monitoring Registry (Clinical) and patient lists for all indicators below*

Positive Test Result, Needs Isolation Order	In Quarantine, Missing Rounds Last 24 Hours	In Isolation, Missing Vital Signs or Rounds Last 24 Hours
0	0	2

4. Hospitalizations and Deaths

COVID Positive and Currently Hospitalized	If Hospitalized, How Many in ICU?	COVID Deaths to Date
0	0	9

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Hospital Network Communications and Capacity - Notes from recent discussions re hospital bed availability with county public health / Utilization	

TOPICS FOR DISCUSSION

Management (notify Dr. Song for assistance at Grace.Song@cdcr.ca.gov):	

Periodically use the Predicted Hospital Volume Report to project how many hospitalizations may occur if your institution sees an increase in COVID cases. The report will show your current infection rate, allows you to choose from different increased rates, and calculates a predicted number of hospital beds needed. To find the report, and click here and select Predicted Hospital Volume tab at left.

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Testing and Movement Plan

5. Vaccination of Patients and Staff – *Click on any underlined header to access a list of staff or patients affiliated with that category*

Staff				Patients			
Number of Staff	Partially Vaccinated	Vaccinated	Declination	Number of Inmates	Partially Vaccinated	Vaccinated	Refusal
1824	43	886	*Coming Soon!*	3847	51	3422	382

Per the CSE, there are 50 patients and 7 staff scheduled for vaccine clinics tomorrow. There are 2 patients who have 3rd doses still pending that are not yet due and a few out to court who have not had their 3rd doses completed who will be offered when qualified and/or back at MCSP.

6. Patient Testing Plan

a. What is the plan for today? This week? (Consider testing close contacts of recent staff and patient positive cases, including contacts with critical inmate-patient workers.)

b. POC testing plan? (NOTE: POC Antigen tests can run 30 tests/hour)

c. Is the institution on track to meet testing requirements per the testing calendar / schedule?

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Surveillance testing every week for all unvaccinated workers. We are testing any patients who received contact visits 5 days post visit as well as patients who had offsite specialty appointments 5 days post appointment. Patients in quarantine/isolation are tested as required per the movement matrix.

9/2/2021 – No Testing.
9/3/2021 – No Testing.
9/4/2021 – Testing All Patients who had an Offsite Specialty Appointment on Monday (8/30/2021)
9/5/2021 – Testing All Patients who had an Offsite Specialty Appointment on Tuesday (8/31/2021)
9/6/2021 – Testing All Patients who had an Offsite Specialty Appointment on Wednesday (9/1/2021).
9/7/2021 – Testing All Patients who had an Offsite Specialty Appointment on Thursday (9/2/2021). Testing D, E, CTC and MSF patients who had a Contact Visit on 9/3/2021 or 9/4/2021 and Unvaccinated Workers (and an additional random sampling of unvaccinated patients in each building as necessary to test a minimum of 25 patients per building).

TOPICS FOR DISCUSSION

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9/8/2021 – Testing All Patients who had an Offsite Specialty Appointment on Friday (9/3/2021). Testing A, B, C (excluding A2) patients who had a Contact Visit on 9/3/2021 or 9/4/2021 and Unvaccinated Workers, patients in A3 who are cellmates of the 12 patients who refused surveillance testing on 9/3/2021 (and an additional random sampling of unvaccinated patients in each building as necessary to test a minimum of 25 patients per building).
9/9/2021 – No Testing.
9/10/2021 – No Testing.
9/11/2021 – Testing All Patients who had an Offsite Specialty Appointment on Monday (9/6/2021).
9/12/2021 – Testing All Patients who had an Offsite Specialty Appointment on Tuesday (9/7/2021).

7. COVID Test Turnaround Time (Days) – Patients *(See Medical Weekly Report)*

MCSP	Statewide Average
1-2 Days	

Testing and Movement Plan

8. Patient Testing Results Last 14 Days

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Total Susceptible Population	Total Tests Collected	Pending Tests	Pending Tests > 2 Days	Completed Tests	Positivity Rate
3813	1709	31	1	1678	0.05%

9. Staff Testing Plan

a. Required frequency per protocol, *and* b. Upcoming testing activity

Effective 8/23/2021 all unvaccinated, partially vaccinated staff and staff who have not provided a record of full vaccination are required to test twice per week and all vaccinated staff are not required to surveillance test. Miradx onsite 7 days a week for staff testing.

Positive staff cases must be communicated to the Office of Employee Health and your county public health department. Upon notification of staff positive begin gathering information to assist the contact tracers i.e.. Last day worked, work locations, staff contact information, etc.

Testing for Week	Total Civil Service Staff	Staff Tested	% Staff Tested	Positive Staff	Positivity Rate

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8/30/2021 – 9/5/2021	1791 Total Staff 947 Unvaccinated/Partially Vaccinated	1,626	172%	15 (13 out 952 of Miradx Results, 2 via outside testing.)	1.37%

TOPICS FOR DISCUSSION

As staff are now required to surveillance test twice per week the percentage of staff tested of the staff required to test is misleading.

10. COVID Test Turnaround Time – Staff

MCSP	2-3 Days	SW Average		

11. Anticipated Movement

Per C&PR, 3 new arrivals today and 4 paroles.

12. Movement Matrix Adherence - *Click on the words "Pre-Transfer" and "Post-Transfer" below to open either registry in a new window.*

Click Here for Instructions on how to Export to Word

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PRE-TRANSFER	Pending Transfers (INST/INST or Release to County)	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	64		13	58	58	1
POST-TRANSFER	Arrivals in Last 21 Days	Needs Quarantine Order	Needs Screening Form	Needs Testing	Requirements Not Yet Met	Housed in Dorm
	110	4	8	44	54	31

Supplies and Equipment Plan - *For PPE and KN95 supplies contact DOC DOCCOVID19@cdcr.ca.gov. Contact HQ for medical supplies and pharmacy for medications and fluids. For public health consultation contact the Local Health Department and CCHCS Public Health CDCRCCHCSPublicHealthBranch@cdcr.ca.gov.*

13. COVID Test Kits *(See Weekly Medical Services Report)*

Inventory as of Noon	Ordered as of 2 PM	Available Test Kit Supply
		9/7/2021 – 2,300

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14. N95 Masks	
Current Inventory	N95 Masks: 195,215 KN95 Masks: 78,660
Who uses N95 masks and in which locations?	All critical workers
15. Resource Requests	
No resource requests at this time.	

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TOPICS FOR DISCUSSION

16. PPE Inventory Report - *Click here to open the CDCR/CCHCS Personal Protective Equipment Statewide Inventory and Usage Report*
Considering the needs of all groups? Issuing excessive PPE? Other medical equipment needs?

Equipment	Total Quantities	Avg Usage Per Day	Estimated Supply Days Remaining	Estimated PPE Outage Date
Surgical Masks	789,906	-3,491	226	4/20/2022
Gloves	453,043	-4,779	94	12/9/2021
KN95 Masks	78,660	-460	170	2/23/2022
N95 Masks	195,215	-663	294	6/27/2022
Eye Protection	91,516	-400	228	4/22/2022

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Gowns	88,090	-185	476	12/26/2022
Cloth Masks	100			
Other (e.g., wipes, hand sanitizer, PPE/Spill kits)				

Staffing Plan - *Describe deficiencies in resources and plan to remedy. Include discussion of specific registry orders, etc.. Consider need to cohort staff so that those working with cases or contacts of cases do not engage with other populations.*

17. Nursing ***(Review Clinical Operations Reports through Regional or HQ Nursing leadership)***

26 staff out in the last 24 hours.

18. Custody

No updates.

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19. Providers
Per the CME, new provider starting today. Transfer from CHCF. 3 provider vacancies remain.
20. Administrative / Other Staff
No updates.

TOPICS FOR DISCUSSION

Other Operations/Stakeholders

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21. Any changes necessary to the following plans to protect staff, patients, or inmate-workers?

- Physical Distancing
- Disinfection/Cleaning
- Environment Controls
- Feeding / showers / phones / canteen / programming / ventilation

A Clinic cleaned by HFM

22. Education/Communication Plan

- Residents and Staff
- Community and/or Public Health Outreach

- Patient Education – No updates.
- Staff Education – Employee Health staff education one on ones for those staff partially vaccinated or unvaccinated staff are on hold at this time.
- Communication/PH Outreach - Weekly updates are provided to Amador County Public Health (ACPH)/Dr. Kerr by PH regarding current cases and vaccination status. CME has frequent contact with ACPH/Dr. Kerr to update on our current numbers. The CME/PH has contact with Sutter Amador Hospital (SAH) on an as needed basis.

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23. Pre-Procedural COVID Testing for Dental Patients

- Effectiveness/challenges of program

Dental will continue to conduct pre-procedural COVID testing for dental patients as long as we have an active patient case.

24. Other

- How are CPAP patients being managed?

# of Patients with CPAP Equipment	236	No updates.

25. Status on Pending Action Items from Previous Meetings

- CEO/Warden Comments

No comments.

26. RHE/AD Comments

TOPICS FOR DISCUSSION

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No comments.

Additional Resources to Review

- *Daily COVID-19 Incident Command Post (ICP) Checklist*
- *Outbreak Preparedness and Management Toolkit*
- *Clinical Guidance and CCHCS Policy at: https://cchcs.ca.gov/covid-19-interim-guidance*
- *Population COVID-19 Tracking - CDCR Patients: Confirmed COVID and Outcomes*
- *QM COVID Risk Registry - to identify patients at a higher risk for morbidity and mortality if they contract COVID*
- *QM COVID Pre-Transfer Registry and COVID Post-Transfer Registry - to identify patients preparing to transfer or who have recently transferred • Questions about this report? Contact QMStaff@CDCR.ca.gov*

EXHIBIT 5

Prison Law Office (PLO) Inquires

Institution	Inquiry	Response
	1.) Some OMTs report weekly testing of unvaccinated staff (e.g., ASP, COR, CMF), some report twice weekly testing of unvaccinated staff has started or is starting soon (e.g., FSP, CCWF, MCSP), and others do not indicate the frequency of staff testing (e.g., CMC). 2.) Which prisons are currently testing unvaccinated staff twice a week, and for each, when did this begin? 3.) Can the frequency of staff testing please be included in future OMTs? 4.) If all prisons are not testing unvaccinated staff twice a week, what is the criteria for deciding and who decides the frequency of testing at each prison?	1.) Prior to the order, surveillance testing was required for unvaccinated staff weekly. If an institution was in outbreak surveillance testing was increased to twice a week. 2.) All institutions are testing unvaccinated staff twice weekly based upon order. 3.) Will have the CEO include testing frequency on the OMT if it differ from the required testing. 4.) Prior to the order, testing frequency was defined by outbreak status and in collaboration with PH/EHP, regional leaders and hiring authorities.
CMF	Per the 8/24/21 OMT, all those residing in G2, G3, P2 and Q3 are on quarantine. 1.) When did the quarantine begin in these units and for what reason are they on quarantine? If on account of an exposure, was the source of the exposure a staff person? If so, was it a different staff person or the same staff person responsible for each of the exposures?	1.) -G2, G3, P2, and Q3 were on quarantine from 8/18/2021-8/25/2021 as a precaution from a low risk staff exposure. The same staff member was responsible for each of the exposures.
COR	The 8/24/21 OMT lists five active cases since last report, but only three active cases are listed on the COVID monitoring patient registry. 1.) What is the reason for the discrepancy? For the three active cases listed in the patient registry, it appears they were each housed in a different building prior to testing positive (S-INFB, MSF, and 03B). 2.) What is known about the source of exposure for each patient?	1.) The reason for the discrepancy for the OMT report is that the data was pulled at 8:34am by QM staff, at that time there were 5 patients listed on the COVID monitoring registry. There were 2 patients that came off the registry by the afternoon of 8/24/21. 2.) S-INFB-There was an outbreak in the CTC, we do not know the source of exposure. MSF-Patient had a contact visit on 8/21/21, however we do not know if the visit was the source of exposure. 03B-Patient had multiple appointments with medical and MH staff prior to positive. The source of exposure is unknown.

Prison Law Office (PLO) Inquires

CRC	CRC lists 87 patients on quarantine due to exposure. 1.) What is known about the source of infection for the patient who tested positive in that dorm and thus resulted in the unit put on quarantine? Per the 8/24/21 OMT, "Request to cease intake of unvaccinated into the institution has been denied effective 8/24/2021." 2.) For what reason was such a request made by CRC and why was it denied in light in the increase in staff and inmate COVID cases?	1.) Contract tracing was conducted but did not identify the source where the IM contracted COVID. 2.) DAI to respond.
HDSP	HDSP-B and HDSP-C have been designated Phase 1, even though it appears per CCCHS data that there has been only one positive case among residents of that prison. 1.) Please explain, given that a Phase 1 designation is to occur when there are three or more related cases among residents. 2.) If there have been three or more related cases, please provide details, including names, numbers, dates of test results, and circumstances showing the cases were related.	1.) Facility B was downgraded to Phase I after three linked cases were discovered. [redacted] positive on August 6, 2021. [redacted] positive on August 6, 2021. [redacted] positive on August 5, 2021. These patients were contact traced to have been exposed within the same building. All three of these patients were resolved on August 21, 2021. 2.) Facility C was downgraded to Phase 1 after three linked cases were discovered. [redacted] positive on August 3, 2021. [redacted] positive on August 3, 2021. [redacted] positive on August 4, 2021. [redacted] positive on August 4, 2021. [redacted] positive on August 4, 2021. [redacted] positive on August 8, 2021. [redacted] positive on August 7, 2021. [redacted] positive on August 19, 2021. These patients were contact traced to have been exposed within the same building and also the same place of work. Seven of the eight patients have been resolved as of August 26, 2021, leaving only one remaining positive inmate, [redacted]
MCSP	Per the 8/24/21 OMT, "Staff Education – Employee Health staff education one on ones for those staff partially vaccinated or unvaccinated are on hold per the CDPH letter dated August 19, 2021 regarding mandatory staff vaccinations and the Warden's email sent to staff on August 20, 2021."	CDPH order of 8/19/21 for Correctional Facilities mandated vaccinations for staff, attached. In response HQ EHP informed MCSP EHP they were placing a hold on staff education 1:1s and MCSP EHP notified Leadership, email attached. Warden's office notified all staff, email attached. On 8/25/21 a memo

Prison Law Office (PLO) Inquires

	1.) Could you provide a copy of both cited documents and note how far MCSP got with staff one-on-ones before they were put on hold?	"Employee Case Management Procedures Temporarily Placed on Hold" was sent out to all staff statewide, attached. MCSP completed 452 1:1s before pausing.
CSP - Solano	Solano-D has been designated Phase 1, even though it appears per CCCHS data that there has been only one positive case among residents of that Facility. 1.) Please explain, given that a Phase 1 designation is to occur when there are three or more related cases among residents. 2.) If there have been three or more related cases, please provide details, including names, numbers, dates of test results, and circumstances showing the cases were related.	1.) CSP-Solano is currently testing all unvaccinated/partially staff twice per week. 2.) Effective August 24, 2021 all unvaccinated/partially vaccinated staff were given the directive to test twice per week until further notice.

SOL PLO Response
Aug 25th, 2021
[redacted]

Institution	Inquiry	Response
SOL	**Global Question** Some OMTs report weekly testing of unvaccinated staff (e.g., ASP, COR, CMF), some report twice weekly testing of unvaccinated staff has started or is starting soon (e.g., FSP, CCWF, MCSP), and others do not indicate the frequency of staff testing (e.g., CMC). Which prisons are currently testing unvaccinated staff twice a week, and for each, when did this begin? Can the frequency of staff testing please be included in future OMTs? If all prisons are not testing unvaccinated staff twice a week, what is the criteria for deciding and who decides the frequency of testing at each prison?	CSP-Solano is currently testing all unvaccinated/partially staff twice per week. Effective August 24, 2021 all unvaccinated/partially vaccinated staff were given the directive to test twice per week until further notice.
	Solano Solano-D has been designated Phase 1, even though it appears per CCCHS data that there has been only one positive case among residents of that Facility. Please explain, given that a Phase 1 designation is to occur when there are three or more related cases among residents. If there have been three or more related cases, please provide details, including names, numbers, dates of test results, and circumstances showing the cases were related.	SOL had 2 related resident cases in Bldg. 22 ([redacted] and [redacted] . Given that at the same time we also had 2 positive employees from Bldg. 22 (likely related) as well as an additional 4 positive staff from Building 20 there was heightened concern about sustained Covid transmission in D-yard, especially since D-yard consists of all large Dorm buildings which don't provide solid door protection for individual residents. After discussions with PH staff it was decided to protect the vulnerable population in D-yard from further transmission of what is likely a Delta variant by going into a Phase 1.

EXHIBIT 6

Prison Law Office (PLO) Inquires

Institution	Inquiry	Response
CAC	The 8/31 OMT reports 61 total custody staff vacancies, and says "[a]n All-Hazards Plan and RDOM on Job Action Contingency Plan and Continuity Plans are in place" at that prison. 1.) If these are written documents, can you please provide copies? The OMT further states that 4 posts were left vacant "per OP 132." 2.) Can you please provide a copy of OP 132? Finally, the OMT says CAC is "in Phase III of the Clinical Operations Plan." 3.) Is this referring to the Roadmap to Reopening, or a different document/plan? If the latter, can you please provide a copy?	1.) DAI to respond. 2.) DAI to respond. 3.) Yes, this is referring to the Roadmap to Reopening. CAC continues in Phase 3 of Roadmap to Reopening.
CHCF	[redacted] (CHCF-D), is the CDCR patient with the highest COVID Risk Score (16) who is COVID naïve and unvaccinated. The most recent documented vaccine refusal in the medical record is dated in June 2021; the refusal form quotes [redacted] as stating, "I don't trust you guys." Subsequent PCP encounters in late June, July and August – there have been nine of them, include no documentation that vaccine was further discussed, including as it relates to the risks posed by the Delta variant. Nor is there any indication in the records that any other staff member has discussed vaccine with [redacted] 1.) Why haven't such discussions been documented, including in particular by the PCP, and has consideration been given to having non-CDCR medical staff talk with [redacted]? 2.) More generally, what system(s) does CHCF have in place to ensure that those who have refused vaccine have been offered it recently, with such offers accompanied by education and discussion of the Delta variant?	1.) Over a 2 ½ month timespan since his June 22, 2021, refusal for vaccination, [redacted] was offered the COVID vaccination two additional times. On July 9, 2021, CHCF's Infection Control RN provided 1:1 consultation to educate [redacted] about COVID-19 Delta variant and reoffered COVID19 vaccine. He again refused. On September 3, 2021 after the PCP discussed the benefits of protection from severe disease and for hospitalization. He also refused. We will continue to offer the vaccine to the unvaccinated despite repeated refusals. We are also available to answer any questions and educate as needed. Nursing has reoffered and provided 1:1 patient education to all high risk patient with COVID risk score 5 and then to all patient

Prison Law Office (PLO) Inquires

		with COVID risk score 5 and below. All patients were provided an education on COVID vaccination and Delta variant handouts that we received from HQs. 2.) In addition, all high risk patient who continued to refused their COVID vaccination are being re-offered their COVID vaccination every Tuesday and SRNIII Petty will be following up with the staff and SRNIIs to ensure that the staff is documenting their encounters in patient's chart every time they provide the patient education on COVID19 and offer COVID vaccination. Starting tomorrow, ICN will be send out a list every week for all patients who refused their COVID vaccination to the SRNIIIs/SRNIIs. The SRNIIs will make sure that their staff are providing the patient education and reoffering the COVID vaccination to these patient and complete their documentation daily and or at least every week.
CMC	Per the most recent OMT, "CMC has two COVID-19 positive cases. Close contact investigation and COVID screening and testing has been done in the housing units of the positives (these two patients did not have any jobs and thus no job close contact investigation is indicated)." 1.) What is known about the source of the exposure and were any close contacts identified? The OMT does not reflect quarantines due to exposure to these patients. 2.) Were there any patients quarantined as a result of being close contacts?	1.) CMC was unable to verify any transmission nexus for either of the two positive cases. No nexus could be established between the two cases themselves. No close contacts were identified. 2.) No quarantines resulted from the close contact investigation of the two CMC positives. The patients are housed in an Ad Seg building unit and no intermingling of patients occurs in this area. In a preponderance of caution, COVID screening and testing was done of the entire housing unit and no new positive cases were identified.
CRC	Since last week, an additional 100 plus patients have gone on quarantine and there have been additional COVID positive patients as well.	1.) The positive patients were housed in buildings 306, 403 and 404, all on C yard. Source of exposure appears to be a positive IM working in plant Ops.

Prison Law Office (PLO) Inquires

	1.) Where were the COVID positive patients housed at the time they were swabbed and what is known about the source of their exposures, if anything?	
CVSP	The 8/31 OMT reports custody vacancies "will be filled either through overtime or the utilization of OP F#53." 1.) Can you please provide a copy of OP F#53?	1.) DAI to respond.
MCSP	1.) All facilities at MCSP are listed as being in Phase 2 of their reopening. Is this correct? If so, why are they are all in Phase 2 and when will they transition into Phase 3?	1.) DAI to respond.
SATF	The 8/31 OMT for SATF lists 652 patients on quarantine on E yard. 1.) Why are these patients on quarantine? If they are quarantined due to possible exposure to COVID-19, what has CDCR/CCHCS identified as the source of that exposure?	1.) These patients are on quarantine because they may have been exposed to staff members who tested positive for COVID-19 during a period the positive staff were assigned and worked in the affected E yard locations.
CSP – SOL	As of 0800 hours on Wednesday morning, 9/1/21, Solano had not offered a third dose of vaccine to any of the 197 patients identified as needing that dose. Solano was the only prison that had not offered any patients a third dose, whereas a number of other prisons had offered it to 50% or more of their patients and some with a similar number of patients who needed a third dose had offered it to well over half. As of 0800 hours this morning, 9/2/21, seven patients at Solano had been offered a third dose, whereas statewide nearly 75% of patients had been offered it. Further, all seven offered it at Solano on 9/1/21 refused a third dose, a seemingly very unusual result. 1.) Why has there been a slow implementation at the prison of the third dose initiative, what is the plan to offer a third dose to all identified as needing that, and why did the first seven patients offered it refuse?	1.) The goal was to complete all 3rd doses offered and/or vaccination before the deadline of 9/6. As of Sep 6th, CSP-SOL has achieved offered and/or vaccinated of 94% of this specific cohort. ❖ 84% accepted, 10% refused Healthcare leadership met to discuss plan of offering and providing the 3rd dose. The providers started placing orders with a deadline of 8/31, and nursing started offering the vaccine on 9/1 and a vaccine clinic was held on 9/3 to offer and or vaccinate all patients who accepted 3rd dose vaccine.
SVSP	Salinas Valley has not uploaded an OMT since August 17. Why?	1.) Salinas Valley State Prison inadvertently misread an email in regards to the OMT reports no longer being required to be uploaded. OMT reports were not uploaded on August 24th and

Prison Law Office (PLO) Inquires

		August 30th. The email was reviewed and there was no mention of the OMT not being required for weekly submittal. SVSP acknowledges a lapse in the reports not being submitted and will immediately correct this identified issue and ensure that OMT reports are uploaded timely for review.
VSP	For VSP, it appears that the current COVID positive patients originally resided in various buildings across the facility (B4, C2, D2, D3). 1.) What is known about the source of the infections? 2.) How many other patients have been quarantined as a result of these positive cases and have all those patients been moved to celled housing? All facilities at VSP are listed as being in Phase II of their reopening. 3.) Is this correct? If so, why? When will they transition into Phase III?	1.) Contact tracing did not identify a single source, one I/P identified staff members as close contacts, this could not be validated. 2.) A total of thirty seven (37) patients have been quarantined as a result of these positive cases and all have been moved to celled housing. 3.) DAI to respond.

EXHIBIT 7

Sophie Hart

From: Taylor, Miranda [redacted] on behalf of Taylor, Miranda
Sent: Friday, September 10, 2021 3:49 PM
To: A. Norris; Alison Hardy; Barrow, Roscoe@CDCR; Bentz, Melissa@CDCR; Bick, Dr. Joseph@CDCR; Clark Kelso [redacted] Damon McClain; David Sanders; Davis, Tamiya@CDCR; Don Specter; Ed Swanson; Ernest Galvan; Ferguson, Patricia@CDCR; Foss, Tammy@CDCR; Gregg Adam; Heintz, Lisa@CDCR; Iram Hasan; Jamie Dupree; Johnson, Gannon@CDCR; Kelso, Clark@CDCR; Kirkland, Richard@CDCR; Kyle Lewis; Laura Bixby; Lisa Ells; Martin Dodd; Matt Lopes; Michael Bien; Neill, Jennifer@CDCR; Ostling, Linda; Paul Mello; Rana Anabtawi; Renteria, Simone@CDCR; Rita Lomio; Ryan Gille; Ryan, Amanda@CDCR; Saich, Lara@CDCR; Samantha Wolff; Sara Norman; Scofield, Bryant; Sean Lodholz; Sophie Hart; Stafford, Carrie@CDCR; Steve Fama; Tang, Shirley@CDCR; Thomas Nolan; Toche, Diana@CDCR; Trace Maiorino; Weber, Nicholas@CDCR
Cc: Benavidez, Suzanne@CDCR; Taylor, Miranda
Subject: COVID Data Summary for 09-10-21 (External Stakeholders)
Attachments: COVID Vaccine Refusal Rate by Mental Health Level of Care Armstrong and Clark 20210910.xlsx

1. POPULATION VACCINATION EFFORTS:

98,545 patients (99.6%) have been offered at least one dose of vaccine; acceptance rate is 79% among those offered.
77,380/98,545 (79% of those offered, 77% of total CDCR population) accepted at least one dose of vaccine.
Percent of COVID-naïve patients vaccinated: 74% (26% of COVID-naïve patients are unvaccinated)
Percent of COVID-resolved patients vaccinated: 84%
49,952 have had a COVID diagnosis.

2. STATEWIDE POPULATION VACCINE DATA:

Patients 65+, Covid Naïve	n=2,563	n= 2,570	n=2,571	n= 2,568
Offered:	2,555 (99.6%)	2,557 (99.4%)	2,560 (99.5%)	2,559 (99.6%)
Accepted (at least 1 dose):	2,366	2,368	2,368	2,368
Declined:	189	202	192	191
Acceptance Rate:	93%	93%	92%	93%
Patients Covid Score ≥6, Covid Naïve	n=2,834	n=2843	n=2,850	n= 2,847
Offered:	2,827 (99.7%)	2,831 (99.5%)	2,840 (99.6%)	2,838 (99.6%)
Accepted (at least 1 dose):	2,648	2,651	2,659	2,661
Declined:	179	180	181	177
Acceptance Rate:	94%	94%	94%	94%
Patients Covid Score ≥3, Covid Naïve	n=8,979	n=9001	n=9,022	n=8,993
Offered:	8,946 (99.6%)	8902 (98.9%)	8,982 (99.5%)	8,965 (99.6%)
Accepted (at least 1 dose):	7,941	7,978	8,002	7,992
Declined:	1,005	986	980	973
Acceptance Rate:	89%	89%	89%	89%
All Patients	n= 99,548	n=99,672	n= 99,801	n=99,597
Offered:	98,345 (98.7%)	98,573 (98.8%)	98,563 (98.7%)	98,545 (98.9%)
Accepted (at least 1 dose):	76,660	77,091	77,455	77,380

Declined:	21,685	21,482	21,108	21,074
Acceptance Rate:	78%	78%	79%	79%

-75
(-75)+ pts
than 09/03/21

3. VACCINE ACCEPTANCE RATE BY MH LOC AND CLARK/ARMSTRONG STATUS

Statewide	PIP	MHCB	EOP	MHSDS Overall	DDP	DPP
Acceptance %	**76%**	**77%**	**82%**	**81%**	**88%**	**90%**

Updated 09/10/21

4. PATIENTS NOT OFFERED VACCINE (by Institution):

	# Pts Not Offered Vaccine And Currently in Institution As of 09/10/21				
Inst	COVID Risk Score ≥6	COVID Risk Score 3-5	COVID Risk Score <3	Total Pts	
ASP			3	3	
CAC			1	1	
CAL				0	
CCC				0	
CCI				0	
CCWF*			8	8	
CEN				0	
CHCF				0	
CIM			3	3	
CIW				0	
CMC				0	
CMF		1	2	3	
COR				0	
CRC			3	3	
CTF			6	6	
CVSP				0	
DVI				0	
FSP				0	
HDSP			8	8	
ISP				0	**
KVSP			1	1	
LAC			2	2	
MCSP			1	1	

NKSP*		3	73	76	
PBSP			1	1	
PVSP			1	1	
RJD				0	
SAC				0	**
SATF			3	3	
SCC			8	8	
SOL			1	1	
SQ			1	1	
SVSP				0	
VSP				0	
WSP*	2	9	441	452	

* Reception centers	**582**

**Two patients allergic to vaccine. (ISP & SAC)

Total	- Allergy	- RCs	=
582	2	522	58

5. INSTITUTIONAL EMPLOYEE VACCINATION EFFORTS:

30,897 institutional staff have been vaccinated with at least one dose of vaccine
30,897 / 55,659 = 56% of institutional staff have been administered at least one dose of vaccine
A total of 18,541 institutional staff have had a COVID diagnosis

6. STATEWIDE STAFF VACCINE DATA:

Updated:	8/20/2021	8/27/2021	9/3/2021	9/10/2021
Staff Vaccine Data:	n=65,810	n= 65,921	n=65,960	n= 65,985
Total Staff Received 1st Dose:	36,451 (56%)	37,069 (56%)	37,522 (57%)	38,083 (58%)
Institutional Staff Data:	n=55,513	n=55,584	n= 55,627	n= 55,659
Inst Staff Received 1st Dose:	29,549 (54%)	29,942 (54%)	30,361 (55%)	30,897 (56%)

7. PATIENT 3RD DOSE NEEDED AND ADMINISTERED BY INSTITUTION

Institution	# patients who meet criteria for a 3rd dose	Of these, # who have received a third dose	of these # who have declined 3rd dose	# of patients waiting to be offered 3rd dose
ASP	9	7	1	1
CAC	7	4	3	0
CAL	10	9	1	0
CCC	1	0	1	0
CCI	13	9	4	0
CCWF	75	66	9	0
CEN	18	13	5	0
CHCF	300	270	15	15
CIM	306	286	14	6
CIW	66	50	10	6

CMC	88	83	5	0
CMF	237	212	23	2
COR	37	34	3	0
CRC	22	20	2	0
CTF	88	81	5	2
CVSP	36	32	4	0
DVI	0	0	0	0
FSP	68	58	9	1
HDSP	19	15	2	2
ISP	17	14	1	2
KVSP	28	24	4	0
LAC	161	139	20	2
MCSP	478	452	18	8
NKSP	17	13	4	0
PBSP	21	17	2	2
PVSP	1	1	0	0
RJD	326	279	41	6
SAC	84	68	14	2
SATF	51	49	2	0
SCC	14	14	0	0
SOL	195	168	25	2
SQ	246	227	14	5
SVSP	77	68	9	0
VSP	91	85	4	2
WSP	19	12	7	0
Totals:	**3,226**	**2,879**	**281**	**66**

Updated
09/10/21

location	# immunocompromised patients due for 3rd dose	of these, # who have been offered 3rd dose	of those offered, # who accepted 3rd dose
SW	**3226**	**3160/3226 (97.95%)**	**2879/3160 (91%)**

Miranda Taylor
Assistant to Director Joseph Bick, M.D.
California Correctional Health Care Services
[redacted]

EXHIBIT 8

HOUSING UNIT AIR HANDLING UNIT INSPECTIONS

Executive Summary

The California Department of Corrections and Rehabilitation (CDCR) directed adult institutions to conduct an inspection of housing unit Air Handling Units (AHUs). The inspection was to include physical inspections of AHUs, ducts and vents, as well as airflow measurements at both the AHU and at supply vents within the housing unit.

An initial review of the submitted inspection data indicated that the task of performing the airflow measurements in the ventilation systems was complex and not evenly understood or implemented. In some instances, the measurements provided for the AHU airflow and resulting housing unit vent airflow seemed contradictory. In other instances, the airflow measurements were based upon fewer individual measurements than had been indicated in the instructions, leading to incomplete measurements. CDCR's Facility Planning, Construction and Management Division (FPCM) staff will be conducting site visits beginning in September to work with individual institutions to review their data collection practices, identify data anomalies, perform additional airflow measurements (if warranted) and assist in prioritizing repairs for underperforming AHUs.

While AHU performance and overall ventilation within a housing unit was the focus of the inspections, the installation of MERV-13 filters in housing unit AHUs that have the capability of recirculating interior air is anticipated to improve filtration of the recirculated air and assist in the reduction of airborne viruses. Prisons were directed in December 2020 to install MERV-13 filters, which provide more effective filtration for smaller particles, such as aerosols and viruses. Currently, 21 institutions have switched to these higher-efficiency filters. The remaining 11 institutions that have AHUs with the capability of recirculating interior air are anticipated to have MERV-13 filters installed by the end of October 2021, when these AHUs switch from cooling to heating mode.

Background

There is a large variety of ventilation system designs within CDCR's institutions. Some housing units have no AHU (i.e. rely on natural ventilation) and provide radiant heat. Other systems use 100% outside air as the intake to their AHUs (there are no fans or ducts to recirculate interior air back through the AHU). However, most AHUs operate with a mix of outside air and recirculated air. Typically, during warmer weather, a large number of AHUs use nearly 100% outside air. During cooler weather, most systems use a higher amount of recirculated air.

For celled housing units built within the last 40 years, a common feature for ventilation is that the cells are under positive air pressure: the air supply to the cell (120 cubic feet per minute) is greater than the volume of air exhausted directly from the cell to outside the housing unit through the exhaust fan (55 cubic feet per minute). Therefore, per design, there is a net flow of air from the cell to the dayroom.

Institutional Plant Operations staff are responsible for the day-to-day maintenance and management of an institution's infrastructure systems, including ventilation systems in the housing units. In addition to performing routine inspections, preventive maintenance and replacing AHU filters, they are called on to investigate, mitigate, and repair AHUs and ventilation systems that are reported to them by the incarcerated population or staff as not operating properly.

HOUSING UNIT AIR HANDLING UNIT INSPECTIONS

Inspection of Housing Unit Ventilation Systems

On March 30, 2021, CDCR headquarters directed adult institutions to have Plant Operations staff at each adult institution perform an inspection of each housing unit's ventilation system. This effort was to identify needed ventilation system repairs for optimal system operation. To that end, Plant Operations staff performed physical inspections of AHUs, ducts and vents, as well as airflow measurements at the supply duct leading from the AHU and a representative sample of supply vents in cells or dormitory areas. Measuring airflow at the supply duct leading from the AHU level is to review if the AHU is supplying air in accordance with its specification. Low airflow measurements could indicate a need for maintenance or repair on the AHU. Measurements at supply vents in cells or dormitory areas are intended to identify potential issues within the air distribution ducting or with blocked vents.

To assist the institutions with this task, CDCR headquarters' staff developed a training tool that specified the methodology to use when measuring airflow, and identified measuring equipment the institutions would need to use to perform these measurements. Additional information provided included instructions, inspection forms, a listing of AHUs specific to the individual sites, and forms to record the measured results. Two statewide training conference calls were also held to provide instruction to the institutions.

Data Analysis, Quality and Follow-Up Actions

Institutions uploaded documentation of the inspection activities on a shared data platform. Overall, Plant Operations staff inspected approximately 1,800 AHUs and performed air sampling measurements at more than 10,000 cell and dormitory supply vents. A "Summary of Performance Measurements" chart has been prepared to summarize information for each prison. The yellow-shaded columns under the "AHU Performance" heading reflect measurements at the supply duct leading from the AHU, and the green-shaded columns under the "Airflow Performance within Living Space" heading reflect measurements taken at supply vents in cells or dormitory areas. The measurements were compared to 90% of the design specification airflow, which is an industry standard developed by the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE). The chart also indicates that additional review is ongoing at identified prisons, often related to identifying the design specifications for older AHUs.

An initial review by FPCM staff of the data submitted from the inspections effort indicated a varying level of expertise across the Plant Operations personnel who performed the inspections and varying levels of completeness of the collected data. While Plant Operations staff are skilled at performing maintenance tasks and otherwise maintaining the variety of infrastructure systems that are needed to operate 24-hour institutions, performing the airflow measurements in the ventilation system proved to be a complex task that was unevenly understood and implemented. In some instances, the measurements provided for the AHU airflow and resulting housing unit vent airflow seemed contradictory, which may indicate that measurements were not taken correctly. In other instances, the airflow measurements were based on fewer individual measurements than had been indicated in the instructions, leading to incomplete measurements.

HOUSING UNIT AIR HANDLING UNIT INSPECTIONS

FPCM staff held subsequent conference calls with each institution to discuss the AHU inspection data. FPCM is working with each prison to prioritize maintenance and repair activities such as re-inspecting any AHU that was identified as underperforming (when airflow measurements were less than 90% of the design specification), correcting any deficiencies noted in the re-inspection, and then re-measuring airflow to determine if the repairs were sufficient to restore airflow to within design parameters. FPCM staff will be conducting site visits in September/October 2021 to work with individual institutions to review and improve their data collection practices, identify data anomalies, perform additional airflow measurements (if warranted) and assist in prioritizing repairs for underperforming AHUs.

MERV-13 Filter Installation

Due to the complexity of ventilation and air circulation patterns within a housing unit, CDCR is following the recommendation of ASHRAE to install MERV-13 filters in housing unit AHUs that have the capability of recirculating interior air based on their effectiveness in capturing particles of a size similar to the COVID-19 virus. Prisons were directed in December 2020 to replace existing filters (mostly were of the MERV-8 level of efficiency) with MERV-13 filters, which provide more effective filtration for smaller particles, such as aerosols and viruses. If MERV-13 filters caused a significant decrease in airflow, institutions were directed to instead install MERV-11 filters. In addition, it was reiterated that institutions should maximize outside air intake and minimize recirculated air.

Since that time, FPCM has been monitoring the institutions' progress in installing MERV-13 filters. Many institutions found that obtaining MERV-13 filters was difficult because of shortages in the supply chain. Currently, 21 institutions have switched to these higher-efficiency filters. The remaining 11 institutions that have AHUs with the capability of recirculating interior air are anticipated to have MERV-13 filters installed by the end of October 2021, when these AHUs switch from cooling to heating mode and the volume of recirculated air will increase.

Housing Unit Air Handling Unit Inspections

- Summary of Performance Measurements -

Institution	AHU Performance				Airflow Performance within Living Space	
	Total Number of AHUs	Number of AHUs with Airflow at Least 90% of Design Specifications	Number of AHUs with Airflow Below 90% of Design Specifications	Number of AHUs Pending Airflow Measurement	Number of Cell/Dorm Level Airflow Measurements	Percentage of Airflow Measurements Taken at Cell/Dorm Level with Airflow at Least 90% of Design Specifications
ASP[1]	66	———	———	66	———	———
CAC	120	30	90	———	420	14%
CAL	70	44	26	———	664	67%
CCC[2]	53	48	3	2	812	91%
CCI	44	31	13	———	362	93%
CCWF	62	49	13	———	118	89%
CEN	68	61	7	———	227	96%
CHCF[3]	62	———	———	———	———	———
CIM[4]	50	6	28	16	1176	15%
CIW	25	25	0	———	75	96%
CMC[4]	64	5	59	———	212	Additional Review Necessary
CMF[4]	21	12	5	4	42	95%
COR	57	55	2	———	330	91%
CRC	16	16	0	———	64	13%
CTF	15	7	8	———	117	60%
CVSP[5]	25	15	10	———	147	96%
FSP[4]	27	16	7	4	167	50%

[1] Due to inconsistencies in the procedures used for the original measurements, re-measurements are underway.

[2] Two AHUs at this prison have inaccessible ductwork and were not available for staff to measure airflow from the AHU.

[3] CHCF was constructed with a Building Management System that automatically controls airflow based on established parameters and field sensor communications. Because the system automatically varies airflow as required, it does not lend itself to the AHU inspection measurements.

[4] AHU and/or Living Unit airflow design specifications require additional review for certain AHU/Living Units at these prisons.

[5] These rows exclude newly-installed AHUs from the ISP/CVSP HVAC replacement project. These AHUs are under warranty by the General Contractor.

Housing Unit Air Handling Unit Inspections

- Summary of Performance Measurements -

Institution	AHU Performance				Airflow Performance within Living Space	
	Total Number of AHUs	Number of AHUs with Airflow at Least 90% of Design Specifications	Number of AHUs with Airflow Below 90% of Design Specifications	Number of AHUs Pending Airflow Measurement	Number of Cell/Dorm Level Airflow Measurements	Percentage of Airflow Measurements Taken at Cell/Dorm Level with Airflow at Least 90% of Design Specifications
HDSP	46	44	2	———	267	63%
ISP[5]	27	1	26	———	246	100%
KVSP	26	21	5	———	816	92%
LAC	68	68	0	———	204	100%
MCSP	63	19	44	———	348	79%
NKSP	54	54	0	———	162	100%
PBSP	60	49	11	———	652	90%
PVSP	66	29	37	———	528	95%
RJD	74	71	3	———	444	91%
SAC[4]	18	12	4	2	308	0%
SATF	80	80	0	———	432	100%
SCC[1]	75	———	———	———	———	———
SOL	67	50	17	———	620	97%
SQ[4]	20	10	0	10	57	Additional Review Necessary
SVSP	62	16	46	———	132	71%
VSP	77	54	23	———	486	69%
WSP	60	59	1	———	142	98%

[1] Due to inconsistencies in the procedures used for the original measurements, re-measurements are underway.

[2] Two AHUs at this prison have inaccessible ductwork and were not available for staff to measure airflow from the AHU.

[3] CHCF was constructed with a Building Management System that automatically controls airflow based on established parameters and field sensor communications. Because the system automatically varies airflow as required, it does not lend itself to the AHU inspection measurements.

[4] AHU and/or Living Unit airflow design specifications require additional review for certain AHU/Living Units at these prisons.

[5] These rows exclude newly-installed AHUs from the ISP/CVSP HVAC replacement project. These AHUs are under warranty by the General Contractor.

EXHIBIT 9

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 10, 2020
To:	Secretary Ralph DIaz
From:	J. Clark Kelso, Receiver
Subject:	CCHCS Guidelines for Achieving and Maintaining Social Distancing in California Prisons

In the face of the ongoing COVID-19 pandemic, California Correctional Health Care Services (CCHCS) will continue to be guided by the developing scientific and medical consensus regarding social distancing in correctional settings, as well as by the Receiver's authority under the Order Appointing Receiver and the applicable regulatory provisions of Title 15 of the California Code of Regulations. Accordingly, the Receiver has determined that CCHCS and California Department of Corrections and Rehabilitation (CDCR) should implement the following steps in their ongoing efforts to mitigate the risks associated with transmission of the COVID-19 coronavirus.

1. CDCR should not authorize or undertake any further movements of inmates between institutions to achieve necessary social distancing without the approval of Health Care Placement Oversight Program (HCPOP) in consultation with the CCHCS public health team. Inter-institution moves risk carrying the virus from one institution to another.

2. The Center for Disease Control's "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities," dated March 23, 2020 (https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html), recommends maintaining social distance of 6 feet between inmates while acknowledging that "Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities." Necessary social distancing is already being achieved in both single- and double-celled units. In double cells, cell mates constitute one another's "social distancing cohort" for correctional purposes and are analogous to a family unit in the free world. With respect to housing in dorm settings, the Receiver has determined that necessary social distancing can be achieved by creating 8-person housing cohorts. Each cohort is to be separated from the others by a distance of at least six feet in all directions.

3. Any movement of inmates out of the dorms to achieve necessary cohort social distancing must be coordinated with, and may not occur without the concurrence of,

MEMORANDUM

HCPOP to ensure to the extent feasible that such movement does not cause, contribute to or exacerbate the potential spread of the disease.

4. CCHCS will continue to monitor developments closely and will modify these guidelines as necessary and appropriate.

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 27, 2021
To:	Secretary Kathleen Allison
From:	J. Clark Kelso, Receiver
Subject:	Rescission of CCHCS Guidelines for Achieving and Maintaining Social Distancing in California Prisons

This memorandum rescinds my memorandum dated April 10, 2020 and my supplemental memorandum dated April 12, 2020, both entitled "CCHCS Guidelines for Achieving and Maintaining Social Distancing in California Prisons." Those memoranda have become outdated by subsequent developments. More recent documents, such as the document dated January 8, 2021, entitled "COVID-19: Interim Guidance for Health Care and Public Health Providers," and subsequent revisions, provide updated recommendations.

If you have any questions, please do not hesitate to contact me.

Attachments: Rescinded memoranda dated April 10, 2020 and April 12, 2020

EXHIBIT 10

CDCR PATIENTS: CONFIRMED COVID-19 AND OUTCOMES

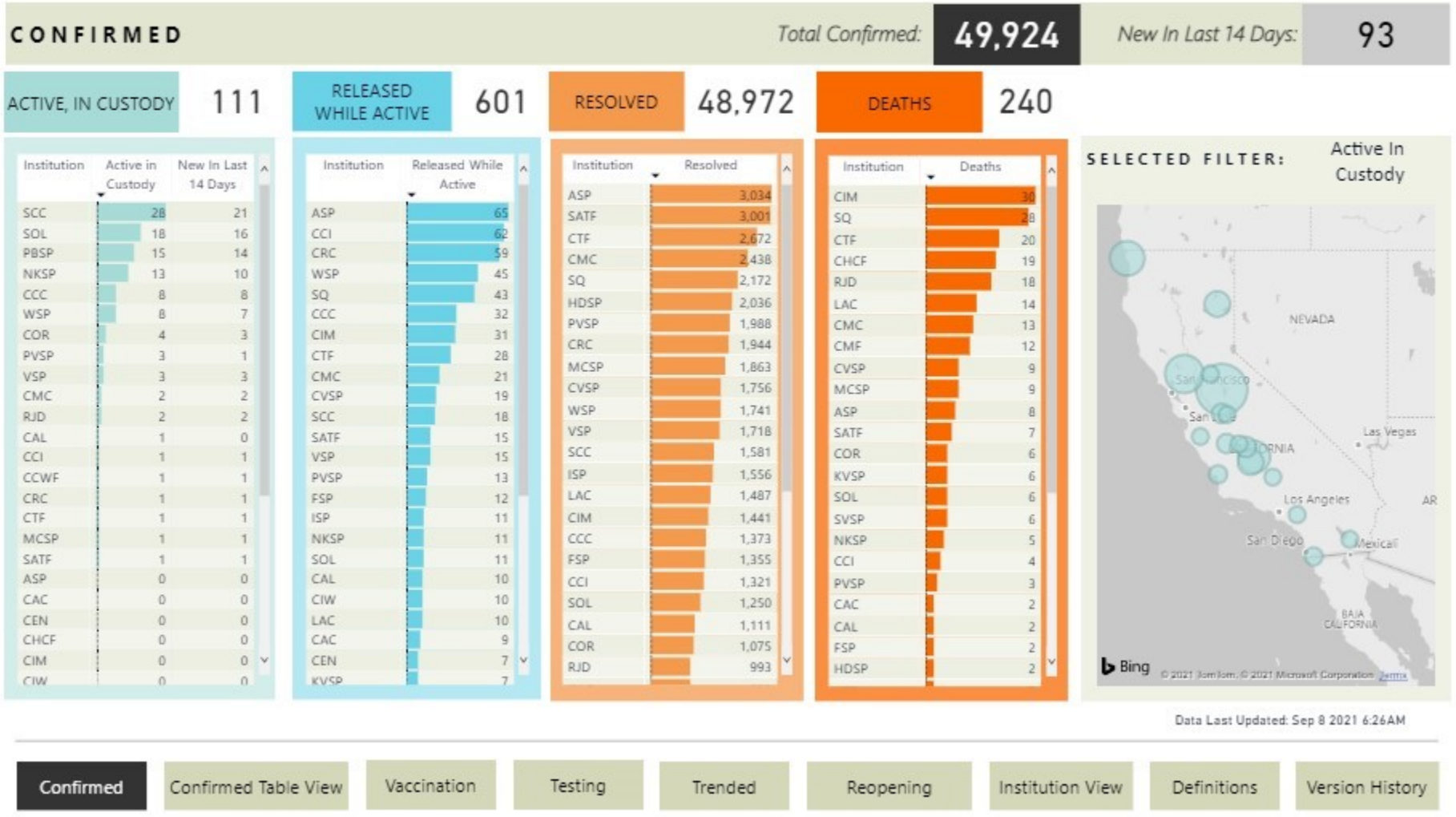

EXHIBIT 11

Morbidity and Mortality Weekly Report

Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020

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On December 4, 2020, this report was posted as an MMWR *Early Release on the* MMWR *website (https://www.cdc.gov/mmwr).*

In the 10 months since the first confirmed case of coronavirus disease 2019 (COVID-19) was reported in the United States on January 20, 2020 (*1*), approximately 13.8 million cases and 272,525 deaths have been reported in the United States. On October 30, the number of new cases reported in the United States in a single day exceeded 100,000 for the first time, and by December 2 had reached a daily high of 196,227.* With colder weather, more time spent indoors, the ongoing U.S. holiday season, and silent spread of disease, with approximately 50% of transmission from asymptomatic persons (*2*), the United States has entered a phase of high-level transmission where a multipronged approach to implementing all evidence-based public health strategies at both the individual and community levels is essential. This summary guidance highlights critical evidence-based CDC recommendations and sustainable strategies to reduce COVID-19 transmission. These strategies include 1) universal face mask use, 2) maintaining physical distance from other persons and limiting in-person contacts, 3) avoiding nonessential indoor spaces and crowded outdoor spaces, 4) increasing testing to rapidly identify and isolate infected persons, 5) promptly identifying, quarantining, and testing close contacts of persons with known COVID-19, 6) safeguarding persons most at risk for severe illness or death from infection with SARS-CoV-2, the virus that causes COVID-19, 7) protecting essential workers with provision of adequate personal protective equipment and safe work practices, 8) postponing travel, 9) increasing room air ventilation and enhancing hand hygiene and environmental disinfection, and 10) achieving widespread availability and high community coverage with effective COVID-19 vaccines. In combination, these strategies can reduce SARS-CoV-2 transmission, long-term sequelae or disability, and death, and mitigate the pandemic's economic impact. Consistent implementation of these strategies improves health equity, preserves health care capacity, maintains the function of essential businesses, and supports the availability of in-person instruction for kindergarten through grade 12 schools and preschool. Individual persons, households, and communities should take these actions now to reduce SARS-CoV-2 transmission from its current high level. These actions will provide a bridge to a future with wide availability and high community coverage of effective vaccines, when safe return to more everyday activities in a range of settings will be possible.

* https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases.

Recommended Public Health Strategies

Universal use of face masks. Consistent and correct use of face masks is a public health strategy critical to reducing respiratory transmission of SARS-CoV-2, particularly in light of estimates that approximately one half of new infections are transmitted by persons who have no symptoms (*2*,*3*). Compelling evidence now supports the benefits of cloth face masks for both source control (to protect others) and, to a lesser extent, protection of the wearer.† To preserve the supply of N95 respirators for health care workers and other medical first responders, CDC recommends nonvalved, multilayer cloth masks or nonmedical disposable masks for community use.§ Face mask use is most important in indoor spaces and outdoors when physical distance of ≥6 feet cannot be maintained. Within households, face masks should be used when a member of the household is infected or has had recent potential COVID-19 exposure (e.g., known close contact or potential exposure related to occupation, crowded public settings, travel, or nonhousehold members in your house). A community-level plan for distribution of face masks to specific populations, such as those who might experience barriers to access, should be developed (Table).

Physical distancing and limiting contacts. Maintaining physical distance (≥6 feet) lowers the risk for SARS-CoV-2 infection through exposure to infectious respiratory droplets and aerosols and is important, even if no symptoms are apparent, because transmission can occur from asymptomatic infected persons¶ (*2*,*3*). Outside the household setting, close physical contact, shared meals, and being in enclosed spaces have all been associated with an increased infection risk (*4*–*7*). Although the impact of physical distancing is difficult to disaggregate from other interventions, one study estimated that physical distancing decreased the average number of daily

† https://www.cdc.gov/coronavirus/2019-ncov/more/masking-science-sars-cov2.html.
§ https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html.
¶ https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

TABLE. Individual- and community-level public health strategies to reduce SARS-CoV-2 transmission*

Recommended public health strategies	Individual- and household-level strategies	Community-level strategies (at state or local level)	Links to guidance
Universal use of face masks	Consistent and correct use of face masks, including within the household if there is a COVID-19 case or a person with a known or possible exposure in the household	Issue policies or directives mandating universal use of face masks in indoor (nonhousehold) settings Plan for provision of face masks for specific populations if needed	Considerations for wearing masks: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html Caring for someone sick at home, when to wear a mask or gloves: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html#face-covering Protect your home: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/protect-your-home.html
Physical distancing and limiting contacts	Maintain physical distance (≥6 feet) from other persons when possible, and limit number of contacts with persons outside the immediate household	Physical barriers and visual reminders might promote adherence to maintaining physical distance	Social distancing: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html Personal and social activities: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/personal-social-activities.html
Avoid nonessential indoor spaces and crowded outdoor settings	Avoid nonessential indoor spaces and crowded outdoor settings	Issue policies or directives restricting some nonessential indoor spaces that pose the highest risk for transmission Promoting flexible worksites (e.g., telework); apply limits to occupancy of indoor spaces and to the size of social gatherings	Daily activities and going out: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/going-out.html Considerations for events and gatherings: https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/considerations-for-events-gatherings.html
Increased testing, diagnosis, and isolation	Persons with a known exposure to someone with COVID-19, with possible exposure, or who experience symptoms should promptly seek testing; symptomatic or infected persons should isolate promptly; exposed persons should quarantine	Increase access to testing, including expanded screening testing of prioritized persons/groups, prioritizing those with many interactions (or interactions with persons at high risk) based on their occupational or residential setting Promptly report test results to the person tested and to public health authorities	Testing: https://www.cdc.gov/coronavirus/2019-ncov/testing/index.html Expanded screening testing: https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html Isolate if you are sick: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/isolation.html Guidance for health departments about COVID-19 testing in the community: https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/testing.html
Prompt case investigation and contact tracing to identify, quarantine, and test close contacts	Persons with diagnosed COVID-19 should provide names of known contacts; close contacts should anticipate a call from the health department, answer the call, adhere to quarantine, seek testing, and encourage their household members to quarantine	When incidence is high and overwhelms capacity, prioritize case investigation and contact tracing to promptly quarantine and test close contacts, based on time since sample collection and risk for spread to others (e.g., those working in high-density settings)	When to quarantine: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html Contact tracing (your health): https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html Contact tracing (health departments): https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/contact-tracing/index.html Prioritizing case investigation and contact tracing: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html Quarantine: https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html
Safeguarding persons most at risk for severe illness or death	Persons with underlying medical conditions or risk factors that place them at increased risk for severe illness or death should minimize contact with nonhousehold members and nonessential indoor spaces	Protect persons most at risk for severe illness or death through 1) identifying populations at high risk in the community and 2) expanding access to testing, provision of support services, and messaging	People at increased risk: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html

See table footnotes on the next page.

TABLE. (*Continued*) Individual- and community-level public health strategies to reduce SARS-CoV-2 transmission*

Recommended public health strategies	Individual- and household-level strategies	Community-level strategies (at state or local level)	Links to guidance
Protecting essential workers	Essential workers should employ all available public health strategies to reduce their risk (e.g., wear face masks and keep physical distance)	Protect essential workers through policies directing administrative and structural prevention as well as expanded testing	Essential services and critical infrastructure: https://www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/essential-services.html COVID-19 critical infrastructure sector response planning: https://www.cdc.gov/coronavirus/2019-ncov/community/critical-infrastructure-sectors.html CISA guidance on the essential critical infrastructure workforce: https://www.cisa.gov/publication/guidance-essential-critical-infrastructure-workforce
Postponing travel	Travel should be postponed. Those who choose to travel internationally should be tested with a viral test 1–3 days before departure and retested 3–5 days after arrival; domestic travelers should also consider getting tested	Issue policies or directives mandating universal use of face masks on all modes of public transportation	Travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
	Travelers should stay home or reduce nonessential activities before and after travel and be diligent about mask wearing, physical distancing, hand hygiene, and symptom monitoring		When not to travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/when-to-delay-travel.html Wear face masks on public transportation conveyances and at transportation hubs: https://www.cdc.gov/coronavirus/2019-ncov/travelers/face-masks-public-transportation.html Mask and travel guidance: https://www.cdc.gov/quarantine/masks/mask-travel-guidance.html Domestic travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html Testing and international air travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/testing-air-travel.html
Increased room air ventilation, enhanced hand hygiene, and cleaning and disinfection	Increase room air ventilation	Enhance ventilation and cleaning and disinfection, particularly of essential indoor spaces	SARS-CoV-2 and potential airborne transmission: https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html
	Frequent handwashing	Ensure provision of adequate hand sanitation supplies	Ventilation: https://www.cdc.gov/coronavirus/2019-ncov/community/general-business-faq.html#Ventilation When and how to wash your hands: https://www.cdc.gov/handwashing/when-how-handwashing.html Cleaning and disinfecting: https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html
Widespread availability and coverage with effective vaccines	Seek vaccine when appropriate following ACIP recommendations	Plan for distribution and administration of vaccines to achieve high community coverage	Vaccines: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html
	Continue to follow all mitigation measures until community vaccination coverage is adequate	Communicate that mitigation measures still need to be followed until community vaccination coverage is determined to be adequate	Vaccination planning: https://www.cdc.gov/vaccines/covid-19/planning/index.html

Abbreviations: ACIP = Advisory Committee on Immunization Practices; COVID-19 = coronavirus disease 2019.
* https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html.

contacts by as much as 74% and reduced the reproductive number (R_0, a measure of transmission, which describes the average number of persons infected by one infectious person) to <1 (*8*). Because the highest risk for transmission has been documented among household contacts of COVID-19 patients (*9*), keeping the household safe requires physical distancing, using the other public health strategies summarized here, and, in particular, consistent and correct use of face masks (outside the household and in some circumstances within the household) to prevent introduction and transmission of SARS-CoV-2. At the community level, physical barriers and visual reminders might promote adherence to maintaining physical distance.

Avoiding nonessential indoor spaces and crowded outdoor settings. Exposures at nonessential indoor settings and crowded outdoor settings pose a preventable risk to all participants.[**,††] Indoor venues, where distancing is not maintained and consistent use of face masks is not possible (e.g., restaurant dining), have been identified as particularly high-risk scenarios (*7*,*10*). Crowded events in outdoor settings have also been linked to spread of SARS-CoV-2, although it can be difficult to isolate the impact of crowded outdoor events from related indoor social interactions (*11*). To reduce risk, some restaurants are providing take-away service and well-ventilated open-air dining, and in many cases, exercise or physical activity (individual or group) can be moved to outdoor settings where physical distance is maintained and face masks are worn. Community-level policies can further reduce transmission by promoting flexible worksites (e.g., telework) and hours, as well as by applying limits to occupancy of indoor spaces and to the size of social gatherings.

Increased testing, diagnosis, and isolation. Isolation is used to separate persons infected with SARS-CoV-2 from those who are not infected; persons who are identified by testing to be infected should be rapidly isolated.[§§] Estimates vary, however, >40% of persons infected with SARS-CoV-2 might be asymptomatic, and transmission from presymptomatic persons (those who are not symptomatic at the time they transmit infection, but who later experience symptoms) and asymptomatic persons (infected persons who never experience symptoms) is estimated to account for >50% of all transmission (*2*,*3*). Therefore, reliance on symptom screening to identify infected persons is inadequate (*12*). Increased testing is an important strategy to interrupt silent transmission of SARS-CoV-2 from asymptomatic and presymptomatic persons. However, because the sensitivity of available tests and the time since exposure varies, a negative test might provide false reassurance; thus, all prevention strategies should continue to be followed including use of face masks and maintaining physical distance. A comparative analysis of data from six large countries demonstrated that high levels of testing, combined with robust contact tracing, can substantially reduce the transmission of SARS-CoV-2 (*13*). Frequent testing and contact tracing, combined with other mitigation measures, effectively limited SARS-CoV-2 transmission on a college campus (*14*). In addition to testing symptomatic persons and those with known exposure, a strategy of routinely testing certain population groups with high numbers of interactions with other persons, based on their occupational or residential setting, can more rapidly identify asymptomatic and presymptomatic infectious persons and their close contacts for isolation and quarantine.[¶¶] Communities with high or increasing SARS-CoV-2 transmission should increase screening testing, focusing on persons at increased risk for exposure (e.g., workers in high-density worksites) or persons who might have the potential to transmit infection to large numbers of other persons (e.g., persons working in congregate settings) or to transmit to persons at risk for severe COVID-19–associated illness or death (e.g., staff members in nursing homes). Expanded screening testing should be implemented in a manner that promotes health equity for persons with limited resources or other barriers to accessing health care. In addition, prompt reporting of test results to the person tested and to public health authorities can facilitate rapid isolation, case investigation and contact tracing, and accurate monitoring of COVID-19 in the community.

Prompt case investigation and contact tracing to identify, quarantine, and test close contacts. Case investigation is the process of obtaining comprehensive information about persons with a diagnosis of COVID-19 and is followed by contact tracing, which includes identifying and communicating with persons exposed to SARS-CoV-2 (i.e., close contacts[***]) to inform them of their exposure, educate them about risks for and symptoms of COVID-19, and encourage them to quarantine, seek testing, and monitor themselves for signs or symptoms of illness.[†††] Quarantine is used to keep a person who was exposed to SARS-CoV-2 away from others.[§§§] Contact tracing is most feasible when the incidence of COVID-19 in the community or workplace is low or declining, when testing and reporting of results can occur quickly (*15*), and when most contacts can be reached and quarantined (*16*). When one or more of these conditions is not met or when local capacity is

** https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/considerations-for-events-gatherings.html.

†† https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/going-out.html.

§§ https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/isolation.html.

¶¶ https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html.

*** https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact.

††† https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html.

§§§ https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html.

overwhelmed, health departments should narrow the scope of contact tracing activities and emphasize community mitigation measures. Investigations should prioritize persons who most recently received positive SARS-CoV-2 test results, as well as identify and quarantine household contacts and persons exposed in a congregate living facility, high-density workplace, or other setting (or event) with potential extensive transmission.[¶¶¶] Because the risk for household transmission is high and occurs rapidly in the absence of face masks or other protective behaviors, household members of persons with diagnosed COVID-19 should be quarantined, and, in the event that they experience symptoms or receive a positive test result, they should be isolated (*9*,*17*). Eliciting and reaching contacts in a timely manner is challenging (*18*,*19*), and quarantine can impose economic and financial burdens (*20*); adherence to quarantine might require provision of appropriate support services.[****] Persons who receive positive SARS-COV-2 test results should also be encouraged to serve as their own contact tracers by informing close contacts that they have been exposed and encouraging those persons to quarantine, monitor for symptoms, and seek testing.

Safeguarding persons most at risk for severe illness or death. To protect those who are at highest risk for severe COVID-19–associated outcomes, universal mitigation efforts are needed. SARS-CoV-2 infection can be completely asymptomatic or can manifest as a life-threatening illness; disease can result in postacute and long-term sequelae or disability among survivors. Risk for severe illness increases with age and is highest for those aged ≥85 years.[††††] In the United States, approximately 80% of reported COVID-19 deaths have occurred in patients aged ≥65 years.

Certain underlying medical conditions also increase risk for severe illness or death for persons of any age with COVID-19.[§§§§] Long-term care facilities serve older adults and persons with complex medical conditions; COVID-19 can spread rapidly in these congregate settings, resulting in high rates of morbidity and mortality. To prevent introduction and transmission of SARS-CoV-2, these facilities should implement strict infection prevention and control measures and expanded screening testing of both staff members and residents to rapidly identify and isolate infected persons.[¶¶¶¶]

COVID-19 has also disproportionately affected racial and ethnic minority groups.[*****] An age-standardized analysis of COVID-19–associated deaths reported to the National Vital Statistics System through November 25, 2020, found that Black persons accounted for 26.9% of COVID-19–related deaths, despite representing 12.7% of the U.S. population.[†††††] Persons who belong to racial or ethnic minority groups are likewise disproportionately affected by the underlying medical conditions that increase risk for severe COVID-19 illness and death, likely because of long-standing inequities in social determinants of health. Members of racial or ethnic minority groups are more likely to experience lower socioeconomic status, to live in crowded housing, and possibly to be employed in occupations that require in-person work.[§§§§§] In addition, access to health care might be limited, including obtaining testing and care for COVID-19.

Persons who are at highest risk for severe COVID-19–associated illness or death or who share a household with someone at high risk should minimize their individual and household risk by avoiding nonessential interactions with persons outside their household whenever possible and implementing all recommended public health prevention strategies. Some approaches to safeguarding those with underlying medical conditions include promoting access to and use of telehealth when feasible and appropriate, use of no-contact pickup for groceries or other essential items, and use of online (versus in-person) educational instruction.

Protecting essential workers. Essential (critical infrastructure) workers include health care personnel and employees in other essential workplaces (e.g., first responders and grocery store workers).[¶¶¶¶¶] Protecting essential workers requires full implementation of all evidence-based strategies outlined in this guidance. When a COVID-19 vaccine is authorized for use by the Food and Drug Administration (FDA) and recommended by the Advisory Committee on Immunization Practices (ACIP), essential workers, including health care personnel, are among the populations being considered for initial phased allocation of limited vaccine doses (*21*). Implementation of infection prevention and control with adequate supplies and extensive use of telehealth options and nurse-directed triage of patients, as well as screening of all persons entering health care facilities for signs and symptoms of COVID-19, can protect health care personnel and reduce risk for SARS-CoV-2 transmission in health care facilities.[******] U.S. food manufacturing

[¶¶¶] https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html.

[****] https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/support-services.html.

[††††] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html.

[§§§§] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

[¶¶¶¶] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-home-long-term-care.html.

[*****] https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

[†††††] https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm.

[§§§§§] https://www.census.gov/content/dam/Census/programs-surveys/ahs/publications/Measuring_Overcrowding_in_Hsg.pdf.

[¶¶¶¶¶] https://www.cisa.gov/publication/guidance-essential-critical-infrastructure-workforce.

[******] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.

and agriculture is another sector that has been substantially affected by COVID-19, especially among workers in meat and poultry processing facilities, with disproportionate effects among persons who belong to racial or ethnic minority groups (*22*). CDC and the Occupational Safety and Health Administration released guidance on administrative and engineering controls that should be part of COVID-19 assessment and control plans for these workplaces.†††††† When cessation of operation of a facility might cause serious harm or danger to public health or safety, essential workers who are known close contacts of persons with confirmed COVID-19 might need to return to work as a last resort; however, if they return to work, they should use face masks and maintain physical distancing, and the workplace should be appropriately disinfected.§§§§§§ These persons should only return to work if they are and remain asymptomatic and undergo at least daily active symptom monitoring with immediate removal from the workplace if any signs or symptoms of possible COVID-19 occur; viral testing of all close contacts is recommended, and those with positive test results should not return to work.

Postponing travel. Travel increases the likelihood of SARS-CoV-2 exposure and infection and could translocate infection between communities. Postponing travel is the best way to reduce this risk.¶¶¶¶¶¶ Any traveler who is symptomatic, has had close contact with a person with COVID-19 and has not met criteria for release from quarantine, or has a positive or pending SARS-CoV-2 test result should not travel.******** For those contemplating international travel, CDC recommends getting tested with a viral test for SARS-CoV-2 1–3 days before departure and getting retested 3–5 days after arrival.††††††† Domestic travelers should also consider testing. Testing does not eliminate all risk and should be combined with other recommended public health strategies. Both domestic and international travelers should stay home or reduce nonessential activities before travel, and for 7 days after travel if tested, even if test results are negative. If not tested, this period should be extended to 10 days. Travelers should be diligent about mask wearing, physical distancing, hand hygiene, and symptom monitoring. For 14 days after arrival, travelers should avoid close contact with persons at higher risk for severe COVID-19–associated outcomes and wear masks in household spaces shared with those who did not travel.

Increased room air ventilation, enhanced hand hygiene, and cleaning and disinfection. Increasing room air ventilation, enhancing hand hygiene, and cleaning and disinfecting frequently touched surfaces might help decrease transmission of SARS-CoV-2 (*23*).§§§§§§§ Although the epidemiology of SARS-CoV-2 suggests that most transmission is close person-to-person, there have been some documented cases of presumed airborne transmission.¶¶¶¶¶¶¶ Avoiding nonessential indoor spaces can help reduce this risk. For indoor settings, increased room air ventilation can decrease the concentration of small droplets and particles carrying infectious virus suspended in the air and, thereby, presumably decrease the risk for transmission.******** Hand hygiene includes handwashing with soap and water or using alcohol-based hand sanitizer.††††††††† Handwashing mechanically removes pathogens, and laboratory data demonstrate that hand sanitizers that contain at least 60% alcohol inactivate SARS-CoV-2 (*24*). These strategies, combined with appropriate cleaning and disinfection of surfaces, might prevent indirect transmission through touching surfaces contaminated with virus from an infected person, followed by touching the mouth, nose, or eyes.

Widespread availability and use of effective vaccines. Widespread availability and high community coverage with safe and effective COVID-19 vaccines represent the most important public health strategy to control the pandemic. Many COVID-19 vaccine candidates are currently in clinical trials. Promising products are being manufactured in anticipation of Emergency Use Authorization from the FDA. The federal government has established a centralized system to order, distribute, and track COVID-19 vaccines through states, tribal nations, and territories; these jurisdictions are preparing for vaccination with extensive planning for vaccine distribution and administration.§§§§§§§§ After FDA authorization of the use of one or more COVID-19 vaccines in the United States, the ACIP will review safety and efficacy data for each of the authorized vaccines and will issue recommendations for use to ensure equitable access (*21,25*). Ensuring transparency in these efforts, monitoring for adverse events, and working with communities to address concerns will be critical to obtaining the confidence and trust of the public and health care providers. CDC and FDA will monitor the effectiveness and safety of all COVID-19 vaccines and update and communicate this information regularly. Vaccinated persons should continue

†††††† https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html.
§§§§§§ https://www.cdc.gov/coronavirus/2019-ncov/community/critical-infrastructure-sectors.html?CDC_AA_refVal.
¶¶¶¶¶¶ https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html.
******** https://www.cdc.gov/coronavirus/2019-ncov/travelers/when-to-delay-travel.html.
††††††† https://www.cdc.gov/coronavirus/2019-ncov/travelers/testing-air-travel.html.

§§§§§§§ https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html.
¶¶¶¶¶¶¶ https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html.
******** https://www.cdc.gov/niosh/conferences/events/heatventair.html.
††††††††† https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/handwashing.html.
§§§§§§§§ https://www.cdc.gov/vaccines/covid-19/planning/index.html.

Summary

What is already known about this topic?

The United States is experiencing high levels of SARS-CoV-2 transmission.

What is added by this report?

COVID-19 pandemic control requires a multipronged application of evidence-based strategies while improving health equity: universal face mask use, physical distancing, avoiding nonessential indoor spaces, increasing testing, prompt quarantine of exposed persons, safeguarding those at increased risk for severe illness or death, protecting essential workers, postponing travel, enhancing ventilation and hand hygiene, and achieving widespread COVID-19 vaccination coverage.

What are the implications for public health practice?

These combined strategies will protect health care, essential businesses, and schools, bridging to a future with high community coverage of effective vaccines and safe return to more activities in a range of settings.

to adhere to all mitigation measures (e.g., mask use, physical distancing, and hand hygiene) until both doses in the series have been received and the duration of immunity provided by vaccines has been sufficiently established.

Discussion

No single strategy can control the pandemic; rather, a multipronged approach using all available evidence-based strategies at the individual and community levels can break transmission chains and address high levels of community transmission; reduce related illnesses, long-term sequelae, and deaths; and mitigate the pandemic's economic impact. Because COVID-19 has disproportionately affected persons with certain risk factors (e.g., age and some underlying medical conditions) and racial/ethnic minorities, implementing public health prevention strategies in a manner that assures health equity is imperative to safeguard those who have borne the worst of the pandemic's impact. The U.S. health care system is being stressed by COVID-19, with multiple jurisdictions establishing expanded or alternative treatment settings. Continuing mitigation efforts will be essential to preserve capacity for adequate treatment of persons with COVID-19 and other urgent health conditions, and to protect essential and preventive services that are not amenable to telehealth. Schools provide numerous benefits beyond education, including school meal programs and social, physical, behavioral, and mental health services. Because of their critical role for all children and the disproportionate impact that school closures can have on those with the least economic means, kindergarten through grade 12 schools should be the last settings to close after all other mitigation measures have been employed and the first to reopen when they can do so safely.¶¶¶¶¶¶¶¶ Similarly, full implementation of public health prevention strategies can help preserve the functioning of essential businesses that supply food to the population, contribute to the health protection of communities and individual persons, and fuel economic recovery. Full implementation of and adherence to these strategies will save lives. As communities respond to high levels of SARS-CoV-2 transmission, these strategies will also provide the necessary bridge to a future with wide availability and high levels of coverage with effective vaccines, and thereby a safe return to more everyday activities in a range of settings.

¶¶¶¶¶¶¶¶ https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/indicators.html.

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CDC's state, tribal, local, and territorial health department partners and CDC staff members supporting the COVID-19 response.

CDC COVID-19 Response Team

Eduardo Azziz-Baumgartner, CDC; Sarah Bennett, CDC; Chris Braden, CDC; Jennifer Buigut, CDC; Tom Chiller, CDC; Cindy R. Friedman, CDC; Carolyn M. Greene, CDC; Olga Henao, CDC; Christine Kosmos, CDC; Adam MacNeil, CDC; Barbara Marston, CDC; Greta Massetti, CDC; Jose Montero, CDC; Cria G. Perrine, CDC; Kara Polen, CDC; Karen Remley, CDC; Reynolds Salerno, CDC; Kelly A. Shaw, CDC; Ian Williams, CDC.

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[1]CDC COVID-19 Emergency Response.

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

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EXHIBIT 12

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	August 25, 2021
To:	CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR) STAFF CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES (CCHCS) STAFF
From:	DocuSigned by: Connie Gipson 60F75B6E86804F7... CONNIE GIPSON Director Division of Adult Institutions DocuSigned by: Joseph Bick 347167202A8A404... JOSEPH BICK, M.D. Director Health Care Services
Subject:	**EMPLOYEE CASE MANAGEMENT PROCEDURES TEMPORARILY PLACED ON HOLD**

On July 28, 2021, a memo entitled, "Employee Case Management of COVID-19 Vaccinations for Unvaccinated and Partially Vaccinated Staff within CDCR Institutions" was distributed to all CDCR and CCHCS staff. This memo announced the implementation of Employee Case Management procedures to facilitate informed decision-making amongst staff regarding the COVID-19 vaccination. As of August 20, 2021, over 5,000 staff members have met with Employee Health Program (EHP) nursing staff to ask their questions and discuss their concerns regarding the COVID vaccine.

On August 19, 2021, a Public Health Order was issued by the California Department of Public Health (CDPH) titled, "State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Order." This order requires workers who are regularly assigned to provide health care or health care services to inmate/patients and in specified correctional health care facilities to show evidence of full vaccination for COVID-19 by October 14, 2021, or to obtain approval for a reasonable medical or religious accommodation precluding them from the mandatory full vaccination.

As a result of this order and the additional workload, we are placing the Employee Case Management process on hold. Once the appropriate staff in posts and locales identified in this public health order are fully vaccinated, a decision will be made regarding the resumption of the Employee Case Management process.

EXHIBIT 13

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	May 26, 2021
To:	California Department of Corrections & Rehabilitation (CDCR) All Staff California Correctional Health Care Services (CCHCS) All Staff
From:	DocuSigned by: Connie Gipson 60F75B6E86804F7... Connie Gipson Director, Division of Adult Institutions CDCR DocuSigned by: Joseph Bick 347167202A8A404... Joseph Bick, M.D. Director, Health Care Services CCHCS
Subject:	**EXTENSION OF ROUTINE SURVEILLANCE COVID TESTING EXEMPTION IN JUNE FOR THOSE EMPLOYEES AND PATIENTS WHO ARE FULLY VACCINATED**

The benefits of being vaccinated for COVID-19 just keep getting better!

During May, CDCR and CCHCS exempted fully vaccinated staff and inmates from routine surveillance testing for COVID. Although we continue to identify cases and clusters of COVID infection among unvaccinated employees, vaccinated staff have not contributed to these outbreaks.

CDCR and CCHCS are extending the reprieve from routine surveillance testing for all fully vaccinated staff and inmates through the month of June. During this time, CCHCS will continue to monitor the health of our staff and residents to determine if routine testing can be stopped altogether for fully vaccinated persons. Testing will continue for inmates and employees who are identified as close contacts of active cases. Testing for inmates will also continue as described in the movement matrix, as part of the in person visiting program, and prior to dental encounters.

If you are vaccinated:

- You have markedly reduced your chances of being infected with COVID-19
- If you do become infected, you have markedly reduced your chances of spreading the virus to loved ones and coworkers
- You have reduced your chances of being hospitalized and/or dying by over 90% if you do contract COVID-19

MEMORANDUM

Additionally:

- You are helping us reach community immunity and safeguarding our vulnerable patients, staff and neighbors
- You are helping our schools and businesses in the community reopen safely
- You are putting us one step closer to ending this pandemic

Some of the benefits of being fully vaccinated[1]:

- You can gather indoors (outside of work) with others without a mask
- You can exercise outside without a mask as long as you maintain 6 feet of distance
- Once state and local government restrictions are lifted, you will be able to resume a more normal life like going to movie theaters, church, grocery stores, restaurants and gyms without a mask
- And, of course, there is no need for routine surveillance testing at work

If you were vaccinated outside of CDCR, please refer to the May 19, 2021, memo titled, "*Submission of COVID-19 Vaccination Record*" for instructions on how to incorporate that information to your CDCR Employee Vaccination Record. The memo can be viewed here: http://lifeline/ExecutiveOperations/Communications/Documents/SubmissionCOVID-19VacRecordCardMemo.pdf.

[1] Centers for Disease Control, Choosing Safer Activities | CDC

EXHIBIT 14

1.2.9 Patient Safety Program: Heat Alert Medications

(a) Policy

The California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) Statewide Patient Safety Committee and Systemwide Pharmacy and Therapeutics (P&T) Committee shall maintain a list of Heat Alert Medications, disseminate the Heat Alert Medication List to all health care staff, and review and update the Heat Alert Medication List at least annually.

(b) Purpose

To ensure the safe and effective use of Heat Alert Medications and the communication and dissemination of the Heat Alert Medication List to all health care staff.

(c) Responsibility

(1) Statewide

The Systemwide P&T Committee Chairperson, in coordination with the Statewide Patient Safety Committee, shall ensure a Heat Alert Medication List is maintained, and that appropriate tools, training, and technical assistance are available to all staff to support clinically appropriate use of the list.

(2) Regional

Regional Health Care Executives are responsible for implementation of this policy at the subset of institutions within an assigned region and shall ensure that the Heat Alert Medications policy and other relevant decision support tools are disseminated and accessible to all health care staff.

(3) Institutional

The Chief Executive Officer and Warden are responsible for implementation of this policy at the institution level. Program Leads shall ensure that the institution uses existing forums such as local quality committees to disseminate the Heat Alert Medications policy, procedure, and other relevant decision support tools to all institution staff.

(d) Procedure Overview

CCHCS and CDCR shall maintain a Heat Alert Medication List and take special precautions to prevent heat-related illness in patients prescribed medications that have the potential to impair thermoregulation. These precautions are documented in a CDCR Heat Plan enforced from May 1 through October 31 each year and whenever temperatures warrant. CCHCS patient care tools located on the Quality Management Portal – All Care Team Tools page are available to assist staff in identifying patients that are prescribed Heat Alert Medications.

(e) Procedure

(1) Heat Alert Medications List

(A) Data shall be drawn from the electronic Health Care Incident Reporting System, current medication usage across the health care system, industry best practices, and relevant clinical information to inform the review of and updates to the Heat Alert Medication List. The Heat Alert Medication List shall be made available to staff via the CCHCS Lifeline Patient Safety Resources page.

(B) Heat Alert Medications are identifiable in existing CCHCS patient care tools, which may include the Electronic Health Record System.

(C) Decision support tools shall be revised or new tools developed to help health care and custody staff identify patients who may be at risk of heat related illness (e.g., Heat Meds Custody Report, Heat Medications Registry, Patient Summary, Patient Medication Profile or Patient Risk Profile).

(D) Institution staff shall not alter the Heat Alert Medication List.

(E) Any recommendation to add or remove a drug from the Heat Alert Medication List shall be submitted in writing to healthincidentreporting@cdcr.ca.gov with proper justification to the CCHCS Statewide Patient Safety Committee and Systemwide P&T Committee.

(2) Heat Medication Reports

(A) Designated health care and custody staff shall obtain a Heat Medication Report of all patients currently prescribed a Heat Alert Medication on a daily basis between May 1 and October 31 and whenever temperatures warrant.

1. The Heat Medication Report shall identify all patients on heat medications while their medication order is active and for a period of time after discontinuation.
2. The period of time that heat medication alerts continue after a medication has been discontinued shall be determined at the time of review of the Heat Alert Medication List. Any additions or deletions shall be

made as appropriate based on available data including, but not limited to, clinical evidence and pharmaceutical parameters.

(B) Care Teams and other appropriate health care staff shall monitor patients listed on the Heat Medications Registry to identify those who may require follow-up health care services or a change in drug therapy due to a heat alert. This registry is available on the Quality Management Portal - All Care Team Tools page.

(C) Custody staff shall identify and locate all patients who are on the Heat Meds Custody Report during Heat Plan activation. This report is available on the Quality Management Portal - All Care Team Tools Page.

References

- Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Part 160, Subpart A, Section 160.103, Definitions
- Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Part 164, Subpart E, Section 164.501, Definitions; Section 164.502, Uses and disclosures of protected health information: General Rules; Section 164.506, Uses and disclosures to carry out treatment, payment or health care operations
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.6, Statewide Patient Safety Program

Revision History

Effective Dates: Policy 08/2018, Procedure 05/2007
Revised: 08/2018

1.3.3 Health Care Ethics Committee

(a) Policy

California Correctional Health Care Services (CCHCS) shall maintain an Ethics Committee at headquarters to support clinicians and improve patient care by:

(1) Consulting on and reviewing cases where ethical dilemmas have been identified and staff, patients, or surrogates have questions or are in conflict.

(2) Educating health care staff and patients using the wide body of literature in bioethics and published legal decisions related to clinical ethics.

(b) Purpose

(1) The CCHCS Ethics Committee shall provide multidisciplinary consultation, guidance, and education about the ethical aspects of providing health care within the California prison system.

(2) The Ethics Committee supports ethical reflection, respectful dialogue, and critical analysis based on standard practices from the ethics literature to facilitate resolution of bioethical dilemmas.

(3) Organizational benefits from the Ethics Committee include:

(A) Enhancing patient care

(B) Conserving resources/avoiding unnecessary costs

(C) Improving accreditation review

(D) Reducing risk of lawsuits

(E) Sustaining organizational integrity

(F) Encouraging professionalism of all staff within the organization

(b) Applicability

The Ethics Committee is accountable to and reports to the Governing Body or a subcommittee which reports to the Governing Body.

(c) Procedure

(1) Ethics Committee Membership

(A) Chairperson and Vice-chairperson

1. Chairperson shall be a clinician or nurse from headquarters or the field appointed by the Director, Health Care Operations or designee.
2. Vice-chairperson shall be a clinician or nurse administrator from headquarters appointed by the Director, Health Care Operations or designee.

(B) General Membership

1. Members will be nominated by leaders of disciplines which support the Ethics Committee. Individuals nominated should have an interest in the area of health care ethics, be willing to serve a minimum of one year on the Ethics Committee, and attend monthly meetings on a regular basis. Membership is composed of approximately 20 members of a multidisciplinary group of CCHCS and California Department of Corrections and Rehabilitation (CDCR) representatives. Each of the following disciplines/groups shall be invited/encouraged to appoint a member to the Ethics Committee:
   a. Medical Services
   b. Nursing Services
   c. Mental Health Services
   d. Dental Services
   e. Custody
   f. CCHCS Office of Legal Affairs
   g. CDCR Office of Legal Affairs
   h. Chaplaincy
   i. CDCR Division of Adult Institutions
   j. Community members
2. Ethics Committee members shall be geographically designated throughout the state.
3. Members with expertise in issues relevant to a referred case will be specifically invited to attend meetings where these issues will be discussed (i.e., a mental health representative for a mental health issue, a dental representative for a dental case, etc.).

(C) Consult Team

As time and support permit, a subset of committee members shall be trained to serve as clinical ethics consultants.

1. Selected individuals shall be among those who have expressed interest and possess the clinical knowledge necessary to triage consult requests.
2. These identified individuals shall receive additional training and mentoring including attending a comprehensive ethics course, if possible, at least once during their first year of service.
3. Attempts shall be made to designate Consult Team members geographically.
4. Designated trained and qualified Consult Team members shall triage Ethics Committee consultation requests from institutions and obtain additional information on each case as needed. In addition, these members may provide ethics education to the referring institution and further guidance if/when an Ethics Committee consultation is deemed not appropriate. Pending the formation of a Consult Team, the Ethics Committee Chairperson, Vice-chairperson, or designee, shall perform these functions.
5. Consultations provided by Consult Team members shall be reviewed at scheduled Ethics Committee meetings.

(2) Meetings

(A) The Ethics Committee shall meet no less than quarterly.

(B) A quorum shall exist when at least six members are present. Each member shall have one vote.

(C) Members of the Ethics Committee in any discipline may vote on Ethics Committee recommendations.

(D) Ethics Committee action is approved with a majority vote. A record of Ethics Committee proceedings shall be kept in a secure location, in which all Ethics Committee actions and recommendations are described.

(3) Ethics Committee Meeting Activities

(A) The Ethics Committee consults on and reviews institutional cases referred by individuals from throughout the organization to the Ethics Committee wherein staff has identified ethical dilemmas and when staff, patients, or surrogates have questions or are in conflict.

(B) Participation of referring individuals is encouraged when discussing referred, institutional cases.

(C) The Ethics Committee also reviews and discusses cases reviewed by Consult Team members.

(D) Meeting agenda includes:

1. New active case consultations, presentations, and discussions.
2. Consults managed in the past month by a committee member.
3. Review of recommendations and topics of interest.
4. Journal club, ethics related topics.

(E) The Ethics Committee may use the four-box method of ethics consultation for all recommendations. (Refer to Appendix 1).

(F) The Ethics Committee does not make health care treatment decisions as these are between providers and their patients. The suggestions presented by the Ethics Committee to the referring institution are not institutionally binding, nor are they legally binding. The Ethics Committee shall make recommendations in specific cases in a prospective manner, but shall not judge the 'ethics' of past events or decisions.

(G) The Ethics Committee provides relevant education and training on ethics topics to Ethics Committee members and to staff via webinar or other appropriate distribution methods.

(4) Confidentiality

The proceedings and records of the CCHCS Ethics Committee shall be confidential and protected from discovery to the extent permitted by law.

Appendices

- Appendix 1: Four Box Method of Ethics Consultation

References

- California Civil Code, Division 1, Part 2.6, Section 56, et seq., Confidentiality of Medical Information Act
- Albert Jonsen, Mark Siegler, William Winslade; *Clinical Ethics, A Practical Approach to Ethical Decisions in Clinical Medicine*, 4th Edition. McGraw-Hill, Inc., New York, 1998

Revision History
Effective: 12/2013

Appendix 1

Four Box Method of Ethics Consultation

Medical Indications	Patient Preferences
The Principles of Beneficence and Nonmaleficence 1. What is the patient's medical problem? History? Diagnosis? Prognosis? 2. Is the problem acute? Chronic? Critical? Emergent? Reversible? 3. What are the goals of treatment? 4. What are the probabilities of success? 5. What are the plans in case of therapeutic failure? 6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?	**The Principle of Respect for Autonomy** 1. Is the patient mentally capable and legally competent? Is there evidence of incapacity? 2. If competent, what is the patient stating about preferences for treatment? 3. Has the patient been informed of benefits and risks, understood this information, and given consent? 4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision-making? 5. Has the patient expressed prior preferences, e.g., Advance Directives? 6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why? 7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
Quality of Life	**Contextual Features**
The Principles of Beneficence and Nonmaleficence and Respect for Autonomy 1. What are the prospects, with or without treatment, for a return to normal life? 2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? 3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life? 4. Is the patient's present or future condition such that his or her continued life might be judged undesirable? 5. Is there any plan and rationale to forgo treatment? 6. Are there plans for comfort and palliative care?	**The Principles of Loyalty and Fairness** 1. Are there family issues that might influence treatment decisions? 2. Are there provider (physicians and nurses) issues that might influence treatment decisions? 3. Are there financial and economic factors? 4. Are there religious or cultural factors? 5. Are there limits on confidentiality? 6. Are there problems of allocation of resources? 7. How does the law affect treatment decisions? 8. Is clinical research or teaching involved? 9. Is there any conflict of interest on the part of the providers or the institution?

Albert Jonsen, Mark Siegler, William Winslade; *Clinical Ethics, A Practical Approach to Ethical Decisions in Clinical Medicine*, 4th Edition. McGraw-Hill, Inc., New York, 1998

2.1.2 Effective Communication Documentation

(a) Policy

California Correctional Health Care Services (CCHCS) shall ensure effective communication (EC) is reached and documented when there is an exchange of health care information involving patients with a hearing, vision, and/or speech impairment; learning disability, developmental disability, and/or functional disability; Test of Adult Basic Education (TABE) reading score of 4.0 or less, which includes zero or no TABE score; and/or Limited English Proficiency (LEP), and in health care grievance communications with such patients. In the exchange of health care information and in health care grievance communications with such patients, the patients' primary method of communication shall be used. If necessary, the patients' secondary method of communication shall be used with the exception of patients needing a Sign Language Interpreter (SLI). Any assistance or accommodation provided, as well as how it was determined EC was reached, shall be documented. If EC is not reached, that shall also be documented.

(b) Purpose

To ensure EC is reached and documented when there is an exchange of health care information and in health care grievance communications.

(c) Applicability

This policy applies to all CCHCS and contracted staff who, in the performance of their duties, are required to communicate health care information with patients in the custody of California Department of Corrections and Rehabilitation identified in Section (a). This policy shall also apply to patient specific communication provided through health care grievance interviews, or health care grievance responses, rejections, or withdrawal letters.

(d) Responsibility

(1) The Chief Executive Officer (CEO), or designee, is responsible for the implementation, monitoring, and evaluation of this policy. The CEO or designee shall ensure a Local Operating Procedure (LOP) is established to implement this policy and its corresponding procedure.

(2) The Chief Executive Officer, or designee, is responsible to ensure staff receive training on EC and to review monthly SLI and EC audits of documented exchanges of health care information submitted by medical, dental, and mental health services, and health care grievance communications with patients identified in Section (a).

(e) Procedure

(1) Determining the EC need for the patient

(A) Health care staff shall determine the primary accommodation or assistance required to reach EC by reviewing information in the following areas:

1. Disability Effective Communication Systems
2. Strategic Offender Management System
3. Patient Health Information Portal
4. TABE
5. LEP
6. CDC 128-B, General Chrono
7. Electronic Health Record System
8. Patient Summary

(B) Health care staff shall consider whether additional steps are necessary to reach EC with a specific patient even if EC information is not identified in the areas listed above.

(C) If the patient's primary method of communication is unavailable, staff shall provide the secondary method of communication and document the reason for the unavailability.

(2) Accommodation or Assistance

Health care staff shall provide the necessary accommodation or assistance to reach EC at each exchange of health care information with patients identified in Section (a). Accommodations may be facilitated by sign language interpretation, certified bilingual health care staff, certified bilingual California Department of Corrections and Rehabilitation staff, other certified contracted language interpreters, assistive devices, or other methods of assistance and accommodation.

(A) Assistive Devices

1. Health care staff shall, in the presence of the patient, determine the need for any assistive device(s). These assistive devices include, but are not limited to, the following:
   a. Sound amplification devices (e.g., hearing aids)

b. Corrective lenses
c. Reading magnifier

2. During an exchange of health care information with a patient, health care staff shall determine and document the presence and the efficacy of the assistive device(s).
3. When a patient presents without his or her prescribed assistive device, health care staff shall document the reason and provide alternate methods of accommodation. The alternate method utilized during the encounter shall be documented.
4. A patient reporting malfunctioning or lost assistive devices shall be referred to designated staff as identified in the LOP to assess or discuss repair or replacement of the assistive devices.

(B) Accommodation or Assistance

1. A patient with hearing, vision, speech impairments and/or those with a TABE reading score of 4.0 or less, which includes zero or no TABE score, may require accommodations or assistance to reach EC. Assistance or accommodations shall be documented and may include one or more of the following:
   a. Additional Time – The patient was given additional time to respond or complete a task
   b. Equipment – Special Equipment was used to facilitate EC (Note the type of equipment used in the "Comments" section of the standard EC sticker, label, document, and/or health record.)
   c. SLI – Sign Language Interpreter
   d. Louder – The provider spoke louder
   e. Slower – The provider spoke slower
   f. Basic – The provider used basic language
   g. Transcribe – Communication was written down (All written notes shall be retained.)
   h. Other – Any other tool that was used to facilitate EC (Note the type of accommodation used in the "Comments" section of the standard EC sticker, label, document, and/or health record.)
2. A patient with a documented learning disability; a TABE reading score of 4.0 or less, which includes zero or no TABE score; or determined limited English proficient shall be queried to determine his or her cognitive ability to engage in conversation and understand information presented during an exchange of health care information, health care grievance interview, and/or health care grievance communication. Through the query, health care staff shall determine the patient's ability to understand and participate in the exchange of health care information. If no assistance or accommodation is needed, the reason shall be documented.
3. Reading assistance may be provided (e.g., documents read aloud in the presence of the patient) and a determination made as to whether the patient understood during exchanges of health care information, health care grievance interviews, and when providing a health care grievance communication where the patient is developmentally disabled, visually impaired, has a documented learning disability, or a TABE reading score of 4.0 or less, which includes zero or no TABE score.

(C) SLIs are required for exchanges of health care information with patients whose primary method of communication is American Sign Language.

1. SLI Services can be obtained through the following means:
   a. Onsite State employee - SLI Services Support Assistant
   b. Statewide State employee - SLI Services Support Assistant through conferencing application (e.g., Jabber)
   c. Local contractors who provide SLI services
   d. "On demand" Video Remote Interpretation (VRI) services
2. If the patient refuses the assistance of an SLI, a CDC 7225, Refusal of Examination and/or Treatment, shall be completed and the EC documented on the form OR if the patient waives the assistance of an SLI, the waiver of SLI services shall be documented and staff shall employ the most effective form of communication available, including written notes. All attempts to accommodate the patient during the encounter shall be documented.
3. In locked units (e.g., Administrative Segregation), during daily Psychiatric Technician rounds, if sign language interpretation is accomplished via video remote, custody staff shall escort patients to a private setting, away from the cell front where the patient can clearly visualize the SLI. If the patient refuses, the

Psychiatric Technician shall refer the patient to a mental health clinician (refer to the Mental Health Services Delivery System Program Guide).

4. For exchanges of health care information requiring SLI, refer to the following tiered approach:
   a. Use of onsite SLI Services Support Assistant, if no availability; then
   b. Use of California Department of Corrections and Rehabilitation Statewide SLI staff through video remote, if no availability; then
   c. Use local contractors who provide SLI services, if no availability; then
   d. Use "on-demand" VRI services.
   NOTE: Local contractors are not consistently obtainable at all institutions; these resources shall be utilized based on availability and operational need.
5. When existing institution SLI Services are unavailable following the tiered approach, staff can then utilize the "on-demand" VRI interpreters using the following steps:
   a. Log into the approved equipment (e.g., tablet, laptop, or desktop computer) installed with a camera.
   b. Open the SLI contract service link icon for remote video services.
   c. Open the SLI Log on the desktop and enter required information.
6. When all above SLI resources have been addressed and determined not available, the reason the SLI was not utilized shall be documented, and the alternate method of accommodation provided shall be documented. When written notes are used, the written notes shall be retained.
   NOTE: During Emergent situations, after business hours, on weekends and holidays, utilize "on-demand" VRI services (refer to Section (e)(2)(C)4.d.).
7. Security and Storage of "on-demand" VRI devices
   a. Nursing staff shall be responsible for the security and storage of "on-demand" VRI devices.
   b. "On-demand" VRI devices shall be stored and secured in accessible areas at all times.
   c. Nursing staff shall maintain an Equipment Accountability Log (Appendix 1, "Sample" Equipment Accountability Log) to account for each time the "on-demand" VRI device is removed from the designated storage area.
   d. "On-demand" VRI devices shall not be removed from the institution at any time.
   e. In the event the SLI devices are not located, follow institutional protocol for missing equipment.
8. During each shift, nursing staff shall document that equipment and tools are accounted for during their daily tool control accountability checks and ensure the following:
   a. "On-demand" VRI devices are powered up and internet connectivity verified.
   b. "On-demand" VRI devices are fully charged and have available power strips.
   c. Equipment is checked with identified tool inventory.
9. Monthly audits of all SLI encounters shall be conducted by Field Operations, Corrections Services.
   a. Any allegations of non-compliance shall be reported to the institution where the non-compliance occurred.
   b. All allegations shall be placed on the DPP Allegation of Non-Compliance Log and an inquiry conducted.
   c. A monthly SLI audit report shall be produced by Field Operations, Corrections Services.
   d. Each institution shall have three calendar days upon receipt to verify audit findings.
   e. The monthly audit data will be displayed on the CCHCS Dashboard for the "Effective Communication: Sign Language Interpreter (SLI) Provided" domain or other appropriate performance reports.

(D) LEP Services

1. Interpretation and translations service shall be provided to patients who have a limited ability to speak, read, write, and/or understand English. The LEP accommodation provided during each encounter shall be documented.
2. Each facility shall designate an LEP coordinator (usually the Americans with Disabilities Act or Litigation Coordinator) to ensure interpretation and translation services are available, current, and operational.
3. LEP services shall be made available through the following:

a. Telephonic interpretation service available 24 hours a day, seven days a week for staff requiring interpretation services for most commonly spoken languages used by non-English speaking patients.
b. List of certified bilingual staff and other local interpreters or interpreters from neighboring institutions or agencies competent to interpret and translate. Certified staff must provide the following: contact information, language(s) spoken, staff duty hours, and availability maintained by the LEP coordinator.
c. Collection of translated forms and documents which have been translated into commonly spoken languages available to staff.

4. The designated LEP coordinator is responsible for providing and posting the following in areas where health care services are provided:
   a. I-Speak cards, used to help identify LEP patients, and
   b. Notice of Interpretation and Translation Service Information (Appendix 2), used to help identify the institution's bilingual staff and list of translated forms available.

(3) Documentation

(A) Health care staff shall document or complete the EC section (e.g., sticker, label, document, and/or health record) when documenting exchanges of health care information and in health care grievance communications.

(B) For face-to-face patient encounters, clinical staff need only document EC on one document completed during the encounter (e.g., Progress Notes). All other documents completed during the same encounter (e.g., Physician Orders) do not require documentation of EC.

(C) Health care encounters that require EC documentation in the health record include, but are not limited to, the following:

1. Determination of the patient's medical history or description of the ailment or injury.
2. Provision of the patient's rights, informed consent, or permission for treatment (including refusal of treatment forms).
3. Diagnosis or prognosis of the ailment or injury (including upon the return from outside clinics).
4. Explanation or response to questions from the patient concerning procedures, tests, treatment, treatment options, or surgery.
5. Explanation or response to questions from the patient concerning medications prescribed (such as dosage, instructions for how and when to be taken, side effects, food or drug interactions).
6. Blood donations and apheresis.
7. Admit and discharge instructions.
8. Post-procedure instructions.
9. DKD (requires dialysis) class members receiving dialysis treatment.
10. Triage and Treatment Area return following discharge from an outside hospital. Patient has/should have received orders from the discharging hospital. If he/she did not, EC is to be provided upon arrival to inform the patient of explanation of discharge and when orders are reconfirmed with a CCHCS provider.
11. Provision of mental health evaluations, group and individual therapy, including psychiatric technician rounds, Interdisciplinary Treatment Team meetings, and all therapeutic activities, educational counseling including self-care instructions.
12. Nursing behavioral checks for patient on suicide watch; any interaction to provide, share, or elicit information (e.g., Registered Nurse who does the assessments, discusses criteria for release from restraints, conducts range of motion, etc., does require EC documentation).
13. Initial admit to an Outpatient Housing Unit, inpatient area, and nursing routine duties (e.g., call light, IV).

(D) Clinical staff assigned to the inpatient unit shall document EC once per patient per shift (e.g., a Registered Nurse conducting rounds several times per shift would only need to document EC the first time conducting rounds.)

(E) EC documentation shall include the following:

1. Disability Code – A patient may have a documented disability, multiple disabilities, a TABE reading score of 4.0 or less, which includes zero or no TABE score, a learning disability, developmental disability, and/or functional disability; or any combination thereof. It is only after a determination of the patient's disability, disabilities, and/or cognitive ability, that a conclusion can be drawn as to the

patient's disability, disabilities, and/or cognitive ability, that a conclusion can be drawn as to the accommodation(s) or assistance required in order to establish EC. The disability codes include the following:

a. TABE less than or equal to 4.0, which includes zero or no TABE score
b. DPH – Permanent hearing impaired
c. DNH – Permanent hearing impaired; improved with hearing aids
d. DPS – Permanent speech impaired
e. DPV – Permanent vision impaired
f. DDP – Developmental Disability Program
g. LD – Learning Disability
h. Not Applicable – No Disability

2. Accommodation – The accommodation or assistance is determined by the patient's disability and/or cognitive abilities. Each checkbox under this category is an EC attribute related to a disability identifier in Column 1 of the EC label and includes the following:
   a. Additional Time – The patient was given additional time to respond or complete a task
   b. Equipment – Special Equipment was used to facilitate EC (Note the type of equipment used in the "Comments" section of the standard EC sticker, label, document, and/or or health record.)
   c. SLI – Sign Language Interpreter
   d. Louder – The provider spoke louder
   e. Slower – The provider spoke slower
   f. Basic – The provider used basic language
   g. Transcribe – Communication was written down (All written notes shall be retained.)
   h. Other – Any other tool that was used to facilitate EC (Note the type of tool used in the "Comments" section of the standard EC sticker, label, document, and/or health record.)
3. Effective Communication - Health care staff shall document the assessment method that validated the patient understood or did not understand the health care information as well as the corresponding EC checkboxes:
   a. Reached – EC validated
      1) Patient asked pertinent questions pertaining to the exchange of health care information
      2) Patient summarized the exchange of health care information in his or her own words
      3) Other: Elaborate in the "Comments" section
   b. Not reached – EC not validated
      1) Other: Elaborate in the "Comments" section
4. Written notes with health care information exchanged between a patient and health care staff in the absence of an SLI shall be retained with the EC documentation.

(4) Accountability

(A) Monthly health record audits shall be conducted to determine compliance with the EC policy.
   1. The audit sample shall include medical, dental, and mental health encounters.
   2. The audit sample shall include health care grievance documents and health records of patients with hearing, vision, speech impairments, a documented LD, a DDP code and/or those with a TABE reading score or 4.0 or less which includes zero or no TABE score.

(B) EC documentation shall be deemed deficient if absent or incomplete.

(C) EC documentation deficiencies shall be reported in accordance with the Health Care Department Operations Manual, Section 5.1.5, Disability Placement Program and Developmental Disability Program Staff Accountability.

(5) Local Operating Procedures

Institutions shall establish an LOP to implement the statewide procedure and submit to the Health Care Regulations and Policy Section at HealthCareDOM@cdcr.ca.gov for submission to Field Operations, Corrections Services, and the applicable Regional Health Care Executive for content review prior to local implementation or distribution.

Appendices

- Appendix 1: "Sample" Equipment Accountability Log
- Appendix 2: Notice of Interpretation and Translation Service Information

References

- Armstrong Injunction Order, *Armstrong v. Newsom*, United States District Court of Northern California, January 18, 2007
- Armstrong Order Granting Motion for a Further Enforcement Order and Denying Motion to Hold Defendants in Contempt of Court, *Armstrong v. Newsom*, United States District Court of Northern California, June 4, 2013
- Armstrong Remedial Plan, *Armstrong v. Newsom*, United States District Court of Northern California, Amended January 3, 2001
- Clark Remedial Plan, *Clark v. California*, United States District Court of Northern California, March 1, 2002
- Health Care Department Operations Manual, Chapter 5, Article 1, Section 5.1.5, Disability Placement Program and Developmental Disability Program Staff Accountability
- California Department of Corrections and Rehabilitation, Division of Correctional Health Care Services, Mental Health Services Delivery System Program Guide
- I-Speak Cards, http://www.lep.gov/resources/OhioLangIDcard.pdf

Revision History

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CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

Appendix 1
"Sample" Equipment Accountability Log
"On-demand" Video Remote Interpretation Device

Designated Area:_____ **Month/Year:**_____

Date	Location for Use of Device	Check-Out Time	Print Name and Title	Check-In Time	Print Name and Title

Appendix 2

Interpretation and Translation Service Information

As a receipient of federal funds, the California Department of Corrections and Rehabilitation (CDCR) is committed to complying with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin, including limited English proficiency, by recipients of federal financial assistance. CDCR takes reasonable steps to facilitate effective communication with non-English speakers or limited English proficient inmates, in order to comply with its responsibility to provide meaningful access to such inmates. This notice serves as a reminder to all staff and inmates of existing policy.

Where an inmate is not a native English speaker, staff should utilize appropriate methods to determine the inmate's primary language, if unknown. Methods include relying on the inmate's own ability to relay this information, coordinating with other English speaking persons who speak the same language, reviewing the CDCR Form 128-G, Classification Chrono in inmate's Central File, consulting with the institution's Limited English Proficient (LEP) Coordinator, utilizing the "I-Speak" cards located in the control booth or officer's station, enlisting the assistance of the facility's contract telephonic interpretation service to identify primary language, etc. Where the inmate is unable to read, write, speak, or understand English fluently, staff should obtain oral interpretation and/or written translation assistance, as appropriate.

The United States Department of Justice advises that language assistance is critical in, but not limited to, situations involving medical, due process, and safety and welfare issues.

For oral interpretation, staff should contact an immediate supervisor and request the use of a certified bilingual staff member. Consult the list, provided at the end of this notice, of individuals deemed by CDCR to be competent to provide language services. For telephonic interpretation 24 hours a day, 7 days a week, staff should contact the institution's designated emergency telephonic interpretation, or access to a telephonic interpreter after hours, staff should contact their watch commander. Whenever using an interpreter, institution staff must consider potential conflicts of interest between the interpreter and the inmate.

A list of general forms/documents translated into non-English languages is provided at the end of this notice. For translation of forms/documents written in non-English languages, or translation/interpretation of English language documents into non-English languages, staff should seek assistance from the institution's designated LEP coordinator or designated bilingual staff members, listed at the end of this notice, following appropriate institutional procedures. Oral interpretation of written documents is an alternative when translation is not possible.

Staff shall not use inmates to provide interpretation/translation services for interactions between inmates and correctional staff when such interactions involve medical, due process, safety and welfare issues, or the exchange of confidential information (for example, disciplinary hearings, classification committee actions, etc.).

The Warden's office has designated the following employee as the LEP coordinator. Please utilize this employee when questions arise regarding limited English proficiency services.

The designated LEP coordinator for this institution is:

Name & Title Telephone Extension

Facility List of Competent Bilingual Staff that can provide interpretation and translation services:

Name & Title		Languages	On Call

Facility List of Translated Forms that are available at appropriate locations:

Form	Language(s)

Warden

2.1.3 Over-the-Counter Products

(a) Policy

California Department of Corrections and Rehabilitation (CDCR) shall maintain a process for the distribution of over-the-counter (OTC) medical products, as identified in the OTC Products List, to the inmate population through the canteen services system.

(b) Purpose

To ensure all inmates have equal access to OTC products without cost to the inmate or the need for nurse protocol or a health care provider's prescription.

(c) Responsibility

(1) The Chief Executive Officer (health care) and Warden, or their designees, of each institution are responsible for implementation, monitoring, and evaluation of this policy and procedure.

(2) The Director, Corrections Services, California Correctional Health Care Services (CCHCS) shall maintain controlling authority over the parameters of the OTC policy.

(3) The Systemwide Pharmacy and Therapeutics (P&T) Committee shall maintain controlling authority over the parameters of the OTC procedure.

(d) Procedure Overview

(1) CDCR shall provide and distribute approved OTC health care products through the inmate canteen services system process.

(2) This procedure is not intended to limit the patient's ability to access primary care services by submitting a Health Care Services Request, or to receive prescribed medications for a condition that may be treated by similar OTC products when necessary.

(3) All patients housed within CDCR institutions shall have access to approved OTC products regardless of custody level or other demographic identifiers. However, certain exceptions exist for patients admitted to the following inpatient health care facilities:

(A) Acute or Intermediate Care
(B) Correctional Treatment Centers (CTCs)
(C) Skilled Nursing Facilities (SNFs)
(D) Psychiatric Inpatient Program (PIP)
(E) Mental Health Crisis Beds (MHCBs)

(4) These exceptions are identified in Section (e)(3)(B). In all other patient areas or levels of care, patient access to OTC products shall only be restricted on an individual, case-by-case basis by health care or custody staff and with appropriate documentation in the health record and on the CDCR 128B, General Chrono, and submitted to the institution's Inmate Trust Office (ITO).

(e) Procedure

(1) Product Procurement and Supply

(A) The list of OTC products shall be maintained by the Systemwide P&T Committee. The current list of approved medicated and non-medicated OTC products is available on the CCHCS Lifeline Pharmacy Services Intranet site within the Resources page, under the OTC tab at: http://lifeline/HealthCareOperations/MedicalServices/Pharmacy/Pages/Resources.aspx and on the internet at: https://cchcs.ca.gov/clinical-resources/ under the Related Resources section.

(B) Prison Canteen Managers (PCMs) shall ensure adequate stock of OTC products is ordered and available for distribution based on the maximum weekly quantity guidelines. Maximum weekly unit quantities are established by the Statewide Chief, Pharmacy Services, for the OTC products based on the institutions' weekly product demands which is available on the CCHCS Lifeline Pharmacy Services Intranet site within the Resources page, under the OTC tab at: http://lifeline/HealthCareOperations/MedicalServices/Pharmacy/Pages/Resources.aspx.

1. OTC weekly orders shall not exceed the maximum unit quantities established without prior approval from the Statewide Chief, Pharmacy Services, or designee.
2. The PCM shall submit a canteen OTC product order form to the Pharmacist-in-Charge (PIC), or designee, of quantities needed of each OTC product. OTC product ordering shall be conducted on a weekly basis to ensure supply stability.

3. If an institution has a need to adjust their weekly maximum unit quantities, a written exemption justification signed by the institution Warden or designee must be submitted to the Statewide Chief, Pharmacy Services, or designee for approval.

(C) The PIC, or designee, shall place the weekly order according to the PCM's request utilizing the institution OTC program account number and pharmacy OTC ordering template established by the pharmaceutical medical supplier and the Statewide Chief, Pharmacy Services, or designee.

(D) The PIC, or designee, shall inform the Statewide Chief, Pharmacy Services, or designee immediately if any discrepancies arise related to the OTC program account numbers, OTC product ordering templates, OTC maximum weekly unit quantities, and/or any other related discrepancies.

(E) If an item needs to be added to the OTC Product List, health care staff shall complete the OTC Request Form, which is available on the CCHCS Lifeline Pharmacy Services intranet site within the Resources page, under the OTC tab at: http://lifeline/HealthCareOperations/MedicalServices/Pharmacy/Pages/Resources.aspx, for submission and review by the Systemwide P&T Committee.

(2) Logistics

(A) Patients shall access OTC products as a function of normal programming.

(B) Patients in the Reception Center shall have access to OTC products through the canteen within 30 calendar days of arrival

(C) If a program modification or lockdown is in effect, OTC product access and distribution will be limited in the same manner as established for canteen services, per the CDCR 3022-A, B, C, D, and/or E, Daily Progress Status Report, for that institution.

(3) Distribution and Limitations

(A) All inmates shall access OTC products free of charge via normal canteen access.

(B) Patients admitted to the following inpatient health care facilities: Acute or Intermediate Care, CTC, SNF, PIP, MHCB, shall have access to all non-medicated comfort products only. These specific items are listed within the OTC Product List. All other medicated OTC products shall be provided by Pharmacy Services as ordered by licensed health care providers as appropriate, pursuant to Title 22.

(C) Patients shall obtain OTC products through the normal canteen process utilizing the standard canteen pick list which shall include products from the approved OTC Product List.

(D) Pick lists shall be made readily available to all patients in all housing areas.

(E) Patients shall be allowed to receive up to three OTC products (units) per canteen period, but shall not be permitted to receive more than two units of a single OTC product per draw. For example, a patient may receive one unit each of three different products, or two units of the same product and one unit of another product, but not three units of the same product.

(F) Patients unable to receive their OTC products during their first canteen draw shall be allowed to receive their allowable OTC products during open line of the current month.

(G) Patients in restricted housing units (e.g., Administrative Segregation Unit [ASU], Psychiatric Services Unit [PSU], and Security Housing Unit [SHU]), shall have access to OTC products as a function of canteen programming in those units. OTC orders shall be bagged by canteen staff for distribution by custody staff as with any other canteen purchases.

(4) Custodial Security and Controls and Safety Considerations

(A) Proper enforcement of the maximum possession limitations shall rely entirely upon custody cell searches and confiscation of any OTC products in excess of two full units of the same product.

1. OTC products shall be considered a portion of each patient's personal property and shall not be exempted from the property volume restrictions specified in California Code of Regulations, Title 15, Authorized Personal Property Schedule. OTC products shall be handled/packed as with all other personal property.
2. Custody staff shall not confiscate OTC products within the allowable limitations without a legitimate custodial safety and/or security concern which shall be documented on a CDC 115, Rules Violation Report.

(B) Removal of excess packaging, plastics, and containers from OTC products due to security concerns is not permitted, with the exception of patients within a segregated housing environment (e.g., ASU, PSU, and SHU) who are placed on container restriction.

(C) OTC products issued through this program and confiscated by custody staff for any reason shall be disposed of by depositing the confiscated products in a standard blue-and-white pharmaceutical waste container.

Pharmaceutical waste containers shall be located in appropriate clinical areas, readily accessible to custody staff for this purpose. All products on the approved OTC Product List shall be disposed of in this manner.

(5) Patient-Specific Restrictions

(A) No blanket restriction is to be placed on any portion of the patient population based on nationality, ethnicity, Security Threat Group membership or affiliation, or other overarching considerations. Restriction of access to OTC products shall be on an individual, case-by-case basis only. The only exception is for patients admitted to inpatient health care facilities.

(B) The placement and removal of restrictions for any patient's access to OTC products shall be accomplished via written communication with the institution's ITO.

1. The ITO shall provide a current list of all patients with OTC product restrictions upon request by a custody manager. The list shall include the items restricted for each patient for the purposes of conducting custody cell and property searches to enforce any restrictions in place.
2. Patients may be restricted from access to OTC products on the basis of a documented health care concern and/or a documented custody concern (i.e., safety and security).
3. If a clinician determines that a specific patient does not possess the ability to utilize an OTC products responsibly and/or safely, they shall document that assessment and restrict that specific patient from access to any OTC products deemed unsafe in his/her professional opinion.
4. If a clinician with prescribing privileges determines that providing a specific patient an OTC product may pose a health risk to that patient, that clinician shall document that assessment and restrict that specific patient from access to any OTC products deemed unsafe in his/her professional opinion.
    a. These restrictions shall be documented in the health record, on a CDCR 128B, and routed to the ITO to enter into the Trust Restitution Accounting and Canteen System (TRACS).
    b. Restoration of access to restricted OTC products shall be made by a licensed health care clinician as the result of a documented assessment of the patient. Optimally, this assessment shall include consultation with the clinician who originally established the restrictions.
5. If custody staff places a restriction for safety and security reasons, it must be supported by a guilty finding in a disciplinary hearing for a serious rule violation involving the misuse of an OTC product or its packaging.
    a. The disposition of the rule violation shall include a CDCR 128B identifying the specific OTC products to be restricted and routed to the institutions ITO to enter into TRACS.
    b. Restrictions on this basis shall remain in effect until restored.
    c. Restoration of access to OTC products restricted in this manner shall be initiated by the written recommendation of a custody supervisor (e.g., Correctional Sergeant or Correctional Lieutenant) and will require review and approval by the facility Captain.

(6) Required Documentation

(A) Pharmacy Services shall maintain data regarding the cost of the OTC program's procurement of products.

(B) The PCM at each institution shall ensure that all OTC product distributions are expediently entered into TRACS.

(C) The Inmate Accounting, Sacramento Accounting Services Branch, Office of Fiscal Services designee, shall utilize the data from TRACS and provide a report of all OTC product distribution indicating the total units of each OTC product distributed within the previous month or 30 calendar day canteen period at each institution.

(D) The Department of Finance requires the Inmate Accounting, Sacramento Accounting Services Branch monitor the Inmate Welfare Fund (IWF) associated costs with each program or benefit provided by IWF.

(E) The distribution of OTC products through the canteen services shall be treated as a separate program/benefit, and will therefore require separate tracking of all associated costs and revenue by PCMs at each institution.

References

- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 2, Article 9, Section 3190
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 3, Section 79651 (j)
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 43, Section 54030

- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 50, Section 54070

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3.1.11 Outpatient Specialty Services

(a) Procedure Overview

This procedure describes the structures, processes and resources that California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) staff shall utilize to ensure patients have timely access to safe and cost-effective specialty services that are medically necessary in order to establish diagnoses, make recommendations for diagnostic work-up, provide therapy, and establish treatment plans that include frequency of follow-up appointments with the specialist and/or the Primary Care Provider (PCP).

(b) Responsibility

(1) Statewide

CCHCS and CDCR 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 patients have timely access to safe and cost-effective specialty services that are medically necessary.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the system at the institution. The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes interdisciplinary teamwork and continuous process improvement. The CEO delegates decision-making authority to the Chief Medical Executive (CME) and Chief Nurse Executive (CNE) for daily operations of specialty services to ensure that resources are deployed to support the system including, but not limited to, the following:

1. Providing access to equipment, supplies, health information systems, Patient Registries, Patient Summaries, and evidence-based guidelines.
2. Adequately preparing new Care Team members to assume team roles and responsibilities, including onboarding.
3. Providing Care Team members with adequate resources, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
4. Requiring that Care Team members review pertinent patient information related to access to specialty services.
5. Requiring that each Care Team conduct Population Management Working Sessions, pursuant to the Health Care Department Operations Manual (HCDOM), Section 3.1.6, Population and Care Management Services, utilizing tools such as Dashboards, Patient Registries, and Patient Summaries to address concerns related to potential gaps in specialty services.
6. Providing ongoing training and assessing competence of Care Team members.
7. Reviewing/comparing institution Care Team performance including the overall quality of services, health outcomes, assignment of consistent and adequate resources; utilization of Dashboards, Patient Registries, Patient Summaries, and decision support tools; and addressing issues as necessary.
8. Updating procedures, roles and responsibilities, and training as new tools and technology become available.
9. Collaborating with the Warden to ensure that custody staff are available to provide timely, safe, and efficient escort and transportation of patients to specialty appointments.
10. Requiring institution leadership to establish a back-up system to ensure that specialty services' scheduling is managed when staff are on leave or otherwise unable to meet daily demands.

(B) The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(C) The CNE is responsible for:

1. Ensuring that the institution has a designated Supervising Registered Nurse (SRN) to monitor specialty scheduling processes on a daily basis and identify and address or elevate barriers to access.
2. Managing and overseeing daily operations of the specialty scheduling system to include telemedicine and onsite and offsite scheduling processes.

3. Coordinating the delivery of health care services.

(D) The Chief Physician and Surgeon (CP&S), SRN, and appropriate specialty services staff shall meet on a weekly basis to ensure that patients with specialty referrals have timely access to these services.

(E) The Institution Utilization Management Committee shall meet pursuant to the HCDOM, Section 1.2.15, Utilization Management Program, to review trends in specialty services including, but not limited to, timeliness of services and unexplained or significant outlier patterns of specialty services in order to reduce avoidable and unnecessary utilization and costs.

(c) Procedure

(1) General Requirements

(A) Specialty services shall be ordered by PCPs who practice within CDCR. The ordering PCP shall complete a Request for Service (RFS) order for each specialty service referral and shall indicate the timeframe in which the service is necessary (e.g., emergent, high or medium priority, routine).

(B) The PCP shall inform the patient of the plan for specialty referral including a general timeframe of expected service.

1. If a specialty service is rescheduled outside of compliance timeframes, the Primary Care Team (PCT) shall evaluate and inform the patient that the requested service has been rescheduled.
2. The information provided to the patient shall be documented in the health record.
3. The specific date, time, and location of the offsite appointment shall not be shared with the patient.

(C) Patients with pending high priority specialty services shall be placed on a medical hold to prevent transfer and discontinuity of care pursuant to the HCDOM, Section 1.2.14, Medical Classification System.

(D) If a patient is approved for a medium priority or routine specialty service and is subsequently transferred to another institution before the service occurs, the receiving institution shall not cancel or void the specialty service unless the PCP at the receiving institution examines the patient and determines that it is no longer medically necessary or can be rescheduled to a later date. The PCP shall document their findings in the health record at the time the specialty service is cancelled or rescheduled.

(E) The PCP shall continue to monitor the patient as clinically indicated until the initial specialty service has occurred. The PCP shall document the patient encounters in the health record.

(2) Pre-authorization Process

(A) Emergent health care requests are exempt from the pre-authorization process.

(B) The PCP shall submit the RFS order for electronic routing to the Utilization Management (UM) nurse. The UM nurse shall complete the first level review to determine if the RFS order meets evidence-based clinical decision support criteria.

(C) Upon completion of the UM nurse review, the RFS order will be electronically routed to the CME or CP&S for second level review.

(D) At their discretion, the CME or CP&S may obtain input from other medical providers at the regularly scheduled provider meetings in order to determine medical necessity. The decision-making authority to approve or deny the RFS order at the second level remains with the CME or CP&S.

1. Requests for high or medium priority specialty services shall be processed in a manner that allows for both the first and second level of review to be completed within five calendar days from the date of the RFS order.
2. Requests for routine specialty services shall be processed in a manner that allows for both the first and second level of review to be completed within seven calendar days from the date of the RFS order.

(E) The Statewide Medical Authorization Review Team (SMART) is the third level of review and shall review cases appealed by the PCP within 14 calendar days of a request for high or medium priority services and within 60 calendar days of a request for routine services.

(F) If the RFS order is denied, the reason for the denial shall be documented in the health record, and the PCP will be notified via the health record. The PCP shall discuss the decision and provide the patient with alternate treatment strategies during the next encounter which shall be within 30 calendar days of the denial of the specialty service.

(G) If the RFS order is approved, the UM nurse or other designated specialty clinic staff shall determine if the services can be provided onsite or require an offsite appointment and schedule as appropriate.

(3) Specialty Appointments Occurring Outside the Institution

(A) The designated health care staff shall complete the clinical portion of the CDC 7252, Request for Authorization of Temporary Removal for Medical Treatment, for health care services that are provided offsite.

(B) The designated health care staff shall include relevant information for transportation staff regarding infectious precautions and disabilities requiring accommodation as well as any medical transportation needs in the "Remarks" section of the CDC 7252.

(C) The designated health care staff shall sign the completed CDC 7252 and forward it to the designated custody staff.

(D) Custody staff shall prepare the "Custodial status" of the CDC 7252 and shall ensure all necessary signatures are obtained. Custody staff shall contact the institutional transportation team that provides transportation for the patient to the scheduled appointment.

(E) The CME or CP&S shall prioritize the scheduled appointments when transportation needs exceed custody availability. Appointments shall be rescheduled and should not exceed the initial timeframe based on clinical needs.

(F) The designated health care staff shall place a copy of the RFS order and any other pertinent clinical information in an envelope and provide it to custody staff for delivery to the specialty provider. Custody staff shall obtain the clinical documentation including, but not limited to, the specialty consultation report, prescriptions, clinical notes, discharge summaries, and brief operative notes, from the specialty provider and return the clinical documentation to the Triage and Treatment Area (TTA) upon return of the patient to the institution.

(G) All patients who receive specialty services outside the institution shall be processed in the TTA upon return to the institution.

(H) The TTA RN shall assess the patient, review the findings and recommendations made by the specialist, and document their findings in the health record.

1. The TTA RN shall notify the PCP or on-call provider of any immediate medication or follow-up requirements.
2. The TTA RN shall enter and implement all telephone orders given by the PCP or on-call provider including but not limited to, housing, Durable Medical Equipment (DME), treatments, and scheduling. For a follow-up appointment with the PCT, the provider shall remain on the line until the order has been read back and verified.
3. The TTA RN shall submit the clinical documentation to Health Information Management (HIM) staff for scanning into the health record.

(I) If a patient returns without the clinical documentation, the TTA RN shall call the specialty provider to obtain a copy of the clinical documentation.

1. The telephone contact shall be documented by the TTA RN in the health record.
2. If the specialty provider is unavailable, the TTA RN shall contact the PCP or on-call provider for direction.
3. The TTA RN shall inform the appropriate health care staff to obtain the clinical documentation which is required to be submitted by the specialty provider within 48 hours of the encounter.

(4) Specialty Clinic Appointments Occurring Within the Institution

(A) If trained and provisioned access, the onsite specialty provider shall document their recommendations and findings in the health record or provide written documentation to the designated nursing staff on the day of the encounter.

(B) The designated nursing staff shall:

1. Review the findings and recommendations made by the specialty provider.
2. Notify the PCP or on-call provider of any immediate medication or follow-up requirements.
3. Implement all telephone orders given by the PCP or on-call provider including, but not limited to, housing, DME, treatments, and scheduling. For a follow-up appointment with the PCT, the provider shall remain on the line until the order has been read back and verified.

(C) All written documentation shall be forwarded by the designated nursing staff to HIM staff for scanning into the health record.

(5) Follow-up with the Primary Care Team after Specialty Services

(A) The PCP shall review and sign the specialty consultation report within three business days of receipt.

(B) The patient shall be seen by the PCP within five calendar days after a high priority specialty services appointment.

(C) Following a medium priority or routine specialty services appointment, the PCT shall review the clinical documentation and schedule the patient for a follow-up appointment with the PCP or RN, as clinically indicated.

(D) At the follow-up appointment, the PCP or RN, shall discuss the specialty provider's findings and recommendations with the patient, as clinically appropriate, and document the discussion in the health record.

1. Ongoing cancer treatments such as chemotherapy, radiation therapy, and follow-up with the oncologist require only an initial approval to initiate the series of treatments and consultations.
2. If the specialty provider recommends a new procedure, surgery, or specialist consultation, and the PCP agrees with the specialty provider's recommendations, a new RFS shall be submitted. A new request for imaging shall be submitted if the PCP agrees with the specialist's recommendations.
3. Follow-up with the specialty provider after a procedure or surgery does not require another RFS order if completed within the global surgery schedule timeframes.
4. All other specialty follow-up services occurring six months or later from the date of the original service require a new RFS order.

(E) Specialty providers may not directly order follow-up consultations, diagnostic studies or treatments. The specialty provider shall make recommendations and the PCP shall review these recommendations to determine the need based on clinical guidelines, if applicable, and medical necessity.

1. If there are questions regarding medical necessity, the PCP shall discuss the case with the CME and/or CP&S including possible referral to the SMART.
2. If it is determined that the follow-up consultations, diagnostic studies or treatments recommended by the specialty provider do not meet clinical guidelines and are not medically necessary, the PCP shall document the reason in the health record.

(6) Statewide Medical Authorization Review Team

The SMART is the third level of review and shall review cases appealed by the PCP or that meet criteria for a higher level of review to determine if the specialty service is medically necessary.

(A) Membership

1. The SMART Chairperson shall be designated by the Deputy Director, Medical Services.
2. The SMART membership shall consist of Regional Deputy Medical Executives, at least two other headquarters-based physician managers, and two physician managers from the field.

(B) Meetings

1. The SMART shall meet as often as is necessary to conduct its business within established timeframes, but not less frequently than monthly.
2. A quorum is met when a minimum of 50 percent of the members are in attendance, either in person or telephonically. A quorum must be present to take action on any agenda item.

(C) Committee Proceedings Documentation

1. Records of committee proceedings shall be kept at a secure, accessible medical program site for a period of three years. At minimum, the record shall describe all committee actions and recommendations.
2. The proceedings and records of the SMART shall be confidential and protected from discovery to the extent permitted by law.

References

- California Civil Code, Division 1, Part 2.6, Section 56, et seq.
- California Evidence Code, Division 9, Chapter 3, Section 1157
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.14, Medication Classification System
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.15, Utilization Management Program
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- California Department of Corrections and Rehabilitation, Department Operations Manual, Section 62070.9.3
- Centers for Medicare and Medicaid Services Global Surgery Booklet

Revision History
Effective: 04/2019
Revision: 07/2020

3.1.12 Outpatient Dietary Intervention

(a) Policy

California Department of Corrections and Rehabilitation (CDCR) provides patients with meals based on a CDCR Standardized Master Menu consistent with a CDCR Heart Healthy Diet. The CDCR Heart Healthy Diet eliminates the need for most therapeutic diets with appropriate patient diet instruction. California Correctional Health Care Services (CCHCS) shall provide diet instruction, outpatient therapeutic diets, texture modified diets, nourishments, and supplements as clinically indicated. It is the responsibility of each patient to monitor their diet in order to maintain optimum health.

(b) Purpose

(1) Provide diet instruction and ordered outpatient therapeutic diets, texture modified diets, nourishments, and supplements to patients with identified nutritional needs.
(2) Ensure that patients have clinically accurate information regarding appropriate nutritional choices.
(3) Ensure that patients receive medically necessary outpatient therapeutic diets, texture modified diets, nourishments, or supplements.

(c) Responsibility

(1) Statewide

The CCHCS Nutrition Subcommittee is responsible for:
(A) Annual review of this procedure.
(B) Recommending diet education handouts for approval by the Clinical Operations Team and the Joint Clinical Executive Team.
(C) Overseeing the distribution of diet education handouts to all institutions.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO), or designee, has overall responsibility for implementation and ongoing oversight of a system to provide outpatient therapeutic diets, texture modified diets, nourishments, or supplements to patients.
(B) The institution-based Registered Dietitian is responsible for:
1. Providing patient nutrition consultation or education as ordered by a Primary Care Provider (PCP) or Dentist, including recommending therapeutic diets, texture modified diets, nourishments, and supplements.
2. Ensuring that standardized CDCR patient diet education handouts are available for use during diet instruction and patient care.
3. Ensuring that therapeutic diets and texture modified diets are prepared pursuant to this procedure.
4. Coordinating the distribution of therapeutic diets and texture modified diets to outpatients.

(C) An institution without a Registered Dietitian shall designate how and by whom the responsibilities of the Registered Dietitian shall be performed in a local operating procedure (LOP).
(D) The PCP or Dentist is responsible for ordering medically necessary therapeutic diets, texture modified diets, nourishments, and supplements following CCHCS guidelines outlined in this procedure.

(d) Procedure

(1) **Dietary Consultation/Instruction**

(A) The PCP or Dentist shall refer patients for dietary consultation by entering an order for "Consult to Registered Dietitian" in the health record. The order shall indicate the medical or dental condition requiring dietary instruction and any special medical and/or dietary considerations.
(B) Conditions for which dietary instruction or consultation may be considered include, but are not limited to:
1. Pregnancy
2. Disorders of mastication or dysphagia
3. Weight loss of greater than five percent of body weight during the prior six months
4. Body Mass Index (BMI) less than 18
5. Diabetes
6. Hepatic disease
7. Kidney disease

8. Celiac disease
9. Patients receiving Liquid Nutritional Supplements (LNS)
10. Food allergies or intolerances
11. Obesity BMI ≥ 30
12. Patients with other medical or dental conditions that the treating clinician determines, based on evidence, will benefit from the instruction

(C) Dietary consultation or diet instruction provided by the Registered Dietitian, or designee, and the recommendations shall be documented in the health record.

(D) Standardized CDCR patient dietary education handouts shall be available to all institutions for use during dietary instruction.

(E) Patients receiving dietary instruction shall not be housed in a Correctional Treatment Center (CTC), Skilled Nursing Facility (SNF), Hospice, or any other licensed bed or Outpatient Housing Unit (OHU) solely to receive this service.

(2) **Food Allergies and Intolerances**

(A) The PCP, or designee, shall evaluate patients who request a special diet due to claimed food intolerance or allergy. If the PCP determines the patient has a severe food allergy based on objective and verifiable information, the PCP shall determine whether the allergy can be appropriately managed by educating the patient to avoid the identified food or if other intervention, such as a nutrition supplement, is required. In extreme cases where the patient does not tolerate the supplement, the patient may require meals to be provided as a medical diet. An example of an extreme case includes patients with all of the following:

1. Multiple food-allergy related hospitalizations.
2. Abnormal food allergy lab profile.
3. Verified food-specific allergen signs and symptoms including, but not limited to, anaphylaxis, eosinophilic esophagitis, hives, and enterocolitis.

(B) In addition to food allergy lab profile testing, subsequent testing, such as skin-testing, may be requested by the PCP to support abnormal laboratory values, unless an allergist states that substantiated, documented risk of anaphylaxis is so severe that skin-testing/additional testing would be life-threatening based on medically proven evidence of anaphylaxis with hospitalization.

(C) If a patient is allergic or intolerant to readily identified food (e.g., lactose intolerance, peanuts, or fish), he/she shall be educated to avoid the offending food, but no food substitution shall be given.

(3) **Nourishments and Supplements**

(A) Indications:

1. The patient shall meet one or more of the following criteria to qualify for nourishments or supplements, except in special situations that shall be approved by the institution Chief Medical Executive (CME) or Supervising Dentist (SD).
   a. Pregnancy and lactation.
   b. Patients with type one diabetes mellitus or brittle diabetes.
   c. Patients with impaired mastication and/or dysphagia, including that caused by:
      1) Dental or oropharyngeal conditions.
      2) Cerebrovascular or other significant neurological condition.
      3) Esophageal obstruction or dysfunction.
   d. Moderate to severe protein/calorie malnutrition due to metabolic deficiency or metabolic response to injury/illness evidenced by:
      1) Significant weight loss of ten percent or more over the prior six months.
      2) BMI less than 18.
   e. Decompensated end stage liver disease with:
      1) Ascites requiring paracentesis; or
      2) Encephalopathy requiring hospitalization.
   f. Bariatric Surgery.

(B) Orders and Renewals:
1. Nourishments and supplements, including vitamin and mineral supplements that are recommended by a Registered Dietitian, are provided only if ordered by a PCP or Dentist according to criteria outlined in Appendix 1.
2. The order shall include the indication for the nourishment or supplement and the maximum duration of the order based on the criteria as noted in Appendix 1.

(C) Implementation:
1. Orders for nourishments and supplements are limited to those listed in Appendix 1, and may not be modified for religious reasons or for other personal requests.
2. Orders for nourishments including LNS shall be stored and distributed by institution food services and custody staff in accordance with established LOPs, and they shall be purchased by CCHCS, medical warehouse, or food services.
3. A system for tracking the distribution of nourishments and LNS to patients, as well as monitoring LNS usage levels and policy compliance shall be developed and incorporated into the LOPs.

(4) **Outpatient Therapeutic Diets and Texture Modified Diets**

(A) The CCHCS authorized outpatient therapeutic diets, their characteristics, and the indications for orders are noted in Appendices 2-A, B, C, D, and E.

(B) If an institution only has an OHU and no Registered Dietitian, therapeutic meals, including outpatient therapeutic diet meals or texture modified diet meals, shall not be prepared, assembled, or served in that OHU.

(C) Outpatient therapeutic diet meals cannot be modified for religious reasons or for other personal requests. If a therapeutic diet is ordered for a patient, it shall take precedence over a religious diet.

(D) Refusal of Therapeutic Diets
1. Patients may refuse an ordered outpatient therapeutic diet and the refusal shall be documented in the health record. If, after educating the patient regarding the health care benefits of the ordered diet, the patient continues to refuse the ordered diet, a CDCR 7225, Refusal of Examination and/or Treatment, shall be completed and scanned into the health record. Patients who refuse an ordered diet shall be offered the CDCR Heart Healthy Diet.
2. Patients shall not be issued a Rules Violation Report (RVR) for refusing an outpatient therapeutic diet. A patient may be issued an RVR for circumventing meal procedures such as picking up a therapeutic meal and a regular meal or other violations of meal procedures. A patient shall not be issued an RVR for eating items other than those on the outpatient therapeutic diet meal (e.g., canteen purchases).

(E) Housing for Patients Requiring an Outpatient Therapeutic Diet
1. Patients requiring an outpatient therapeutic diet or texture modified diet shall be housed only at institutions listed in Appendix 3 that have the capability to prepare these diets under the direction and supervision of a Registered Dietitian and trained dietary staff.
2. When a patient is not housed at one of the listed institutions and is identified by a PCP or Dentist as requiring an outpatient therapeutic diet or texture modified diet, the PCP or Dentist shall initiate a transfer per the LOP. While the transfer is pending, the patient shall be given dietary instruction for making appropriate food choices from the CDCR Standardized Master Menu, or an LNS if texture modification is needed, but shall not receive an outpatient therapeutic diet.
3. Patients receiving an outpatient therapeutic diet or texture modified diet shall not be housed in a CTC, SNF, Hospice, or any other licensed bed or OHU due solely to receive the ordered diet.

(F) Meals and Meal Service
1. Outpatient Therapeutic Diets Using the CCHCS Standardized Health Care Menu
   a. For outpatient therapeutic diet meals, the CCHCS Standardized Health Care Menu shall be followed. The menu is based on using approved frozen dietary meals.
   b. CCHCS is responsible for purchasing the frozen dietary meals, plus all special foods (e.g., low sodium, low fat, gluten free) used in the outpatient therapeutic diet meals.
   c. The CCHCS Standardized Health Care Menu has been analyzed and is consistent with recognized standards established by the Food and Nutrition Board, Institute of Medicine of the National Academies of Sciences, and the Academy of Nutrition and Dietetics.

d. Frozen dietary meals are a component of outpatient therapeutic diets, but they do not meet all the nutritional needs of patients. Outpatient therapeutic diets that include frozen dietary meals shall be assembled and supplemented under the direction of a Registered Dietitian.
e. Staff shall not open the frozen dietary meals unless necessary to modify the texture or make food substitutions per diet order. The meals shall be provided to the patient in a sealed state except in settings where packaging may pose a security risk such as the segregated housing units.
f. The meals vary in their amounts of key nutrients from day to day. Therefore, the standardized menu includes varying amounts and types of accompanying food items. Dietary staff preparing the therapeutic meals shall ensure that the indicated amount of margarine, bread, and other food items specified on the daily menus are being served with the frozen meal.

2. Kitchen Prepared Therapeutic Diet Meals
   a. Institutions with a therapeutic diet kitchen are exempt from using the frozen dietary meals or CCHCS standardized health care menus.
   b. The Registered Dietitian at these facilities shall develop and prepare therapeutic diet meals based on the diet parameters in Appendices 2-A, B, C, D, and E.
3. Delivery
   a. Outpatient therapeutic diet meal trays or texture modified diet meals shall be fully assembled and identified by diet type in the medical dietary preparation area or in a designated area of the main kitchen and be ready for delivery to patients.
   b. Outpatient therapeutic diet meals or texture modified diet meals shall be delivered to the patients in accordance with established LOPs.
   c. Food service and custody staff assigned to the dining rooms that serve outpatient therapeutic diet meals or texture modified diet meals shall maintain a list of patients who are ordered these diets.
4. The health care Food Administrator I, Food Administrator II, or Registered Dietitian shall ensure culinary staff is trained to prepare and serve the outpatient therapeutic diet meals or texture modified diet meals.

(G) LOP

Each institution CEO is responsible for ensuring that the institution has an approved and current LOP that includes, at a minimum:

1. Contact information for the Registered Dietitian or for the person designated to perform the responsibilities of the Registered Dietitian.
2. Methods for distributing patient diet education handouts, expected reorder levels for handouts, or reproduction procedures.
3. Procedures for referring patients for diet instruction and dietitian consultation.
4. Procedures for obtaining CME or SD approval of nourishments or supplements for patients that do not have one of the listed indications.
5. Procedures for how approved nourishments and supplements are billed to health care services, distributed, and tracked.
6. Procedures for routine delivery of outpatient therapeutic diet meals and texture modified diet meals to patients and delivery during lockdown situations.
7. A tracking method to ensure patients are receiving outpatient therapeutic diet meals and texture modified diet meals at the proper food temperatures.
8. Development and implementation of a local training plan.
9. A process for approval and local sign-off of the LOP.

Appendices

- Appendix 1, Approved Nourishments And Supplements With Indications
- Appendix 2-A, Gluten-Free Diet
- Appendix 2-B, Hepatic Diet (2 gram Sodium)
- Appendix 2-C, Renal Dialysis Diet
- Appendix 2-D, Renal Non-Dialysis Diet
- Appendix 2-E, Bariatric Surgery
- Appendix 3, Institutions Providing Outpatient Therapeutic Diets

References

- California Code of Regulations, Title 15, Division 3, Chapter 1, Article 4, Section 3054(d)
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 51, 54080.3, 54080.5-6, 54080.14
- Nutrition Care Manual, 2019, Academy of Nutrition and Dietetics

Revision History
Effective: 12/2003
Revision: 01/2020

Appendix 1
Approved Nourishments And Supplements With Indications

CONDITION	NOURISHMENT	SUPPLEMENT	FREQUENCY
Pregnancy and lactation	• Two extra 8 oz. cartons of milk a day AND • Two extra fresh fruit servings a day AND • Two extra fresh vegetable servings a day	**Prenatal vitamins If lactose intolerant, provide 600 mg calcium supplement daily.	Order may be written to be valid up to the estimated date of confinement plus 90 days.
Type one diabetes mellitus or brittle diabetes	• Two, 1 oz. pkgs. of either peanut butter & crackers • OR cheese & crackers AND one fresh fruit	None	Order may be written with no stop date.
Malnourishment evidenced by: Significant weight loss (> 10% in prior 6 months) OR BMI <18	None	***Liquid Nutritional Supplement (LNS) • Ensure Original • Jevity 1 CAL • Boost, or • Nutren 1.0. An equivalent liquid product may be substituted.	Order may be written for up to 90 days.
End-stage liver disease with ascites requiring paracentesis or encephalopathy requiring hospitalization	None	***LNS High Calorie • Ensure Plus • Isosource 1.5 • Nutren 1.5 • Boost Plus, or • Jevity 1.5. An equivalent liquid product may be substituted.	Order may be written with no stop date.
Oropharyngeal or dental conditions impeding mastication and/or other conditions resulting in dysphagia*	None	***LNS • Ensure Original • Boost, or • Nutren 1.0. An equivalent liquid product may be substituted.	Order may be written for up to 90 days.
Bariatric Surgery *	• 1 Tablespoon of peanut butter with 6 saltine crackers or 1 slice whole wheat bread OR • 1 oz. sliced cheese with 6 saltine crackers or 1 slice whole wheat bread		Order may be written up to 90 days

* Only if the patient is not meeting nutritional needs as determined by a Registered Dietitian.
** Distributed by nursing.
*** The most cost effective LNS meeting patient needs shall be utilized.
LNS Diabetic- Glytrol, Glucerna 1.0 CAL, Glucerna Shake, Glucerna 1.5 CAL or Boost Glucose Control.
LNS Renal- Novasource Renal or Nepro with Carb Steady.
These products may be used for patients who qualify for a supplement but have diabetes or renal disease.

Appendix 2-A

Gluten-Free Diet

A gluten-free diet is one that eliminates gluten-containing grains from the diet.

INDICATIONS

Patients with celiac disease confirmed by:

1. PCP assessment documenting medically verified signs and symptoms,
2. Positive laboratory serologies specific for celiac disease, and/or
3. Small bowel biopsy result consistent with celiac disease.

SPECIFICATION

- 2,200 – 2,600 Calories, Regular Heart Healthy Diet

All foods containing wheat, rye, barley, or oats are eliminated.

Appendix 2-B

Hepatic Diet (2 gram Sodium)

A hepatic diet (2 gram sodium) is one that controls sodium content while providing adequate protein to maintain positive nitrogen balance for patients with decompensated cirrhosis. These patients should have frequent weights recorded. Calorie count should be monitored. Consider enteral feeding supplementation if oral intake is suboptimal.

The goal of the diet is to:

- Correct malnutrition and prevent metabolic complications.
- Improve quality of life.
- Reduce perioperative complications for those patients who will require liver transplantation.

INDICATIONS

Patients with end stage liver disease complicated by ascites requiring paracentesis and/or a prior history of encephalopathy requiring hospitalization may benefit from dietary modification. A consultation with a Registered Dietitian should be ordered for evaluation of special dietary needs. If recommended by the Registered Dietitian, a Hepatic Diet (2 gram sodium) may be ordered.

SPECIFICATION

- 2,200 – 2,600 Calories.
- Protein: 70 -105 grams (1.0-1.5 grams Protein/kg dry body weight).
- Sodium: 2,000 mg/day.
- Water restriction is not recommended, unless serum sodium is less than 125 mEq/L.
- A daily multivitamin is recommended.
- Calcium supplementation (1,200-1,500 mg/day) indicated for patients with osteopenia and osteoporosis.

Appendix 2-C

Renal Dialysis Diet

A renal dialysis diet controls protein and electrolytes in order to slow the progression of azotemia and electrolyte imbalance between dialysis sessions.

INDICATIONS

All patients receiving dialysis shall be ordered an outpatient therapeutic renal dialysis diet.

SPECIFICATION

- 2,200 – 2,600 Calories (30-35 Calories/kg ideal body weight [IBW])
- 30-35 kcal/kg
- Protein: 84 -105 grams (1.2-1.5 grams Protein/kg IBW)
- Phosphorus: 800-1,000 mg/day
- Sodium: <2400 mg/day
- Potassium: 2,000-3,000 mg/day
- Renal disease specific vitamin (Nephro-vite® or equivalent) is formulary restricted to dialysis patients only (This vitamin product contains vitamin C, folic acid, and B complex vitamins including niacin [B3], pantothenic acid [B5], pyridoxine [B6], riboflavin [B2], thiamine [B1], biotin [aB complex vitamin], cyanocobalamin [B12]).

Appendix 2-D

Renal Non-Dialysis Diet

A renal non-dialysis diet controls protein and electrolytes in order to reduce the demand on the kidneys in patients with renal failure that do not yet require dialysis.

INDICATIONS

Patients with kidney disease and a glomerular filtration rate (GFR) <60, but who do not yet require dialysis, are eligible to receive a renal non-dialysis diet at an approved institution. This diet is the same as the renal diet but it contains less protein and does not usually restrict potassium.

SPECIFICATION

- 2,200 – 2,600 Calories (30-35 kcal/kg ideal body weight [IBW])
- Protein: 42-60 grams (0.6-0.8 gm/kg IBW)
- Phosphorus: 800-1000 mg/day
- Sodium: <2400 mg/day

Appendix 2-E

Bariatric Surgery

Preoperative and Postoperative Diet

A series of diet steps that have been carefully planned for the bariatric patient before and after surgery for weight loss success.

INDICATIONS
Preoperative and postoperative bariatric diets are for the patients who have successfully completed the Medical Weight Monitoring Program (MWMP) and have been approved for bariatric surgery by the CCHCS Statewide Medical Authorization Review Team (SMART).

SPECIFICATION
Preoperative and postoperative dietary regimens are essential to a patient's success. The diets may vary slightly depending on the type of bariatric surgery or the surgeon. The registered dietitian will work with the surgeon to individualize the diet plan. Most individualized plans will include the following:

- Preoperative - typically one to two weeks before surgery
- Postoperative
  - **Stage One—Bariatric Clear Liquid**
    Estimated duration 1 day to 1 week after surgery
  - **Stage Two—Bariatric Full Liquid Pureed**
    Estimated duration 1week to 4 weeks
  - **Stage Three—Bariatric Soft**
    Estimated duration 2 weeks to 6 weeks
  - **Stage Four—Regular Heart Healthy Diet**
    Estimated duration begins at 4 to 8 weeks
- Snack may be needed due to smaller meals being consumed

Appendix 3

Institutions Providing Outpatient Therapeutic Diets

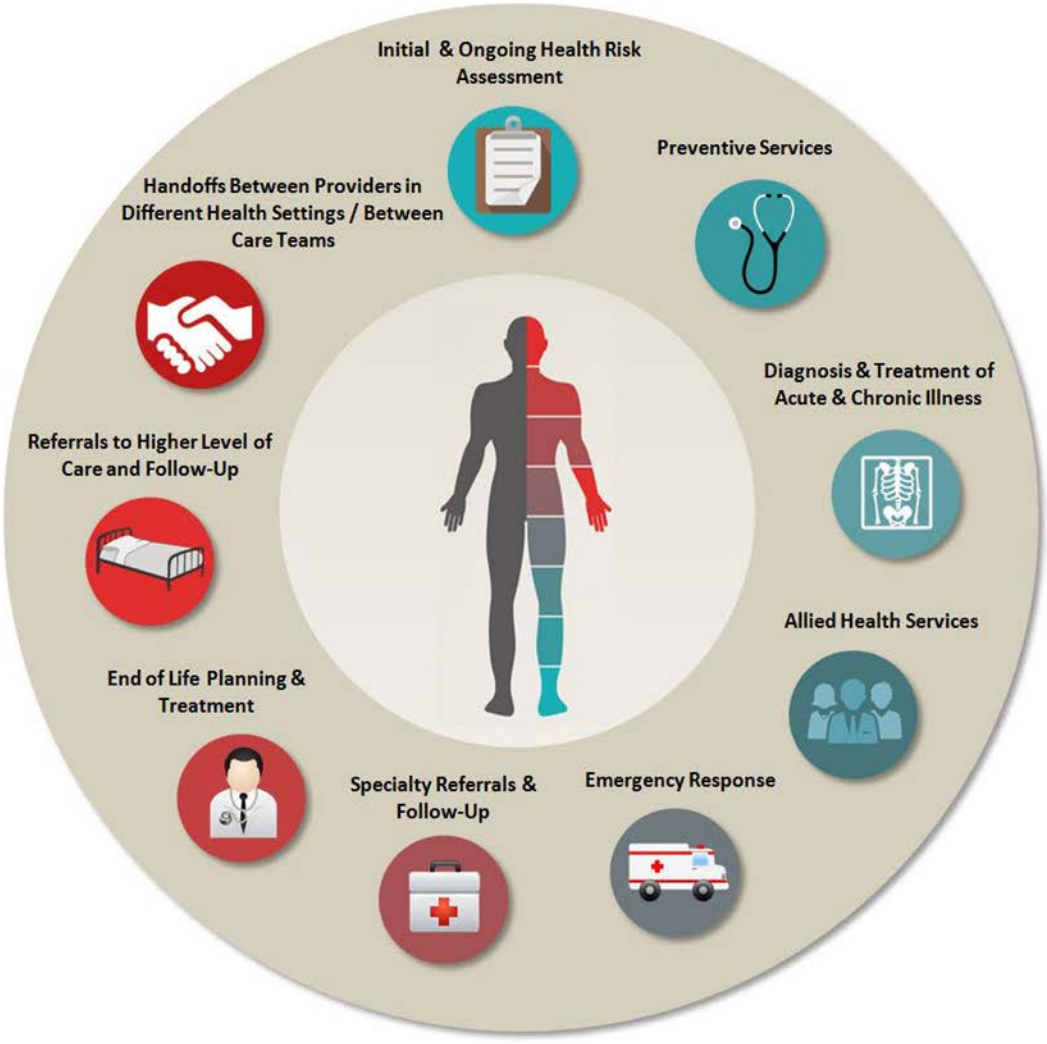
Central California Women's Facility
California Health Care Facility
California State Prison, Centinela
California Institution for Men
California Institution for Women
California Men's Colony (East)
California Medical Facility
California State Prison, Corcoran
California Substance Abuse Treatment Facility and State Prison, Corcoran
High Desert State Prison
Kern Valley State Prison
California State Prison, Los Angeles County
Mule Creek State Prison
North Kern State Prison
Pelican Bay State Prison
Pleasant Valley State Prison
Richard J. Donovan Correctional Facility
California State Prison, Sacramento
California State Prison, Solano
San Quentin State Prison
Salinas Valley State Prison
Wasco State Prison

3.1.2 Scope of Patient Care Services

(a) Procedure Overview

(1) Under the Complete Care Model (CCM), an assigned Primary Care Team (PCT) serves as the center of each patient's Health Home, directly delivering the majority of dental, medical, mental health, and nursing services and coordinating all care that falls outside the team's scope of services (refer to the figure below). Applicable standards for the delivery and coordination of the services outlined in this procedure can be found in existing California Correctional Health Care Services (CCHCS) and Division of Health Care Services policies and procedures. PCTs remain responsible for adhering to these standards under the CCM (refer to Appendix 1, Services and/or Coordinated by the Primary Care Team and Associated Standards in the Health Care Department Operations Manual).

Complete Care Model Patient Care Services



(2) This procedure incorporates existing policies and procedures that describe the scope of primary care services provided and coordinated by the PCTs to fulfill their role as the center of each patient's Health Home by following the CCM. Refer to the Health Care Department Operations Manual and the Mental Health Services Delivery System Program Guide. In addition, the PCTs shall utilize existing decision support tools such as Care Guides, Nursing Protocols, Order Sets, Standing Orders, etc., when providing services.

(b) Responsibility

(1) Statewide

California Department of Corrections and Rehabilitation 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 so that Care Teams can successfully implement the Scope of Patient Care Services Procedure.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of a system to provide management of the Scope of Patient Care Services. The CEO delegates decision-making authority to designated Institutional Health Care Executives for daily operations of the Scope of Patient Care Services Procedure and ensures adequate resources are deployed to support the system.

(B) The CEO and all members of the institution leadership team are responsible for ensuring all necessary resources are in place to support the successful implementation of this procedure at all levels including, but not limited to, the following:

1. Institution level
2. Patient panel level
3. Patient level

(C) The CEO and all members of the institution leadership team shall ensure access to and utilization of equipment, supplies, health information systems, patient registries and summaries, and evidence-based guidelines.

(D) The CEO and all members of the institution leadership team as a part of the Quality Management process on an ongoing basis shall:

1. Review and compare institutions' PCT performance, including the overall quality of services, health outcomes, assignment of consistent and adequate resources, utilization of Dashboards, Master Registries, Patient Summaries, decision support tools and address issues pertaining to delivery of the Scope of Patient Care Services.
2. Provide PCT members with adequate resources, including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
3. Work with custody staff to minimize unnecessary patient movement and ensure appropriate escort and transport.

(E) The Chief Nurse Executive is responsible for the overall daily clinic operations and ensuring that the institution has designated supervisors to monitor clinic operations including, but not limited to:

1. Efficiency.
2. Coordination.
3. Supplies.
4. Equipment.
5. Physical plant issues.
6. Scheduling and access to care on a daily basis.
7. Identifying and addressing or elevating concerns regarding barriers.

(c) Procedure

Services Delivered and/or Coordinated by the Primary Care Team

(1) The PCT is responsible for coordinating care for patients within the assigned panel and pulling in other health care staff as necessary to meet the needs of the patient. The PCT identifies services that are outside of the team's purview, coordinates patients' access to necessary services, and ensures appropriate follow up after services have been provided by other providers in other health care settings.

(2) The PCT provides the full scope of primary care services to patients within an assigned patient panel including, but not limited to:

(A) Care coordination.

(B) Initial and ongoing health risk assessment.

(C) Preventive services, such as health screenings, health promotion, and health maintenance services.

(D) Diagnosis and treatment of acute and chronic illness.
(E) Allied Health Services required for diagnosis and treatment of acute and chronic illness such as diagnostic testing, medication administration, nutritional services, and health care equipment and supplies.
(F) Emergency response.
(G) Planning for end-of-life care such as advance directives, Physicians' Orders for Life-Sustaining Treatment, and palliative care.
(H) Specialty referrals and follow up.
(I) Referrals to higher levels of care and follow up.
(J) Facilitating handoffs between providers in different health care settings or between Care Teams to ensure the best possible care for the patient and continuity of planned care, pending appointments or services, medications, medical equipment and supplies, and all other necessary treatment.

Appendices

- Appendix 1: Services Delivered and/or Coordinated by the Primary Care Team and Associated Standards in the Health Care Department Operations Manual

References

- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.1, Complete Care Model
- Health Care Department Operations Manual, Chapter 3, Article 3, Dental Care
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision
- National Committee for Quality Assurance – Patient-Centered Medical Home Recognition http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- The Joint Commission Primary Care Medical Home Certification http://www.jointcommission.org/accreditation/pchi.aspx
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center http://www.pcmh.ahrq.gov/
- Commonwealth Fund – Safety Net Medical Home Initiative http://www.commonwealthfund.org/interactives-and-data/multimedia/videos/2011/safety-net-medical-home-initiative)
- Robert Wood Johnson Foundation / Improving Chronic Illness Care – The Chronic Care Model http://www.improvingchroniccare.org/index.php?p=About_US&s=6 and Reducing Care Fragmentation http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf)

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Appendix 1
Services Delivered and/or Coordinated by the Primary Care Team and Associated Standards in the Health Care Department Operations Manual

Service Type	Applicable Standards
Initial and Ongoing Health Risk Assessment	• Reception Center (HCDOM Section 3.1.9) • Health Care Transfer (HCDOM Section 3.1.10) • Comprehensive Accommodation (HCDOM Section 3.6.2) • Medical Classification System (HCDOM Section 1.2.14) • Care Team and Patient Panels (HCDOM Section 3.1.3) • Scheduling and Access to Care (HCDOM Section 3.1.6) • Population and Care Management Services (HCDOM Section 3.1.7)
Preventive Services	• Public Health and Infection Control (HCDOM Chapter 3, Article 8) • Patient Health Care Education (HCDOM Section 3.1.4) • Patient Care During Pregnancy and Childbirth (HCDOM Section 3.1.17) • Dental Services (HCDOM Chapter 3, Article 3)
Diagnosis and Treatment of Acute and Chronic Illness	• Scheduling and Access to Care (HCDOM Section 3.1.6) • Medication Management (HCDOM Chapter 3, Article 2) • Clinical Guidelines (HCDOM Section 1.2.2) • Gender Dysphoria Management (HCDOM Section 4.1.7) • Hepatitis C Management • Nursing Services/Protocols • Dental Services (HCDOM Chapter 3, Article 3)
Allied Health Services	• Laboratory Services (HCDOM Section 3.1.15) • Medical Imaging Services (HCDOM Section 3.1.14) • Outpatient Dietary Intervention (HCDOM Section 3.1.12) • Durable Medical Equipment and Medical Supply (HCDOM Section 3.6.1) • Pharmacy Services (HCDOM Chapter 3, Article 5)
Emergency Response	• Emergency Medical Response (HCDOM Chapter 3, Article 7)
Specialty Referral and Follow-Up	• Outpatient Specialty Services (HCDOM Section 3.1.12) • Utilization Management Program (HCDOM Section 1.2.15) • Physician Orders for Life Sustaining Treatment (HCDOM Section 2.4.2)
End-of-Life Planning and Treatment	• Palliative Care and Treatment (HCDOM Section 3.1.18) • Advance Directive for Health Care (HCDOM Section 2.4.1) • Physician Orders for Life Sustaining Treatment (HCDOM Section 2.4.2)
Referrals to Higher Levels of Care and Follow-Up	• Health Care Transfer (HCDOM Section 3.1.10) • Specialized Health Care Housing (HCDOM Section 3.1.11)
Handoffs Between Providers in Different Health Settings/Between Care Teams	• Health Care Transfer (HCDOM Section 3.1.10)

This list is not a complete listing of all associated policies and procedures.

3.1.3 Care Teams and Patient Panels

(a) Procedure Overview

(1) The Complete Care Model Policy maintains a Patient-Centered Health Home for each patient consisting of an interdisciplinary Care Team responsible for delivering comprehensive care for patients in accordance with their health care needs, directly providing the majority of clinical care services, and coordinating care when patients require services beyond what the Care Team provides.

(2) This procedure defines interdisciplinary Care Teams, identifying the team members and outlining their roles and responsibilities. In addition, this procedure outlines the process for assigning each patient to a Care Team, presents the expectations for notification to patients and panel management, and introduces daily and twice-monthly forums that Care Teams shall use to monitor and manage both clinic operations and changes in the patient panel.

(b) Responsibility

(1) Statewide

California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) 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.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has the 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:

1. Ensuring access to and utilization of equipment, supplies, health information systems, patient registries, patient summaries, and evidence-based guidelines.
2. Assigning patients to a Care Team.
3. 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.
4. Ensuring consistent Care Team staffing with a back-up system for core members.
5. Providing Care Team members with the information they need during huddles (e.g., Huddle Report).
6. Ensuring protected time for Care Teams to hold daily huddles.
7. Documenting and tracking huddle actions and attendance.
8. Ensuring that at least twice-monthly, each Care Team conducts a Population Management Working Session utilizing tools such as dashboards, patient registries, patient summaries, and Electronic Health Record System (EHRS) tools to address concerns related to potential gaps in care and improve patient outcomes.
9. Adequately preparing new Care Team members to assume team roles and responsibilities.
10. Assessing competence of existing Care Team members.
11. Updating procedures, roles and responsibilities as new tools and technology become available.
12. Reviewing/comparing institution Care Team performance, including the overall quality of services, health outcomes, assignment of consistent and adequate resources, utilization of dashboards, patient registries, patient summaries, and other decision support tools and address issues as necessary.
13. Providing Care Team members with adequate resources, including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
14. Working with custody staff to minimize unnecessary patient movement that results in changes to a patient's panel assignment.
15. 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.
16. Requiring institution leadership to establish a back-up system to ensure scheduling queues are managed when Scheduling Support staff are on leave or otherwise unable to meet daily monitoring requirements.

(B) The CEO, or designee, and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork across disciplines.

(C) The CNE, or designee, is responsible for:

1. The overall daily operations of the scheduling system for health care within the EHRS.
2. The coordination of health care between health care scheduling systems (e.g., outside specialty appointments).
3. Oversight and management of the scheduling processes and resources, including personnel.
4. Ensuring that the institution has a designated scheduling lead to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
5. Ensuring that Scheduling Support staff is available for all clinical areas.

(D) The Chief Medical Executive (CME), or designee, is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(E) The Supervising Registered Nurse and Chief Physician and Surgeon or CME, or designees, shall meet as needed to review the Care Team's performance, including the overall quality of services, health outcomes, level of care utilization and shall utilize dashboards, patient registries, patient summaries, and all electronic decision support tools to address or elevate issues as necessary.

(c) Procedure

(1) Patient Panels

(A) Institution leaders shall adopt methods to promote a consistent, ongoing relationship between patients and their Care Teams to achieve operational efficiency; ensure timely access to care; optimize movement and escort capabilities; balance workload; address patient acuity and complexity to support patients in the management and organization of their care.

(B) Each patient shall be assigned to a Care Team and be notified of the Care Team assignment.

(C) Assignment to a Care Team may be organized in a variety of ways, as dictated by the needs of patients and the institution including, but not limited to, assignment by the following:

1. Housing unit.
2. Alphabetical roster.
3. Last two digits of CDCR number.
4. Custodial factors.
5. Mental health program assignment.
6. Medical factors and other special patient needs.

(D) All Care Teams shall have access to the master registry.

1. Institutions shall communicate any change in their strategy for panel assignment to headquarters to preserve the accuracy and reliability of the master registry.
2. The Care Team is responsible for tracking the status of the assigned patient panel and shall monitor the master registry and Huddle Report daily, identifying changes to the assigned patient panel and communicating changes to team members using the daily huddle or other appropriate forums.

(2) Care Team Members

(A) Care Team Composition

1. At a minimum, each Care Team shall consist of the following core members:
   a. Primary Care Providers (PCPs).
   b. Primary Care – Registered Nurse (RN).
   c. Provider support staff (e.g., Certified Nursing Assistants, Medical Assistants, or Licensed Vocational Nurses [LVN]).
   d. Medication Administration Nurse (LVN/Psychiatric Technician).
   e. Care Manager – RN
   f. LVN Care Coordinator.
   g. Administrative support staff.
   h. Other members, as needed.
2. Other team members may be added to the Care Team on a per-patient basis. For example, the Care Team would include a dentist and other dental staff when planning, delivering, and coordinating services for a patient with complex dental needs. The range of possible Care Team members includes, but is not limited

to, custody staff, pharmacy staff, dietitians, specialists, specialty nursing staff, laboratory or imaging staff, and therapists (e.g., occupational, recreational, respiratory, and other types of therapists).

3. Depending on the mission of the institution and the needs of the patient panel, members may be added to the Care Team as core members. For example, if there is a high proportion of patients with serious mental illnesses in a patient panel, a Primary Mental Health Clinician and/or Primary Psychiatrist may serve as members of the Care Team.

(B) Continuity in Team Membership

1. Institutions shall avoid unnecessary changes in the membership of the Care Team to reduce disruptions in care. Individual changes in Care Team membership do not require formal notice to patients.
2. The institutions' CME, or designee, shall ensure the Care Team has assigned and available Care Team members at all times with minimal disruptions to continuity.
3. The institution CEO, CME, and CNE, or designees, shall ensure each core member of the Care Team:
   a. Is assigned and available.
   b. Has a consistent back-up staff member.
   c. Has a coordinated schedule to optimize continuity.
   d. Has scheduled hours of work in alignment with clinic operational needs.
   e. Has scheduled work hours and hours of clinic operation in alignment for the entire Care Team.
4. Contingency plans shall be in place to optimize continuity in the event of scheduled absences and, whenever possible, in the event of unscheduled absences. Back-up designations shall be included in the Care Team.

(C) In recognition that communication and collaboration between Care Team members is greatly facilitated by being present in the same clinic space at the same time, institution leaders shall:

1. Review the schedules and work locations of Care Team members, at least annually, and take action to optimize the number of hours that core members work in the clinic together and have access to patients.
2. Ensure that Care Team members are located in close proximity to each other when they are providing services to patients, wherever possible.

(3) Roles and Responsibilities of the Care Team

(A) The entire Care Team shall be accountable for the outcomes of patients in the assigned patient panel, and each Care Team member shall be responsible to ensure efficiency and effectiveness of the Care Team (Refer to Appendix 1, Care Team Roles and Responsibilities).

(B) All Care Team members shall be required to:

1. Establish and maintain professional, effective, and therapeutic relationships with patients.
2. Create a climate of mutual respect in which individual Care Team members feel comfortable sharing their concerns about unsafe, ineffective, or inefficient processes, systems, or operations, including the inappropriate management of individual patients.
3. Promote clear and frequent communication between Care Team members.
4. Participate fully in the Care Team's collective efforts to manage the patient panel, including identifying necessary patient care activities and allocating work among Care Team members.
5. Maintain an up-to-date knowledge of trends, best practices, and guidelines in clinical practice and operations as relevant to each Care Team member's respective licensure.
6. Evaluate the quality of clinic processes and services in the course of day-to-day work and collaborate with other Care Team members to investigate and resolve quality problems.
7. Promote a safe, effective, efficient, and collaborative work environment.

(C) Documentation of patient care and the patients' response to care is essential for effective communication between health care providers and providing quality health care. To ensure accurate recording of patient care activities and to ensure the transfer of information between the members of the interdisciplinary care team, health care staff shall:

1. Document all patient contacts, interventions, observations, care and treatments provided and the results of the care and treatment in the health record at the time of service.
2. Record documentation using the Subjective, Objective, Assessment, Plan, Education format or use other forms of documentation such as narrative charting, charting by exception, focused assessment, etc., as indicated by the clinical situation. However, all documentation shall contain subjective and objective patient care data at a minimum regardless of format.

3. Ensure that all documentation complies with the documentation standards contained in the Health Care Department Operations Manual, Chapter 2, Article 3, Health Information Management.

(4) Daily Care Team Huddle

(A) The Care Team shall convene each business day in a Care Team Huddle to:

1. Monitor changes to the patient panel, such as transfers to and from the panel, and take action to continue and/or coordinate care for these patients.
2. Discuss recent health care events, problems and trends that impact patients within the assigned patient panel, identify services that may need to be provided to patients, and determine how and when services will be provided including, but not limited to the following:
   a. Unscheduled Triage and Treatment Area visits.
   b. Medical holds.
   c. Transfers to and from higher levels of care.
   d. Pending consultations and specialty services requests.
   e. New patients assigned to the Care Team. Once seen in the clinic, the RN or PCP shall order a follow up based on their chronic care conditions.
   f. Abnormal laboratory findings.
   g. High risk patient/care management issues.
   h. Mental health issues (e.g., self-injurious behavior, suicidal/homicidal ideation, coordination of testing procedures).
   i. Medication line issues, including specialty medications that require coordination with offsite (e.g., chemotherapy, Narcotic Treatment Program methadone).
   j. Polypharmacy.
3. Manage day-to-day clinic operations, including preparation for that day's encounters, conferring with custody, addressing security or construction impacts to clinic processes, and planning coverage of clinic services while staff are on leave.
4. Discuss daily clinical operational problems, such as the following:
   a. Episodic care triage.
   b. Same day and next day relevant health information availability (e.g., diagnostic study reports, consultation notes, and discharge summaries) and add-on appointments.
   c. Review and resolution of scheduling concerns.
   d. Potential barriers to care, including lockdowns, restricted movement, fog lines, backlogs, and other considerations.
   e. Staffing issues, such as upcoming vacation, mandatory training, or other events affecting availability of staff.
   f. Supply/resource issues.
   g. Review and discussion of the Care Team's performance with respect to targeted disease management and preventive service metrics.
   h. Ongoing evaluation and improvement.

(B) Institutional leadership shall establish a standard start time for Care Team Huddles to ensure that Care Team members have protected times for huddles and that huddles begin on time.

(C) Huddle Preparation

Institutional leadership shall work with Care Team members to:

1. Incorporate the use of the Patient Summary.
2. Use a standard Daily Huddle Script and Daily Huddle Report that prompts Care Team members to address topics mandated in this procedure (Refer to the Daily Huddle Script and Daily Huddle Report).
3. Determine who shall be responsible to have the Huddle Report at each daily huddle, and what other information shall be provided to the Care Team in advance of the huddle.

(D) Huddle Documentation

1. Care Teams shall document patients and issues discussed during the Primary Care Huddle and actions taken as a result, monitoring to ensure that necessary follow up has occurred.
2. Each Care Team shall be responsible for monitoring the Daily Huddle Script, and Training Participation Sign-in Sheet.

(5) Monitoring and Sustainability

(A) Institutional leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the Complete Care Model monitoring activities. The Care Team shall:
1. Take corrective action to resolve and/or elevate concerns identified in the review.
2. Review and action shall be documented and forwarded to the designated committee.

(B) The CEO and institutional leadership team shall establish an ongoing monitoring program to periodically assess the quality of Care Team services and adherence to this procedure including, but not limited to:
1. Accuracy and efficacy of panel assignment strategies.
2. Stability of Care Team staffing and use of back-up systems.
3. The amount of time each day that all Care Team members are working in the clinic together and any associated physical plant issues.
4. Inclusion of other team members/disciplines to manage patient care.
5. Care Team Huddle attendance.
6. Frequency, quality, and timeliness of daily Primary Care Huddles.
7. Documentation of Primary Care Huddle activities and necessary follow up.
8. Frequency and quality of Population Management Working Sessions.
9. Adverse events or barriers linked to Care Team processes described in this procedure.

(C) The CEO and institutional leadership team shall utilize or implement a monitoring process to assess the Care Team members and staff supporting Care Team processes. The monitoring process shall include, but is not limited to, feedback about skills required to successfully provide or support primary care services such as:
1. Clinical skills (e.g., history-taking, physical examinations, assessment, and treatment planning).
2. Adherence to policy guidelines, protocols, and decision support tools.
3. Recognition of patient care needs that fall outside the scope of what is provided by the Care Team and appropriate and timely referral.
4. Management of handoffs as patients move from one Care Team to another or across levels of care.
5. Care management of patients who are high risk or otherwise clinically complex.
6. Population and panel management, including provision of preventive services and managing subpopulations with specific chronic diseases.
7. Self-management planning and patient education.
8. Effective communication.
9. Optimizing access to care through use of co-consultation, appointment bundling, same-day appointments, and other strategies.
10. Redesigning clinic processes to increase efficiency and use team members to the full extent of their licensure.
11. Identification, analysis, and resolution of quality problems, including use of data to evaluate performance and investigate problems.
12. Application of available patient management tools, including patient registries and EHRS.
13. Overall contribution to the Care Team and a culture that promotes teamwork.

(6) Training and Decision Support

The CEO and institutional leadership team shall establish an orientation and training program to ensure that all staff serving as members of a Care Team or supporting Care Team functions fully understand their roles and responsibilities prior to assuming their duties. Elements of the program shall include, but are not limited to review of:

(A) Expectations in this procedure.
(B) Any changes to local Care Team processes.
(C) National health care industry advances pertinent to the Patient-Centered Health Home.
(D) New information systems or technology that may increase the efficiency or effectiveness of Care Team processes or forums.
(E) Updates in clinical practice, including new CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
(F) Training needs.

Appendices

- Appendix 1: Care Team Roles and Responsibilities

References

- Health Care Department Operations Manual, Chapter 2, Article 3, Health Information Management
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- 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
- Agency for Healthcare Research and Quality – Patient Centered Medical Home Resource Center, http://www.ahrq.gov/
- Commonwealth Fund – Safety Net Medical Home Initiative, http://www.commonwealthfund.org/interactives-and-data/multimedia/videos/2011/safety-net-medical-home-initiative
- Robert Wood Johnson Foundation / Improving Chronic Illness Care – The Chronic Care Model, http://www.improvingchroniccare.org/index.php?p=About_US&s=6, and Reducing Care Fragmentation, http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

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Appendix 1
Care Team Roles and Responsibilities

Care Team	Roles and Responsibilities
Primary Care Provider	a. Attend and actively participate in the daily huddle. b. Diagnose and manage the patients' episodic illnesses, chronic conditions, preventive care, and their complex needs. c. Order and coordinate patient care services including, but not limited to, specialty and higher level of care. d. Support Transitional Services Team (Resource Registered Nurse [RN]) in transition planning for complex medical conditions.
Mental Health Clinician and/or Psychiatrist	a. When indicated, attend and actively participate in Primary Care Huddles to provide mental health input into patient behaviors, compliance, and treatment options as they relate to the patient's mental health condition. b. Coordinate mental health care, as needed. c. Provide relevant mental health history. d. Support Transitional Services Team (Resource RN) in transition planning for complex mental health conditions.
Dentist	a. When indicated, attend and actively participate in Primary Care Huddles to provide input concerning dental treatment needs. b. Coordinate patient care services including, but not limited to, oral surgery services, lab tests, diagnostic imaging and diagnostic procedures. c. Consult with other care team members on the patient's episodic illnesses, chronic conditions, preventive care needs, and mental health conditions. d. Provide input on dental infections/conditions, refusals of dental care and planned dental care that may affect other aspects of the patient's overall health care needs.
Primary Care Provider Support Staff	e. Attend and actively participate in the daily huddle. f. Prepare patients for visits (e.g., vital signs, weights, gathering specialty reports and diagnostic results, other health information preparation). g. Conduct/perform Point-of-Care testing and administration of treatments in accordance with licensure/certification. h. Assist with tracking and access to Durable Medical Equipment.
Primary Care RN	a. Attend and actively participate in the daily huddle. b. Manage the patient's episodic illnesses, chronic conditions, preventive care needs, and their complex care management using established protocols and other decision support. c. Advocate for the patient. d. Coordinate the patient care services for the designated patient panel.

Care Team	Roles and Responsibilities
	e. Manage medication for patients assigned to the team. f. Provide patient education. g. Conduct/perform Point-of-Care testing. h. Participate in discharge planning.
Licensed Vocational Nurse Care Coordinator	a. Attend and actively participate in the daily huddle. b. Advocate for the patient. c. Monitor designated patient panel registries and report any changes to the team members. d. Coordinate the patient care services for the designated patient panel. e. Manage medication for patients assigned to the team. f. Provide patient education. g. Conduct/perform Point-of-Care testing. h. Participate in discharge planning.
Supervising Registered Nurse (SRN) II	a. Attend and actively participate in the daily huddle as indicated. b. Oversight of key clinical processes including, but not limited to, scheduling and medication management, and management of refused orders inbox. c. Audit compliance for a variety of nursing measures including, but not limited to, quality of care. d. Identify opportunities for improvement. e. Communicate staffing needs. f. Coordinate with custody to mitigate barriers affecting access to health care. g. Facilitate conflict resolution. h. Provide clinical support as indicated.
Primary Care Team Office Technician	a. Attend and actively participate in the daily huddle. b. Ensure all patients are appropriately scheduled. c. Ensure access to care barriers are made known to the full Care Team. d. Retain records from daily huddles. e. Prepare information for daily huddles. f. Maintain attendance records for daily huddles. g. Schedule patients in the scheduling system in accordance with policy timeframes. h. Ensure Care Team workload is balanced for scheduled patients. i. Maintain a current and accurate schedule for the clinic. j. Support improvements in the design of the clinic schedule to optimize efficiency and access to care, such as open access scheduling, or consolidation of multiple appointments for the same patient into a single encounter.
Transitional Services Team (Resource RN)	a. When indicated, attend the Daily Huddle to provide pertinent information to Care Team members regarding transitional planning for qualifying complex patients, and communicate any needed

Care Team	Roles and Responsibilities
	support from Primary Care Team (PCT) members. b. Assessing identified patients with complex care needs across all health care domains, and liaise with other internal and external stakeholders to ensure care needs are addressed prior to release to the community, and when possible, prior to entry into the prison system. c. Support the PCT when transition planning to the community involves specialty health care and rehabilitative services. d. Coordinate with community health care and rehabilitative agencies to ensure continuity of care for qualifying complex patients. e. Coordinate care with prisons and jails for patients departing on a temporary basis, such as transfers related to court appearances, higher levels of care for medical, mental health, or dental reasons. f. Communicate identified needs with parole offices and probation offices and arranging specialize care services with community health care providers, when and where appropriate.
Medication Administration Nurse	a. Attend and actively participate in the daily huddle when possible. b. Ensure timely delivery of prescribed medications to patients on the panel. c. Alert the Care Team of adherence issues and adverse medication events. d. Alert pharmacy or the SRN II when prescribed medications are unavailable. e. Report medication errors. f. Alert the SRN II to medication administration access issues. g. Reconcile medication orders in the Electronic Health Record System. h. Perform routine vitals that are associated with medications. i. Conduct/perform Point-of-Care testing as associated with medication delivery.

3.1.4 Patient Education

(a) Policy

(1) California Correctional Health Care Services (CCHCS) staff shall provide clinical and health education to patients regarding disease prevention, recommended treatment modalities, and available health care resources at all stages of their confinement within any California Department of Corrections and Rehabilitation (CDCR) facility. Patient education shall be a continuous and ongoing process designed to educate and inform the patient beginning with the patient's arrival at a Reception Center and continuing throughout incarceration.

(2) The CCHCS/CDCR Patient Education Program supports the Complete Care Model by recognizing that the patient is an active partner in their own health care. The patient, their Primary Care Team, and other health care providers determine the most appropriate health care goals, interventions, and outcomes based on the patient's health care needs and personal objectives with the understanding that an informed patient delivers an improved patient outcome and reduces overall morbidity and mortality.

(3) Patient education within CCHCS consists of two main components which are Clinical Patient Education and Health Education. Clinical Patient Education is a planned, systemic, and sequential program of teaching provided to patients in a clinical environment based on the patient's assessment, evaluation, diagnosis, prognosis, individual needs, and care requirements pursuant to the patients' health status and desired outcomes. Health Education is provided to all patients to promote general health and wellness, disease prevention, and is designed to change and improve health behaviors within the patient population.

(b) Purpose

To provide education that promotes wellness and empowers patients to actively participate in their disease management and prevention.

(c) Responsibilities

(1) Statewide

(A) 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 so that health care staff can successfully implement and maintain the Patient Education Program.

(B) The Undersecretary, Health Care Services, CDCR, and the Directors of CCHCS are responsible for statewide planning, implementation, and evaluation of the Patient Education Program.

(C) The Undersecretary, Health Care Services, CDCR, and the Directors of CCHCS shall designate a statewide committee with responsibility for the oversight of all aspects of the Patient Education Program within CCHCS/CDCR. The designated committee shall be multidisciplinary and consist of, at a minimum, the following members, or their designees, the Deputy Directors of Medical, Nursing, Mental Health and Dental Services, Pharmacy, Ancillary and Allied Health Services, and the Regional Health Care Executives (RHCEs). The committee shall be responsible for ensuring appropriate, standardized patient education material is developed and available for patients statewide and at all levels of care.

(2) Regional

RHCEs are responsible for implementation of this policy and procedure at the subset of institutions within an assigned region.

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of a system to provide management of Patient Education Programs in their institution. The CEO delegates decision making authority to designated health care executives for daily operations of the Patient Education Program and ensures adequate resources are deployed to support the program.

(B) The CEO and all members of the institution leadership team are responsible for ensuring resources are in place to support the successful implementation of this procedure at all levels, which include access to and utilization of equipment, supplies, health information systems, patient registries and summaries, and evidence-based guidelines.

(C) Institution-specific local operating procedures shall be developed and implemented based upon the tools provided by statewide health care leadership.

(D) Each institution shall designate a subcommittee in writing that has responsibility for the oversight and coordination of all Patient Education Programs within the institution. The designated subcommittee shall report to the institution's Quality Management Committee. At a minimum, the designated subcommittee shall ensure that patient education (clinical and peer mentoring) is provided based on the identified needs of their patient population by:
1. Identifying high-risk groups within their patient population.
2. Facilitating health care events within CDCR and/or the Local Community (e.g., Substance Abuse Prevention, Influenza Campaigns, Heat Injury Prevention).
3. Reviewing clinical and health education needs identified during discussions with Patient Representative Groups (i.e., Men's Advisory Council [MAC], Women's Advisory Council [WAC], and Inmate Family Council [IFC]).
4. Identifying needs based on reviews of patient grievances.
5. Identifying needs based on internal and external audits and reviews (e.g., Patient Safety, Medication Administration Process Improvement Program, Office of Internal Affairs, or Prison Law Office visits).
6. Holding discussions with CDCR partners (i.e., custody, Inmate Education Services and Vocational/Prison Industry Authority [PIA] Training and Services).

(E) Each institution shall ensure that clinical education, health education, and Patient Education Programs are:
1. Coordinated.
2. Mutually supportive and meet the needs of the patient population as a whole.
3. Address the needs of identified high-risk patient populations as well as the health care needs and goals self-identified by the patient population.

(d) Procedure Overview

(1) This procedure provides guidelines for the development, utilization, provision, and documentation of health care education to CDCR/CCHCS patients. The purpose of the Patient Education Program is to promote wellness and empower patients to actively participate in disease prevention and management. This program aims to reduce morbidity/mortality and overall health care costs.

(2) Patient education shall be provided to each patient within CDCR on a continuous and ongoing basis using processes designed to educate and inform the patient beginning with arrival at a Reception Center (RC) and continuing throughout incarceration. The CCHCS/CDCR Patient Education Program consists of two main components which are Clinical Patient Education and Health Education, both of which are an integral part and support of the Complete Care Model.

(3) CCHCS/CDCR Patient Education Program shall support the goals of the Public Safety and Rehabilitation Act of 2016 (Proposition 57) through clinical and peer mentor programs designed to encourage and enable patients to understand and take responsibility for their health care needs and decisions, gain insight, and actively and fully participate in rehabilitative programs in preparation for their reintegration into the community once they complete their incarceration and transition to supervision.

(e) Procedure

(1) General Requirements

(A) The Patient Orientation to Health Care Services Handbook shall be available in each institution law library and shall be provided to each patient within 14 business days upon arrival and upon patient request by the Receiving & Release (R&R) or Primary Care Nurses at any CDCR institution.

(B) Each Standardized Nurse Protocol/Procedure and Care Guide shall include a patient education component, including printed material that shall be provided to the patient.

(C) All patient education material shall be provided in a manner that can be used by the patient population to which it will be distributed.
1. The Statewide Patient Education Committee shall ensure printed materials are developed in both English and Spanish to the greatest extent possible. Languages other than English or Spanish shall have patient education material translated into the identified language.
2. To the extent possible, printed materials shall also be provided in formats, or by methods, accessible by patients with visual impairments in accordance with the Health Care Department Operations Manual (HCDOM), Section 2.1.2, Chapter 28, Effective Communication (EC). Institutions where the identified

visually impaired population (DPV) exceeds 10% shall coordinate with the headquarters Patient Education Committee to have selected patient education material published in a large print version.

(2) Reception Centers

Patient education shall begin with the patient's arrival into CDCR custody at the RC. The RC R&R nursing staff shall:

(A) Identify barriers to learning and ensure accommodations are documented in the health record. Examples include, but are not limited to:
1. Language.
2. Learning difficulties as documented in the patient's transfer records or reported by the patient such as necessary EC accommodations (visual, hearing, speech).

(B) Accommodations shall be provided based on the patient's reported needs until formal testing can be performed (i.e., Hearing Testing or Test for Adult Basic Education testing, or Developmental Disabilities Program [DDP] screening).

(3) Clinical Education Programs – Verbal and Written Patient Education

(A) As described in (e)(1) above, CDCR/CCHCS shall develop and/or provide written material designed to support patient education, develop health literacy, improve the overall quality of life and health care outcomes, and reduce morbidity and mortality.

(B) Individual face-to-face patient education
1. The most significant and effective method of patient education is direct verbal contact with a health care provider. Within CCHCS/CDCR, most patient education is performed during face-to-face clinical encounters. CCHCS/CDCR staff shall utilize every patient visit as an opportunity for therapeutic intervention and education.
2. CCHCS/CDCR staff who provide patient education shall document in the health record the education provided, the patient's understanding of the information provided, and EC accommodations used (if needed).

(4) Clinical Education Program – Institutional General Requirements

(A) Each institution shall develop a Patient Education Program tailored to the identified needs of their institution. At a minimum, the program shall include the following elements:
1. R&R patient education (i.e., Patient Orientation to Health Care Services Handbook, Sick Call Process for the institution, the conduct of pill lines, access to health care processes, etc.)
2. Patient education during clinical contacts as needed
3. Nursing-led Therapeutic Groups (NL-TGs)
4. Orientation to available self-management and substance abuse programs
5. Peer Mentor Program
6. Woman's Health Program (Central California Women's Facility, California Institution for Women, and Folsom State Prison-Women's Facility)

(B) The patient education process shall begin upon arrival at the institution. The R&R nurse shall ensure that each patient requiring accommodation has access to the Durable Medical Equipment necessary for effective learning and communication (e.g., glasses, hearing aids, and batteries).

(C) Patient education shall be a component of each health care visit. Documentation in the health record may include the following, as applicable:
1. Patient education provided
2. Printed material provided
3. Patient's understanding of the education provided
4. EC process used (if applicable)
5. Topics include, but are not limited to:
   a. Wellness & Prevention
   b. Newly Diagnosed Disease (Episodic or Chronic)
   c. Treatment Plan
   d. Patient Goals
   e. Medications and Treatments (Therapies)
   f. Procedures, Diagnostic Tests, and Preventative Screening

g. Compliance/Adherence
h. Men's/Women's Health to include disease prevention and family planning

(D) During Primary Care Team Huddles, Population Management Working Sessions, and/or mental health (MH) Interdisciplinary Treatment Team (IDTT), health care staff shall identify therapeutic groups which would be beneficial to include in a patient's treatment plan or plan of care. This may include NL-TGs, mental health groups, self-management, etc. Any discussions and recommendations shall be documented in the health record.

(E) Patient education for patients participating in the Mental Health Services Delivery System (MHSDS) shall receive patient education as described in the MHSDS Program Guide.

1. Patient education provided under this section shall supplement the clinical patient education provided under this procedure and be designed to meet the patient's unique mental health needs as identified in their MH Interdisciplinary Treatment Plan.
2. The patient's MH treatment team shall coordinate with the patient's primary care team to meet the full range of clinical education needs through the development of adaptations to the educational process necessitated by clinical and mental health diagnosis (e.g., adapting IDTT plan based on visual problems, or Chronic Care Plan based on MH diagnosis, [i.e., schizophrenia or DDP status]).

(F) Dental patients shall receive patient education as described in the HCDOM, Chapter 3, Article 3, Dental Care. Dental staff shall coordinate with the patient's primary care and MH Health Treatment Teams (as applicable) to coordinate education activities and necessary adaptations to the standard dental education program and/or materials.

(G) Where indicated, health care staff shall coordinate with other institutional staff to coordinate Patient Education Programs based on identified needs for rehabilitation and success such as:

1. Division of Rehabilitative Program staff for educational, vocational, and Cognitive Behavioral Therapy programs.
2. PIA to develop works skills.
3. Community Transition Program staff to coordinate pre-release activities and possible parole needs, etc.

(5) Clinical Education Programs – Nursing-led Therapeutic Groups

(A) Each patient shall be provided the opportunity to participate in nursing-led group activities that provide education on disease processes, positive health behaviors and health improvement, therapeutic interventions (clinical and self-directed), and are designed to improve the patients overall quality of life and health status.

(B) Content development

1. An approved set of NL-TGs shall be developed to meet identified patient needs on a statewide basis.
2. Content and curricula shall be developed and standardized statewide. A multidisciplinary team shall develop NL-TGs under the direction of a Headquarters Chief Nurse Executive (HQ CNE).
3. Each NL-TG shall meet established guidelines and quality metrics as determined by the Statewide Patient Education Committee.
4. The HQ CNE shall designate a Nurse Consultant Program Review (NCPR) to lead the NL-TG development process. The NCPR shall collaborate with other disciplines to ensure content is accurate, relevant, and evidence-based.
5. NL-TGs will be written in a manner to qualify for Milestone, Rehabilitative Achievement, or other inmate participation credits as delineated in California Proposition 57.
6. NL-TGs shall be separated into broad categories. Each category may have multiple individual lesson plans which support the overall category patient education goal. A list of approved NL-TGs shall be maintained under the direction of the designated HQ CNE.

(C) NL-TG Scheduling

1. The institution CNE shall coordinate with the Community Resource Manager as outlined in the established workflow and collaborate with medical, mental health, dental, and custody staff to create a Master Schedule of Groups offered within the institution.
2. The institution CNE is responsible for approving and signing the Nursing Master Schedule and ensuring that it is included in the designated subcommittee's discussion and minutes.
3. The institution CNE shall build upon the Nursing Group schedule utilizing the needs of the patient population being served to ensure the quality and variety of the NL-TGs as well as their relevance to the patient population.

4. NL-TGs may be scheduled and offered seven days per week on both second and third watch (See Appendix 1).
5. Groups shall be considered for all patients including those in the general population, patients with physical disabilities, cognitive impairments or substance use disorders, and all participants in the DDP and/or MHSDS.
   a. Individual patient factors to be considered may include:
      1) Patient classification and/or housing
      2) Groups available on the master schedule
      3) Times groups are scheduled
      4) Any current behavior issues or concerns, any precipitating event
      5) Perceived knowledge deficit
   b. Institutional factors to be considered may include:
      1) Whether classifications of patients (i.e., DDP and Enhanced Outpatient Program patients) are permitted to mix for therapeutic purposes
      2) Physical plant limitations – available space
      3) Custody support

(D) Based on the category, the Primary Care Registered Nurse (PCRN) or Mental Health Registered Nurse (MHRN) shall determine specific groups to be provided from those that are made available in the statewide nursing education library available on Lifeline. When possible, suggestions for classes shall be discussed with the patient before scheduling. This discussion shall be documented in the health record.

(E) The PCRN or MHRN shall place an order in the health record for each category of the group.

(F) The patient shall be scheduled for a group encounter via the Health Care Priority Ducat Scheduling System by category and specific group content desired.

(G) At the conclusion of each therapeutic group session, the nurse facilitator shall document participation, attainment of goals, and other pertinent information in each attendee's health record. Attendance shall also be documented in the patient scheduling system.

(6) Health Care Education – Peer Education Programs

(A) Peer Health Care Education (PHE) is an effective means of providing health care education in a manner that is relevant and relatable for the individual patient. Each institution shall develop a Patient Education Program designed to improve overall health literacy based on the needs identified by their patient population.

(B) PHE shall be developed collaboratively with input from each health care discipline and institutional stakeholders (e.g., custody, MAC/WAC, IFC).

(C) Patients may be referred to a PHE group by any CDCR/CCHCS staff member, or they may request enrollment by submitting a CDCR 22, Inmate/Parolee Request for Interview, Item or Service, and/or CDCR 7362, Health Care Services Request, per the local operating procedure. The patient shall be notified of the results of the request in writing via institutional mail within 14 business days of the request.

(D) General Requirements

1. The CDCR/CCHCS Patient Education Program is designed to provide ongoing peer mentoring and informal education for the management of chronic health issues (e.g., diabetes mellitus, pain, weight control) using an evidence-based curriculum.
2. The CDCR/CCHCS Patient Education Program is a partnership between health care, institutional staff, and the patients, each of whom are equally involved in the program's development and implementation.

(E) Inmate Peer Mentors (IPMs) provide their peers with structured health information and education which will help create the kind of cultural change that benefits the incarcerated, parolees, their families and communities through a common frame of reference and set of shared experiences relevant to the patient.

(F) Each institution shall coordinate with institutional custody leadership to establish a sufficient number of paid IPM positions to meet the identified needs of the institution. IPMs shall be assigned, monitored, supervised, and evaluated in compliance with the requirements set forth in California Code of Regulations, Title 15, and the Department Operations Manual for participation in the Inmate Work Incentive and Training Program (IWTIP). Nursing Supervisors may be designated as supervisors for the IPMs working in patient education.

(G) Trained staff shall facilitate the Patient Education Program. While the primary support for the program shall be provided by nursing staff, each discipline shall provide expertise as necessary.

1. Each institution shall designate one Lead PHE Facilitator and a sufficient number of PHE coordinators to coordinate and, as necessary, conduct activities related to the implementation and administration of the Patient Education Program.
2. These positions do not necessarily need to be licensed clinical staff; however, if they are not, a Registered Nurse shall be designated as a resource for the Lead PHE Facilitator.

(H) Program Development (Curricula)

1. A multidisciplinary team shall develop each Peer Health Group curriculum under the direction of a HQ CNE.
2. PHE classes shall include, but not be limited to:
   a. Vaccines
   b. STDs
   c. HIV
   d. Hepatitis C
   e. Norovirus
   f. Healthy Lifestyle
   g. Depression
   h. Grief
   i. Substance Use
3. Nursing staff shall collaborate with other health care professionals and interact with patients to ensure that health-related information discussed in peer mentoring meetings is of reasonable accuracy so as to promote health maintenance.

(I) Each institution shall develop a program in which IPMs are randomly observed to ensure the quality of material and to support the IPMs in group facilitation activities.

(J) Each IPM shall be trained and their "mastery" of the material verified prior to their conducting of any peer health care education activities. Training, competency, and periodic observations shall be documented in the IPM's IWTIP files.

(K) A local community connection is a valuable resource for the IPMs. It is important that each institution coordinate their Patient Education Program with programs offered by community-based organizations. Community-based organization shall be encouraged and recruited to participate in facilitating the program training patients and in the sharing of resources, expertise, and follow up upon release from CDCR custody.

Appendices

- Appendix 1: Sample NL-TG Schedule

References

- California Penal Code, Part 3, Title 2, Chapter 3, Sections 3407 and 3409
- California Proposition 57: The Public Safety and Rehabilitation Act of 2016
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 3, Article 3, Dental Care
- California Correctional Health Care Services, Performance Improvement Plan 2016-2018: Improvement Strategies (2017). Retrieved from:
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Revision History

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Revision: 07/2019

Appendix 1

Sample Nurse Lead Treatment Group Schedule

Institution: Anywhere State Prison

Day of Week	Hours	Title	Location
Monday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 1)	A3-101
Tuesday	1300-1400	Anger Management (Module 2)	A5-102
	1415-1545	Men's Health	A5-102
Wednesday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 1)	A3-101
Thursday	0900-1000	Stress Management	A5-102
	1030-1200	Men's Health	A5-102
	1230-1400	Diabetes's Education & Spt. Gp	A3-101
	1415-1545	Asthma Education & Spt. Gp	A5-102
Friday	0900-1000	Cancer Awareness	A5-102
	1030-1200	Medication Management	A5-102
	1230-1400	Anger Management (Module 1)	A3-101
	1415-1545	Victim Awareness	A5-102
	1830-2000	Self Care Skills (Module 2)	A3-101

3.1.5 Scheduling and Access to Care

(a) 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 ensure timely patient access to health care services. This includes a flexible appointment system that accommodates various encounter appointment types, encounter lengths, same-day encounters, 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.

(b) Responsibility

(1) 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.

(2) Regional

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

(3) Institutional

(A) 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:

1. Ensuring access to and utilization of equipment, supplies, health information systems, Patient Registries, Patient Summaries, and evidence-based guidelines.
2. Assigning patients to a Care Team.
3. 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.
4. Ensuring consistent Care Team staffing with a back-up system for core members.
5. Providing Care Team members with the information they need during huddles (e.g., communication of on-call information).
6. Ensuring protected time for Care Teams to hold daily huddles.
7. Documenting and tracking huddle actions and attendance.
8. Ensuring that at least monthly, each Care Team conducts a Population Management Working Session utilizing tools such as Dashboards, Patient Registries, and Patient Summaries to address concerns related to potential gaps in care and improved patient outcomes including, but not limited to:
   a. High risk patients.
   b. Contract Management.
   c. Patient safety alert.
   d. Trends in access to care.
   e. Surveillance of communicable disease.
   f. Patient risk stratification.
   g. Data entry completeness and accuracy.
9. Adequately preparing new Care Team members to assume team roles and responsibilities.
10. Assessing competence of existing Care Team members.
11. Updating institution procedures, roles, and responsibilities as new tools and technology become available.
12. Reviewing/comparing institution Care Team performance including the overall quality of services, health outcomes, assignment of consistent and adequate resources; utilization of Dashboards, Patient Registries, Patient Summaries, and decision support tools; and addressing issues as necessary.
13. Providing Care Team members with adequate resources including protected time, staffing, physical plant, information technology, and equipment/supplies to accomplish daily tasks.
14. Working with custody staff to minimize unnecessary patient movement resulting in changes to a patient's panel assignment.

15. 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.
16. 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.

(B) The CEO and all members of the institution leadership team are responsible for establishing an organizational culture that promotes teamwork among Care Team members and across disciplines.

(C) The CEO and institution leadership team shall review institution-wide scheduling and access to care data monthly in the context of local Quality Management Committee and subcommittee meetings.

(D) To ensure accuracy of scheduling system data, the institution leadership team shall:
1. Periodically evaluate the reliability of scheduling system data through comparison with independent data sources, such as movement or ducat reports and progress notes, or audits for abnormal or incomplete entries.
2. Take effective action to remedy unreliable data, including creating or revising decision support, updating desk procedures, and redesigning orientation and training strategies.
3. Re-validate problematic data monthly until the data reliability issue is resolved.

(E) Local quality improvement forums shall take action as appropriate to investigate quality problems and develop interventions to improve access.

(F) The CNE is responsible for:
1. The overall daily operations of the scheduling system for medical care.
2. The coordination of health care services between health care scheduling systems.
3. Oversight and management of scheduling processes and resources including personnel.
4. Ensuring that the institution has a designated Scheduling Supervisor to monitor scheduling processes on a daily basis and identify and address or elevate barriers to access.
5. Ensuring that Scheduling Support Staff is available for all clinical areas.

(G) 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.

(H) At least monthly, the CME and CNE shall review the following in each Primary Care Clinic to determine if adjustments need to be made to the overall clinic schedule plan to meet patient care needs:
1. Scheduling Diagnostic Report.
2. Schedule plan.
3. Utilization of open access time and co-consultation.
4. Number of additional “add-on” appointments.
5. Current backlog.

(I) The Supervising Registered Nurse (RN) and Chief Physician and Surgeon shall meet to review the Care Teams’ performance including the overall quality of services, health outcomes, and level of care utilization and shall utilize Dashboards, Patient Registries, Patient Summaries, and decision support tools to address or elevate issues as necessary.

(J) Institution leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the scheduling system.

(K) The Scheduling Supervisor and Clinic Manager
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 RN, and Primary Care Providers (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 scheduling management reports on a daily basis including, but not limited to, the following:
   a. Scheduling system diagnostic data to identify data entry errors and appointment trends.
   b. Scheduling queues not managed properly.
   c. Duplicate appointments.
   d. Unscheduleable appointments.
   e. 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, encounter consolidation, and co-consultation.
5. The Scheduling Supervisor shall work with the Clinic Manager to improve communication processes within the Care Team and across health care settings that impact scheduling and access, including daily huddles.
6. The Clinic Manager 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.

(L) The 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 PCP.
   d. Effectiveness of scheduling strategies, such as open access, encounter consolidation, 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, and grievances.
   h. Allocation of work across team members.
   i. Clinic closures.
   j. Specialty provider network issues.
   k. Completeness and accuracy of scheduling data.
   l. Security and construction impacts to access.
   m. Population management health care alerts.
2. The Care Team shall take corrective action to resolve and/or elevate concerns identified in the review. The Care Team review and corrective action shall be documented and forwarded to the designated committee.

(M) All health care staff shall be trained in scheduling and access to care concepts and principles. Targeted training shall be provided to those who have specific roles in the scheduling process (e.g., providers, nurses, schedulers). A system for the orientation, mentoring, and cross-training of all critical positions in the scheduling system shall be maintained.

(N) Each institution shall ensure all Scheduling Support Staff have 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.

(O) Each institution 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 including, but not limited to, the following:

1. Prompting clinic staff to communicate clearly to Scheduling Support Staff.
2. Giving tips on how to enter data in a way that is recognized by the scheduling system.
3. Reminding Scheduling Support Staff and clinic staff of new scheduling procedures and updated access to care timeframes.

(P) 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.

(c) Procedure

(1) 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

Staff shall submit a Solution Center ticket to add or change a provider or location.

(2) Access to Health Care Services

(A) Hours of Access

1. All CDCR inmates shall have access to medically necessary health care services 7 days per week, 24 hours per day.
   a. RNs shall be onsite at the institution 7 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
   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, verbal report, or demonstration of urgent/emergent health care needs.
   b. At any time, patients with health care needs may submit a CDCR 7362, Health Care Services Request Form. Patients with urgent health care needs may complete a CDCR 7362 or notify any institutional staff, including correctional staff for assistance. Patients with life-threatening conditions shall receive immediate medical attention.
   c. If a patient is unable to complete a CDCR 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 CDCR 7362 and shall sign and date the CDCR 7362.
   d. Institutions shall ensure the CDCR 7362 is available to patients in the housing units, clinics, and Reception Centers. Housing unit staff and health care staff shall make the CDCR 7362 available upon request. Each institution shall have at least one locked box on each yard/facility designated for patients to deposit the CDCR 7362.
3. Initial Review and Triage of a CDCR 7362
   a. On normal business days:
      1) A designated health care staff member on each yard/facility shall collect the CDCR 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 CDCR 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) Patients who submit CDCR 7362s that describe symptoms shall be seen by the Primary Care RN within one business day.
      4) If the Primary Care RN determines a PCP referral is necessary, the patient shall be seen based on the following timeframes:
         a) Emergency – immediately
         b) Urgent – within 24 hours
         c) Routine – within 14 calendar days
      5) The Primary Care RN shall separately address CDCR 7362s that do not include symptoms, such as requests for eyeglasses or medication renewals, routing them to appropriate staff. CDCR 7362s that do not describe symptoms shall be delivered the same day to the designated program representative on normal business days.
      6) A CDCR 7362 requesting services from more than one area (e.g., medical and dental) shall be copied and delivered to the requested service areas by the RN reviewing the CDCR 7362.

b. On non-business days:
   1) All CDCR 7362s shall be sent to the Triage and Treatment Area (TTA) RN for triage. Upon receipt of the CDCR 7362s, the TTA RN shall review, initial, and date each. The TTA RN shall ensure that the routine CDCR 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 pursuant to the Health Care Department Operations Manual (HCDOM), Chapter 3, Article 7, Emergency Medical Response.
   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 CDCR 7362 shall be forwarded and a Mental Health Consultation ordered.
   d. Patients with a potential mental health emergency (i.e., danger to self or others) 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 encounter 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 CDCR 7362, health care staff shall copy and forward the request to the other clinical disciplines as soon as possible. The original shall be forwarded to the first requested service area.

(3) Scheduling Strategies

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

(A) Services that Require Appointments

1. Health care encounters shall be considered appointments and shall be ordered and scheduled within the Electronic Health Record System including, but not limited to, the following encounter reasons:
   a. Episodic care encounters, including Primary Care RN encounters and provider referrals.
   b. Well patient encounters.
   c. Chronic care follow-up appointments.
   d. Specialty services.
   e. Care management encounters.
   f. Interdisciplinary treatment planning sessions.
   g. Recurring patient monitoring or follow-up appointments, such as dressing changes and blood pressure checks.
   h. Injection appointments.
   i. Public health screening and treatments.
   j. Patient education and non-adherence counseling.
   k. Special situations such as hunger strike evaluations and monitoring.
   l. Follow up after return from a higher level of care.
   m. Health care grievances.

2. In the event a patient transfers to another institution, 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 continued in Orders Reconciliation including, but not limited to, the following:
   a. TTA encounters.
   b. Receiving and Release intake.
   c. 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 pursuant to HCDOM, Section 2.1.2, Effective Communication.

(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 encounter.
   b. Each institution shall establish a procedure by which health care ducats are issued as priority ducats and delivery by custody is verified/documented. This procedure shall include the following:
      1) The method by which priority health care ducats are delivered to each patient.
      2) The individual responsible for issuing priority health care ducats.
      3) Verification by custody staff that the priority health care ducats were issued to the patient.
      4) A method of re-routing priority health care ducats to patients and documentation of the re-routing.
   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 their 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 CDCR 7225, Refusal of Examination and/or Treatment, if the patient continues to refuse treatment after the counseling. The CDCR 7225 shall be filed in the health record.

4) Patients who are insistent in their refusal 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 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 CDCR 7362. The rounds and collection of the CDCR 7362 shall be documented by nursing staff in the housing unit logbook.

(E) Security Precautions During Health Care Encounters

1. Health care encounters shall be provided in a manner that affords both auditory and visual confidentiality consistent with security and safety concerns of patients and health care providers.
2. Health care staff shall carry a whistle and, where available, a personal alarm and position themselves to have a clear egress route from the treatment room while performing assigned duties.
3. Health care screenings, evaluations, interviews, and treatment shall be held in a private setting unless the security of the institution or safety of staff will be compromised, or unless health care staff in the presence of the patient requests the presence of custody staff. As a default, custody staff is not required during a health care encounter with a patient who is not maximum custody or whose current behavior does not present a threat to the safety of staff or other patients.
   a. A patient shall not be placed in mechanical restraints during a health care encounter unless they are a safety concern for staff or others as determined by custody staff.
   b. Health care staff may ask custody staff to leave the room if they are comfortable with the patient and custody staff shall respect the request of health care staff and leave the room.
   c. If health care staff asks custody staff to exit the room and leave the door propped open, custody staff shall be in control of the door to remain in compliance with State Fire Marshall requirements.
4. A treatment module shall be utilized for the duration of encounters with patients who are a safety and security risk.
   a. Upon removal of the mechanical restraints, the front port on the module shall be closed during the encounter.
   b. Health care staff shall not put their face in or near the opening of a cuff or food port.
   c. If it is necessary to perform a procedure, the patient shall be removed from the treatment module and placed in waist restraints while being treated outside the module.
5. When health care staff are in housing units or on the tiers, custody staff shall maintain visual surveillance.

a. Visual surveillance shall not interfere with the privacy of the encounter with the exception of cell front medication distribution.
b. When unscheduled clinical encounters need to occur within a housing unit, staff shall conduct the encounter in a confidential setting with custody staff maintaining visual observation when necessary.

(F) 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.

(G) 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, access to care timeframes should be viewed as the maximum allowable timeframe 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. Patients with chronic conditions shall have follow-up encounters according to the timeframes in the applicable care guides. If there is no applicable care guide, the follow-up shall be as ordered or no less frequently than 365 days.
3. Patients discharged to an outpatient setting from the TTA who are clinically high risk shall be seen by their PCP within 5 calendar days of discharge. Patients discharged to an outpatient setting from the TTA who are clinically low or medium risk shall be seen by their Primary Care RN or PCP as clinically indicated.
4. Patients discharged to an outpatient setting from a community hospital, emergency department, or any non-mental health CDCR health care bed shall be seen by their PCP within 5 calendar days of discharge.
5. Patients discharged to an Enhanced Outpatient Program level of care from a Mental Health Crisis Bed (MHCB) or Psychiatric Inpatient Program (PIP) bed shall be seen by the Mental Health RN Care Manager within 3 calendar days of discharge and by a psychiatrist within 14 calendar days of discharge.
6. Patients discharged from a MHCB or PIP bed to a Correctional Clinical Case Management System Program level of care, and on psychiatric medications at present or in the last 6 months shall be seen by a psychiatrist within 14 calendar days of discharge.
7. If the MHCB or hospital psychiatrist asks that a patient be seen sooner than 14 calendar days after discharge, the psychiatrist's order for when the patient should be seen shall be followed.

(H) Scheduling Queues and Building the Clinic Schedule

Health care staff shall place orders for appointments that need to be scheduled, which will flow into various request queues in the scheduling system. Scheduling Support Staff are responsible for monitoring the appropriate request 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 cancelling 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) Confirmed Appointments Already Seen

The Primary Care Scheduler, or designee, is responsible to contact members of the Care Team to obtain any missing information or address discrepancies.

(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:
   a. Follow-up on abnormal diagnostic results or other critical abnormal clinical findings.
   b. Community hospital discharge follow-up.
   c. Urgent TTA follow-up.
   d. High priority specialty referral follow-up.
   e. High-risk/complex patients new to the Care Team.
   f. Patients whose condition has become clinically complex.
   g. 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 patient need and health care staff coverage may vary, clinic schedules shall be booked 14-30 calendar days out (except for "Open Access" slots).

(P) Encounter Consolidation Appointments

To increase clinic efficiency and timely access, Scheduling Support Staff shall review all pending appointments for possible encounter consolidation 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 issues in one encounter that would likely result in a referral to another member of the Care Team, thus eliminating the need for the patient to return to the clinic for a second time.

(R) Provision of Additional Health Care Staff During Examinations

1. An additional health care staff shall be present during all examinations of patients involving genital, rectal, or breast examinations.
2. Upon patient request, an additional health care staff may be present during other examinations.

References

- Code of Federal Regulations, Title 45, Parts 160 and 164. Health Insurance Portability and Accountability Act
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 2, Section 3270, General Policy
- California Code of Regulations, Title 15, Division 3, Chapter 1, Article 1, Section 3014, Calls and Passes
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.1, Patients' Rights
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.6, Population and Care Management Services
- Health Care Department Operations Manual, Chapter 3, Article 7, Emergency Medical Response
- 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

Revision History
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3.1.9 Health Care Transfer

(a) Procedure Overview

(1) The transfer of care between health care providers is a high-risk, complex, and multifaceted health care event. The goal of the California Department of Corrections and Rehabilitation (CDCR) is to perform each patient transfer in a manner that ensures the continuity of high-quality, safe care for each patient within CDCR. A transfer of care includes not only the processes and activities required to transport the patient, but also those activities, discussions, processes, and tasks required for admissions and discharges from differing locations, care settings, and levels of care within CDCR and external to CDCR. Transfers of care are accomplished by verbal communication between the sending and receiving care teams, with written documentation accompanying the patient as an adjunct to the conversation between health care providers.

(2) Under the Complete Care Model, the health care transfer procedure is designed to ensure seamless continuity of patient care through the timely and complete communication of information between members of the patient's care team using a series of standardized systems and processes across the continuum of patient care activities. These procedures and processes mitigate risk, promote patient safety, maintain continuity of care, improve access, and enhance professionalism, teamwork, and the formation of new patient-provider care relationships.

(b) Responsibility

(1) Statewide

(A) CDCR and California Correctional Health Care Services (CCHCS) departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place, and appropriate tools, training, technical assistance, and levels of resources are available to ensure that the Health Care Transfer Procedure is successfully implemented and maintained.

(B) CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, are responsible for ensuring appropriate services are available for patients statewide, coordination of care, providing access to the appropriate level of care, development of decision support and technological tools, contact lists, and reducing the risks associated with handoff and transfer of patients between care teams, institutions, and levels of care.

(C) The Headquarters Utilization Management Committee (HUMC) shall be responsible for ensuring processes are in place for continuity of care of high-risk medical patients and those with scheduled care needs as they transition from CDCR custody to the community (i.e., parole, probation, or discharge). CDCR/CCHCS Utilization Management (UM) collaborates with institutional staff, Division of Adult Parole Operations (DAPO), Post Release Community Supervision (PRCS), and community providers and agencies to ensure appropriate placement and services for patients who require ongoing care for chronic diseases after their release from CDCR facilities.

(D) The statewide mental health program shall be responsible for ensuring processes are in place for continuity of care of mental health patients.

(E) Health Care Placement Oversight Program (HCPOP), in coordination with the HUMC and/or the statewide mental health program, is responsible for the endorsement of patients between health care facilities if the institution cannot provide appropriate, medically necessary health care treatment to the patient. HCPOP facilitates the transfer of a subset of complex, high-risk patients between institutions in collaboration with clinical services.

(2) Regional

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

(A) Regional leadership, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place, and appropriate tools, training, technical assistance, and levels of resources are available to ensure that this procedure is successfully implemented and maintained.

(B) Regional leadership, in coordination with the Regional Quality Management Support Unit (QMSU), shall monitor and analyze the transfer process metrics outlined in Section (b)(3)(D)1-2 for their subset of institutions in order to identify trends, process lapses, and opportunities to mitigate risk to patient care.

(C) Regional QMSU shall report trended data, analysis, and process improvement activities to the designated statewide committee, no less than quarterly. Identified patient safety issues shall be addressed through the

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

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

(3) Institutional

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

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

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

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

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

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

(c) Procedure

(1) Patient Handoff Overview

(A) Each transfer of care within CDCR shall be facilitated through a handoff process where information is provided by the designated sending care team member to the designated receiving care team member.

1. Transfers of care can occur between points of care (locations) (i.e., facility to facility), providers of care (i.e., Primary Care Registered Nurse [PCRN] to Primary Care Provider [PCP]), or between levels of care (i.e., Clinic to Correctional Treatment Centers [CTC], or Mental Health Crisis Beds [MHCB] to Enhanced Outpatient Programs [EOP]).
2. For transfers of care between points of care, the patient's Primary Care Team (PCT) shall ensure that all outstanding primary care has been provided, ordered, and communicated to the receiving care team. For example, the PCT shall ensure that the patient's preventive care screening, immunizations, and/or routine lab work are current. This is particularly significant for high-risk and complex care patients.

(B) Patient care handoffs shall be tailored to the circumstances necessitating the transfer of care and the individual patient's care needs.

(C) Handoffs shall occur prior to the time of transfer, allowing for sufficient time for the sending and receiving care teams to ensure that all necessary supplies, equipment, medications, and other items necessary to provide care to the patient are available.

(D) Handoffs shall include a verbal discussion and written documentation necessary to ensure that the patient's care needs are communicated to the receiving provider.

(E) Transfer between levels of care shall include verbal communication between the designated sending and receiving RN.

(F) For transfers involving a change in institution, the Receiving and Release (R&R) Nurse shall:

1. Screen the health record prior to transfer for indications of potential and/or scheduled health care appointments.
2. Coordinate with the patient's PCP, mental health clinician and/or dental provider to ensure that continuity of care is maintained before, during, and after the transfer.

(G) Reasons for a patient care handoff include, but are not limited to:

1. A transfer from one area of the institution to another, resulting in a new care team (i.e., intrafacility transfers).
2. A transfer from one medication point of service (e.g., pill window) to another requiring the transfer of medications to the new point of service.
3. A permanent (i.e., interfacility transfers) or temporary (i.e., Medical/Psychiatric and Return) transfer to another CDCR institution.
4. An urgent/emergent (i.e., through an Emergency Department [ED]) or planned (i.e., a medical appointment or planned treatment/admission) outside facility transfer.
5. Transfers to or from a different level of care within CDCR including, but not limited to:
    a. Mental health levels of care
        1) Correctional Clinical Case Management System (CCCMS)
        2) MHCB
        3) EOP
        4) Acute Care Facility (ACF), including transfers to or from the Department of State Hospitals (DSH)
        5) Intermediate Care Facility (ICF), including transfers to or from DSH
    b. Medical levels of care
        1) Ambulatory Care
        2) Specialized Health Care Housing (e.g., Outpatient Housing Unit [OHU], CTC, Skilled Nursing Facility [SNF]).
6. Transfers to or from CDCR Division of Adult Institutions control
    a. Intake - Reception Center
    b. Release from custody
    c. Temporary transfer to community custody (e.g., out-to-court)

(2) Transfer of Information During the Patient Handoff

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

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

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

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

(3) Patient Transfer Process

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

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

b. Communicate with the patient's care team to resolve issues and concerns. The PCP shall update the Medical Classification Chrono and initiate a medical hold if necessary, pursuant to the HCDOM Section, 1.2.14, Medical Classification System.
c. Communicate with the pharmacy to identify transfer medications and establish the supply that shall be sent with the patient (e.g., high cost, nonformulary).
d. Notify the Classification and Parole Representative (C&PR) or designated custody representative if there is a contraindication to the patient's transfer.
e. Complete the Interfacility Transfer Screening.

3. The provider shall communicate verbally or electronically with the receiving institution's PCP or R&R Nurse regarding patients with special clinical requirements including, but not limited to, medications, treatments, or significant medical issues that may affect housing placement at the receiving institution.
4. Designated health care staff shall prepare the transfer envelope for the patient as stated in Section (c)(2)(B).
5. Within 24 hours prior to the transfer, the R&R Nurse shall conduct a face-to-face interview and assess the patient for contraindications to transfer.
6. The evening prior to transfer, the medication nurse shall medicate the patient per provider orders and deliver patient-specific NA/DOT medications to R&R for transfer with the patient.
7. On the day of transfer the R&R Nurse shall:
   a. Provide required medications.
   b. Verify receipt of the patient's NA/DOT and KOP medication.
   c. Verify the patient's possession of DME.
   d. Ensure items are placed in the white transfer envelope with the transfer documents.
   e. Provide rescue medications to the patient for holding during the transportation process.
8. The R&R Nurse shall complete the Pre-Boarding and ensure required handoff documentation is contained in the transfer envelope.
9. The R&R Nurse shall verbally communicate with the receiving institution all information necessary to ensure the smooth transfer of care between institutions.

(B) Interfacility Transfer (Institution to Institution) – Receiving Institution

1. The R&R Nurse shall complete the Initial Health Screening.
   a. If the Initial Health Screening is completed by anyone other than an RN, and the patient answers "yes" to any questions, health care staff shall contact an RN for assessment and disposition of the patient. Health care staff, other than an RN, shall document the referral to the RN on the Initial Health Screening in the health record.
   b. The RN shall document their assessment and disposition of the patient in the health record.
2. Patients shall be screened for Tuberculosis (TB) and Coccidioidomycosis according to current public health guidelines.
3. Pending specialty orders and other information shall be communicated to the UM RN, Specialty RN, and PCP via the Cerner Specialty message pool and the designated care team's message pool.
4. The receiving institution shall ensure the patient is scheduled for an initial new arrival assessment encounter as clinically indicated, as follows:
   a. High Risk/Complex Care: PCP encounter within seven calendar days.
   b. Medium/Low risk patients with one or more chronic conditions with prescribed medications: PCP or PCRN encounter within 30 calendar days or as ordered by the provider.
   c. Medium/Low risk patients without known chronic conditions with prescribed medications shall be seen by a care team member as needed, or based on applicable care guides.
   d. Mental health LOC patients: Initiation of a Mental Health PowerPlan previously ordered in a planned state. If a Mental Health PowerPlan has not been ordered in a planned state, the patient shall be referred to mental health via the Mental Health Primary Clinician (MHPC) or Psychiatrist Routine Consultation (MHMD).
5. The PCP, or designee, shall complete order reconciliation by the close of the next business day.

(C) Non-CDCR Institution Transfers (Out-to-Court, Release from Custody)

1. Prior to the patient's transfer, the R&R Nurse shall complete the steps in Section (c)(3)(A)5-7.
2. Release from custody

a. Custody staff shall notify health care staff of pending transfers via the Parole/Transportation List.
   1) Patients in a community health care facility – Custody staff shall notify Headquarters UM who shall assist with obtaining an appropriate community placement and the transfer of health records, as needed to ensure continuity of care.
   2) Patients housed in a CDCR facility with ongoing health care needs (i.e., pending surgery, on TB treatments) – Custody staff shall notify institutional UM staff who shall:
      a) Coordinate with HIM to obtain the required medical Release of Information.
      b) Coordinate with community health care providers, DAPO, and PRCS to ensure continuity of care.
      c) Coordinate with the PCT to ensure that the patient is provided educational materials and a 30-day supply of medications and health care supplies. Medication orders shall be compliant with current pharmacy policy and regulatory limitations.
   3) Patients housed in a CDCR facility who have ongoing acute mental health needs (e.g., housed in a MHCB or higher LOC facility, on Clozapine) – the patient's mental health clinician shall coordinate with the appropriate CDCR, DAPO, and PRCS staff to ensure continuity of care upon release from CDCR custody (refer to the Statewide Mental Health Program Pre-Release Program Policy and Procedure).

3. Out-to-Court
   a. C&PR staff shall notify health care staff in advance of scheduled court dates as outlined in the institution's transfer LOP.
   b. The R&R Nurse shall screen the health record for contraindications to transfer (e.g., medical holds, potential medical holds, dental holds, specialty appointments) and contact the PCT to resolve. If issues are identified, the following shall be completed, as applicable:
      1) The provider or care team shall contact the institution's C&PR for assistance in contacting the gaining jurisdiction's PCP.
      2) If the PCT determines a patient is too ill, unstable, or unable to participate in the court proceedings effectively, institutional clinical leadership (e.g., Chief Medical Executive, Chief Nurse Executive, CEO, Warden) shall contact the CCHCS Office of Legal Affairs to coordinate and determine options for the patient.
      3) For mental health patients at the MHCB, ICF, or Acute Psychiatric Program, procedures established by the statewide mental health program shall be followed.
      4) The provider or care team shall coordinate with the Pharmacist-in-Charge and the out-to-court provider for transfer of unusual medications, (i.e., Factor IX®, Harvoni®, transplant medications) to ensure continuity of care.
   c. Out-to-Court Returns – seven or more calendar days
      1) The R&R Nurse shall:
         a) Process patients who are out-to-court for seven or more calendar days as an interfacility transfer upon return.
         b) Complete an Initial Health Screening and registration.
         c) Ensure High-Risk/Complex Care patients have a PCP encounter within seven calendar days.
         d) Ensure Medium/Low Risk patients have a PCP or PCRN encounter within 30 calendar days or as ordered by the provider.
         e) Initiate a Mental Health PowerPlan previously ordered in a planned state for mental health LOC patients. If a Mental Health PowerPlan has not been ordered in a planned state, the patient shall be referred to mental health via the MHPC or MHMD.
      2) The PCP, or designee, shall complete order reconciliation by the close of the next business day.
   d. Out-to-Court Returns – less than seven calendar days
      The R&R Nurse shall:
      1) Complete an Initial Health Screening.
      2) Notify the PCT to ensure that order reconciliation is completed by the close of the next business day.

(D) Layovers

The R&R Nurse shall:

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

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

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

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

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

b. Provide rescue medications to the patient for use during the transfer as clinically indicated (i.e., KOP or with an escort).

4. Patients transferring to or from a higher LOC including, but not limited to, CTC, SNF, PIP, MHCB, community hospital or other community-based licensed inpatient facility, or OHU shall go through the TTA.
5. The TTA Nurse shall contact the PCP, or designee, to obtain orders for medication, therapies, and diagnostics, as indicated, to ensure continuity of care.
6. Patients discharged to an outpatient setting from a community hospital, ED, or any non-mental health CDCR health care bed shall be seen by their PCP within five calendar days of discharge.

(G) Level of Care Changes – To or From Higher Levels of Care, Mental Health

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

References

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

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

Revision History
Effective: 01/2010
Revision: 04/2019

3.2.4 Medication Administration

(a) Procedure Overview

This procedure provides guidelines for the administration or delivery and documentation of medications to California Department of Corrections and Rehabilitation (CDCR) patients by licensed health care staff.

(b) Responsibility

The Chief Executive Officer (CEO), or designee, is responsible for the implementation, monitoring, evaluation of and compliance with this procedure.

(c) Procedure

(1) General Procedures

(A) Licensed health care staff shall issue, administer, monitor, and document administration or delivery of all medications ordered by authorized prescribers (physician, nurse practitioner, physician's assistant, dentist, psychiatrist, podiatrist, etc.) within their scope of licensure under California law.

(B) Prior to administering medications, licensed health care staff shall:

1. Check each patient's Medication Administration Record (MAR) for potential allergies.
2. Document verification on the MAR that it has been reconciled to the prescriber orders.
3. Verify the medication order has not expired.
4. Verify the medication has not expired.

(C) Medications shall be prepared by licensed health care staff when the patient presents for their medications at the pill line/window.

(D) Prepared medications shall be administered by licensed health care staff on the shift they are prepared.

(E) The same licensed health care staff who prepares the unit dose package medication shall also administer and document the administration of the medication during the same shift that they are pre-poured/packaged.

(F) At the time of medication administration, licensed health care staff shall ensure that the "Six Rights" are followed:

1. Right Patient – Medication administration staff shall verify the correct patient by checking the patient's CDCR picture identification card and one other patient identifier. In locked units, the patient's picture ID or bed card with picture should be posted next to the cell door. Custody staff shall be consulted if there is any concern regarding accurate identification of the patient.
2. Right Medication – Compare the medication label to the MAR to verify medication.
3. Right Dose – Compare the medication label to the MAR to verify dose.
4. Right Route – Compare the medication label to the MAR to verify route.
5. Right Time – Compare the medication label to the MAR to verify time.
6. Right Documentation – Licensed health care staff administering medication shall record the medication administered on the patient's MAR directly after administration. The route of administration and injection site shall also be recorded on the MAR if a medication is administered by injection. Insulin administration is recorded on the insulin MAR.

(G) Medications ordered on an "AM and PM" or twice daily basis shall be administered with at least eight hours between the two dosing times unless otherwise indicated on the CDCR 7221, Physician's Orders, or Medication Reconciliation form.

(H) Hour of Sleep Medications – When clinically indicated, medications may be ordered at bedtime or hour of sleep. Medications ordered at bedtime/hour of sleep shall be administered after 2000 hours.

(I) Every effort shall be made to ensure that unit dose medications are not opened until the time of administration.

(J) At no time will medication of any type be slid and/or placed under the door or between the door and doorjamb of a patient's cell.

(K) Licensed health care staff shall forward all completed MARs to Health Information Management (HIM) as soon as possible and at month's end, but no later than the seventh day of the following month, to be scanned. Completed, signed, and dated Keep-on-Person (KOP) MARs shall be returned daily to HIM after medication distribution.

(2) Medication Administration Lines – General Population

(A) All general population (GP) patients, including those housed in Level IV 180 design units, shall receive all medications at a pill window as routine function of regular programming. Cell front medication delivery shall

not occur in a GP setting unless there is no other reasonable alternative available as determined by the CEO, or designee, in consultation with the Warden or designee.

(B) Medication may be administered up to four times daily in medication lines with the exception of Minimum Support Facilities and Fire Camps.
1. Morning (AM)
2. Noon
3. Evening (PM)
4. Bedtime (Hour of sleep)

(C) Custody staff shall be present at the medication window to directly observe the medication process, maintain order, and provide assistance if necessary.

(D) Patients will bring a cup of water to the pill window unless Local Operating Procedures (LOPs) direct otherwise.

(E) Medication lines shall continue until the last patient in line has received their prescribed medication or all patients who have not received their medications have been contacted either via custody or face-to-face.

(F) At the conclusion of the medication line, the medication administration nurse shall review the MARs to identify patients who did not present to the pill window to receive their routine medications. The medication administration nurse shall coordinate with custody to attempt to locate the patient for:
1. Medication administration.
2. Documentation of refusal of medication and the reason for refusal.
3. Documentation of barriers that prevented the patient from presenting to the medication line.

(3) Medication Administration at Cell Front – Locked Units

(A) Custody staff shall accompany licensed health care staff on medication administration rounds to facilitate opening of the food port or the cell door, if necessary, for administration of medications.

(B) The patient shall be instructed to turn on the light, bring a cup of water, and come to the cell front to be clearly visible.

(C) Licensed health care staff shall provide the patient's oral medication through the opened cell door, food port, or bars of the cell door. At the request of licensed nursing staff, custody staff shall open cell doors during medication administration to permit reasonable visualization of the patient's ingestion of medication.

(D) At no time shall medication of any type be slid and/or placed under the door or between the door and doorjamb of a patient's cell.

(E) Medication administration shall continue until all patients in the unit with prescribed medications have received or refused the prescribed medication.

(4) Medication Administration During Lockdown or Modified Program

(A) Patients requiring medication while on a modified program shall be escorted to the pill window for all medication needs/times (i.e., AM, Noon, PM, Hour of sleep, KOP), except as outlined below in (B).

(B) Medication administration during modified program for the below stated reasons shall be by podium pass or at cell front.
1. Modified program as a result of staff related threats.
2. Modified program as a result of documented/confirmed violence within a group to such an extent that patients within this group cannot safely be escorted without jeopardizing the safety and security of staff, patients, and/or the institution.

(C) If GP patients on lockdown or modified program are provided any yard access, programming, critical work release, or receive their meals in the patient dining facility, they shall also have access to the pill window to receive their medication.

(D) When the state of the lockdown or modified program is such that no movement is permitted, medication administration shall occur at the cell front or podium pass until restrictions on movement are relaxed to the extent that once again permit patient access to the pill window.

(E) The method of medication delivery for the above concerns shall be determined/approved by the CEO, or designee, in agreement with the Warden or designee.

(5) Methods of Medication Administration/Delivery

(A) Directly Observed Therapy (DOT)
1. Required for patients:
   a. With Penal Code (PC) 2602 (Keyhea) or Probate Code 3200 court orders.

b. Receiving any narcotic or controlled medications.
c. Receiving medications on the Systemwide Pharmacy and Therapeutics (P&T) crush and float list.
d. Receiving medications for active tuberculosis (TB) or suspected TB disease.
e. Receiving medications for latent TB infection.
f. Whenever specified by the prescriber.

2. DOT Procedure
   a. The patient will present to the medication line (GP) or the cell front (locked units) with a cup of water.
   b. Licensed health care staff administering medication shall verify the patient's identity by checking the patient's CDCR picture identification card and one other patient identifier.
   c. Using the "Six Rights" of medication administration, licensed health care staff shall provide the prescribed oral medication to the patient.
   d. Licensed health care staff shall observe the patient take the oral medications into his/her mouth and swallow all pills followed by an adequate amount of water. The patient shall remain clearly visible to health care staff.
   e. Licensed health care staff, with assistance from custody as needed, shall verify that the patient swallowed the medications by completing a visual mouth check, viewing the empty cup, and other checks as indicated.
   f. If staff cannot verify that the patient swallowed the medication and followed all steps of the above procedure, licensed health care staff shall request that custody staff escort the patient to an area with clear visibility where medication administration can be verified.
3. Orders for DOT administration of medications that are not required per pharmacy policy to be DOT shall have clinical justification for DOT documented in the health record. Before determining the means of administration, the clinician shall consider the following:
   a. Potential for self-harm.
   b. Potential for diversion.
   c. History of non-compliance or overdosing.
   d. Problems with medication adherence.
   e. Recent history (within the past year) of suicidal ideation, threats, or attempts.
4. "Crush/Open and Float" Requirements
   a. It is the policy of CCHCS to administer oral medications with significant potential for diversion as "crush/open and float" when product formulation permits. The Systemwide P&T committee shall maintain the current list of such medications.
   b. Strict adherence to this policy is required from all licensed health care staff administering "crush/open and float" medications.

(B) Nurse Administered (NA)

1. Required for patients:
   a. Who cannot safely or properly self-administer medications.
   b. Who are receiving medications required by policy to be administered NA.
   c. Whenever specified by the prescriber.
2. NA Procedure
   a. The patient will present to the medication line (GP) or the cell front (locked units) with a cup of water.
   b. Licensed health care staff administering the medication shall verify the patient's identity by checking the patient's CDCR picture identification card and one other patient identifier.
   c. Using the "Six Rights" of medication administration, licensed health care staff shall provide the prescribed oral medication to the patient.
   d. The licensed health care staff shall give the medication to the patient, observe the patient take the oral medications into his/her mouth followed by an adequate amount of water and swallow all pills. The patient shall remain clearly visible to health care staff.
   e. If staff cannot verify that the patient swallowed the medication and followed all steps of the above procedure, licensed health care staff shall request that custody staff escort the patient to an area with clear visibility where medication administration can be verified.

(C) KOP: Self-administered

1. Patients receiving prescribed KOP medications shall be able to produce a valid current label for each medication and may be required to return medication containers prior to receiving refills or additional medication.
2. All inhalers shall be refilled on a 1:1 exchange basis. If the patient does not return his/her inhaler, a new inhaler shall be issued and custody shall be notified for assistance in locating the missing inhaler.
3. Patients shall be notified that their KOP medications are available for pick up at the pill window. Notification methods may include:
   a. Posting the KOP Ready List at the clinic for patients whose KOP medications are available for pick up.
   b. A verbal notification to the patient.
   c. Contacting the housing officer to announce that the patient should report to the medication line.
   d. Providing a KOP Ready List to the program offices for distribution to the housing units.
   e. KOP medications for patients in locked units shall be delivered during medication administration rounds in accordance with LOP.
4. In the event a patient does not pick up the KOP medications within four business days of the medication becoming available, the licensed health care staff shall utilize the institution's established process in accordance with their LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include:
   a. Ducating the patient to the medication line.
   b. Notifying custody to have the patient escorted to the pill line.
5. Documentation on the KOP MAR shall indicate patient receipt or refusal of the KOP medication.
   a. Receipt of KOP medications: Licensed health care staff shall initial on the KOP MAR each medication distributed and received as well as print his/her name, then sign and date the KOP MAR.
   b. Refusal of KOP medications: Licensed health care staff shall document "refused" on the KOP MAR for each medication the patient refuses. The licensed health care staff and the patient shall sign and date the KOP MAR.
6. Patients who refuse KOP medications shall be referred to the Primary Care Team for appropriate management.

(D) Injectable Medications

1. Licensed health care staff shall record the route of administration and injection site on the back of the MAR. The MAR shall include the following:
   a. Patient name
   b. CDCR number
   c. Prescription number
   d. Date, time, and signature of the licensed health care staff administering the medication
   e. Injection site
2. Injections shall not be administered through the food port or cell bars. If a patient requires medication to be administered by injection, custody staff shall have the patient escorted to clinical space in the housing unit (if available) or to the clinic where the licensed health care staff can safely administer the medication.
3. Whenever possible, injections shall be drawn at the time of administration. In the case of mass Influenza vaccination campaigns or annual TB testing, a small quantity of the injections may be pre-drawn no more than one hour prior to administration. Each licensed health care staff may draw a small quantity of vaccine to meet the initial needs of the clinic, but no more than can be administered in one hour.
4. Insulin and Glucose Monitoring
   a. When necessary, licensed health care staff shall provide designated custody staff with a list of names and housing units of patients requiring glucose monitoring in the morning and/or in the evening. A list of patients receiving insulin can be obtained from the pharmacy to assist in identifying patients who require glucose monitoring.
   b. Institutions shall ensure that patients receiving insulin receive meals within a consistent timeframe to avoid the possibility of hypoglycemia.
   c. Insulin administration shall be recorded on an insulin MAR.
   d. Glucose monitoring is recorded on the CDCR 7247, Diabetic Flow Chart.

(6) Involuntary Medication Administration

(A) PC 2602

1. Certain patients are under court order to receive involuntary administration of mental health medications.
2. Medications ordered under PC 2602 are administered DOT.
3. The PC 2602 ("Keyhea") Coordinator shall forward a list of all patients under PC 2602 orders to designated personnel.
4. The pharmacy shall label the MAR such that the licensed health care staff administering medications is aware of those patients with orders for involuntary medication administration.
5. A list of patients with PC 2602 orders shall be maintained in each medication administration area to ensure that the licensed health care staff administering medications is aware of those patients.

(B) Probate Code 3200

1. In rare circumstances, there may be a patient for whom a court order has been issued for involuntary medical treatment which may include medications.
2. Medications ordered under Probate Code 3200 are administered DOT.
3. Institution medical management shall inform designated personnel of patients with Probate Code 3200 orders.
4. The pharmacy shall label the MAR to ensure the licensed health care staff administering medications is aware of those patients.
5. A list of patients with Probate Code 3200 orders shall be maintained in each medication administration area to ensure that the licensed health care staff administering medications is aware of those patients.

References

- California Business and Professions Code, Division 2, Chapter 9, Article 2, Section 4016
- California Penal Code, Part 3, Title 1, Chapter 3, Article 1, Section 2602
- California Probate Code, Division 4, Part 7, Section 3200
- California Code of Regulations, Title 15, Division 3, Chapter 1, Rules and Regulations of Adult Operations and Programs
- Health Care Department Operations Manual, Chapter 3, Article 5, Section 3.5.5, Prescription/Order Requirements

Revision History

Effective: 10/2008
Revision: 01/2016

3.5.14 Handling of Confiscated Medications

(a) Procedure Overview

Inmates are not authorized to possess any medications that meet the criteria identified in this policy. Unauthorized medications shall be confiscated and returned to health care staff unless there is a possibility of a disciplinary charge. The confiscated medications shall be disposed of or sent to the pharmacy for identification if needed.

(b) Purpose

To provide guidance to custody and health care staff regarding confiscation of medications.

(c) Procedure

(1) The following medications shall be confiscated:

(A) Prescription medications found outside of an approved medication container (e.g., unlabeled container). Approved medication containers shall bear a California Correctional Health Care Services pharmacy label which lists:

1. Patient name.
2. California Department of Corrections and Rehabilitation number.
3. Name of the medication as well as strength, dosing instructions, and quantity supplied.
4. Stop date of the medication.

(B) Medications for which the prescription is past the stop date on the label.

(C) A mixture of medications in any labeled or unlabeled container.

(D) Prescription medications which are not prescribed to the inmate.

(E) Unauthorized medications from an outside source.

(F) Over-the-counter medications not in consumer-ready packaging or otherwise properly labeled by pharmacy.

(G) Any medications which are expired and/or adulterated.

(H) Medications not used as prescribed, for example:

1. Medications passed to other inmates.
2. Alterations of an inhaler or other medication container.
3. Hoarded.
4. Crushed or altered.

(2) Chain of Custody for Confiscated Medications

(A) When medications are confiscated, except as described below in Section (c)(2)(A)1., custody staff shall place the medication in an unsealed envelope containing cell search receipts, label the envelope as "confiscated medication," and deliver to nursing staff. Nursing staff shall examine the contents, notify the prescriber of the incident within the same shift, and dispose of the medication. If identification of the medication is necessary, nursing staff shall seal the contents in the envelope under custody observation to send to the pharmacy for identification and disposition.

1. When there is a possibility of a disciplinary charge (including referrals for criminal prosecution), custody staff shall maintain possession of medications to preserve the chain of evidence only allowing for examination of the substance by pharmacy staff to the degree necessary for positive identification.
2. Upon request, pharmacists shall assist in the identification of intact medications for the purposes of internal investigations.

(B) Follow-up physician orders shall be documented in the health record.

(C) The on-duty nursing supervisor shall be contacted for further direction if there are any immediate concerns regarding confiscated medications.

(D) Nursing staff may return confiscated medications to the patient if all of the following criteria are met:

1. The medication was found in an approved container as outlined in the Section (c)(1)(A).
2. The contents of the container were verified by a pharmacist to be accurate according to the label on the container.
3. The medication is neither expired nor adulterated.
4. There is an active order in the health record for the medication.
5. There is no evidence of hoarding.

(3) Disposition of Medications

(A) Confiscated medications shall be disposed of in compliance with the Health Care Department Operations Manual, Section 1.2.12, Disposal of Regulated Waste Generated by Health Care Staff.

(B) Illegal drugs shall not be taken to medical or pharmacy for disposal but shall remain within custody control. The internal investigation authority shall direct disposition of illegal drugs pursuant to the Department Operations Manual, Sections 52010.24, 52010.25, and 52010.26.

References

- California Department of Corrections and Rehabilitation, Department Operations Manual, Section 52010.10 - Controlled Medication, Section 52010.24 - Destruction of Controlled Substances, Section 52010.25 - Obtaining a Court Order for Destruction, and Section 52010.26 - Controlled Substance Destruction Schedule
- Health Care Department Operations Manual, Chapter 1, Article 2, Section 1.2.12, Disposal of Regulated Waste Generated by Health Care Staff

Revision History

Effective: 10/2008
Revised: 04/2021

Article 6 – Durable Medical Equipment/Supplies and Accommodations

3.6.1 Durable Medical Equipment and Medical Supply

(a) Policy

(1) California Correctional Health Care Services (CCHCS) shall provide Durable Medical Equipment (DME) and medical supplies to California Department of Corrections and Rehabilitation (CDCR) patients at no charge, and as medically necessary to ensure the patients have equal access to prison services, programs, or activities. All patients shall be held financially responsible for damage to DME while in their possession unless the damage is caused by another inmate or employee action.

(2) Medically necessary implanted medical devices and dental prosthetic appliances are excluded from this policy

(b) Purpose

The purpose of the DME and medical supply policy is to ensure the following:

(1) Patient DME needs are properly addressed.

(2) Institution safety and security is maintained by working with and advising custody staff regarding the distribution and maintenance of DME.

(3) Efficient use of resources.

(4) Standardized processes and prescribing practices.

(5) Compliance with appropriate constitutional standards of care.

(c) Responsibility

(1) The Chief Executive Officer and the Warden at each institution are jointly responsible for the implementation and monitoring of this policy and procedure.

(2) The Deputy Director, Medical Services, is responsible for the implementation and monitoring of this policy at headquarters.

(3) The Headquarters DME Committee provides headquarters level oversight and management of functions necessary for the implementation of this policy.

(4) CCHCS headquarters is responsible for the Headquarters DME Committee.

(5) Headquarters DME Committee (HDMEC)

(A) The responsibilities of the HDMEC are as follows:

1. Review all approved requests for nonformulary DME from institutions.
2. Review provider appeals of denied nonformulary DME requests.
3. Review and resolve issues pertaining to security concerns versus health care needs.
4. Provide written response to the requestor.
5. Maintain the DME and medical supply formularies.
6. Provide periodic guideline review

(B) Membership

1. The HDMEC shall consist of members designated by the Deputy Director (DD), Medical Services.
2. No fewer than two members shall be physicians.
3. Membership may include executive or managerial representation from Medical Services, Nursing Services, the Mental Health Program, Procurement Services, Utilization Management (UM), Direct Care Contracts, the Health Care Correspondence and Appeals Branch, CDCR Headquarters staff, and institutionally based health care and custody staff.

(C) Reporting Structure

The HDMEC shall report to the DD, Medical Services or designee.

(D) Meeting Frequency

The HDMEC shall meet as directed by the DD, Medical Services, but not less than annually.

(E) Committee Quorum

A quorum shall consist of at least five voting members in attendance, either in person or telephonically, at least two of whom shall be physicians. The committee may not take action on any agenda item without a quorum.

(F) Confidentiality
The proceedings and records of the HDMEC shall be confidential and protected from discovery to the extent permitted by law.

(6) Institution DME Committee
Each institution shall assign responsibility for the local operation of the DME and medical supply policy and procedure including authorization, review, and procurement of DME.

(d) Procedure Overview

The following procedures have been established to ensure efficient use of resources, statewide standards and processes, and coordination with custody staff.

(e) Procedure

(1) Durable Medical Equipment and Medical Supplies

(A) DME and medical supplies shall be distributed by health care staff based on medical necessity as defined in the Durable Medical Equipment and Medical Supply Formulary then in effect unless approved through the nonformulary request process as outlined in Section (e)(4).

(B) All associated supplies and accessories listed in the Durable Medical Equipment and Medical Supply Formulary shall be provided to patients currently issued the DME (without an additional order) unless the establishment of additional medical necessity is required as described in Section (e)(4).

(2) Hygiene Supplies

(A) Hygiene supplies normally provided by custody, as defined in the CDCR Department Operations Manual (DOM) shall not be considered medical supplies or DME and are not prescribed by health care staff. Hygiene supplies do not need consultation or approval from health care staff. Patients shall request hygiene supplies from custody staff who shall be solely responsible for distribution of requested supplies.

(B) Items that may be provided by custody depending on job assignment and institution location are as follows:

1. Analgesic balm
2. Burn spray
3. Hydrogen peroxide
4. Insect repellent
5. Lip protection
6. Sunblock

(3) Miscellaneous Supplies

(A) Mobility, hearing, and vision-impaired disability identification vests are a miscellaneous supply that are included as a standard item of DME. Disability identification vests shall be prescribed, purchased, and issued by health care staff.

(B) The following miscellaneous supplies shall not be considered medical supplies or DME and not prescribed by health care staff:

1. Blankets
2. Clothing
    a. Boxer shorts
    b. Brassieres
    c. Hats
    d. Shoes, including tennis shoes
    e. Sunglasses
    f. Thermal underwear
3. State-issued mattresses including foam pads

(4) Durable Medical Equipment and Medical Supply Formulary

(A) The Durable Medical Equipment and Medical Supply Formulary shall address as relevant the following:

1. Item name
2. Reference brands, sources, relative prices
3. Variations
4. Indications and contraindications
5. Establishment of medical necessity including associated supplies
6. Trial period

7. Prescription requirement versus authorization
8. Security considerations, settings, accountability plan, tagging or marking
9. Review of usage such as CPAP hours
10. Reusable or single-patient use
11. Ability to loan
12. Manufacturer's user manuals/patient education handout (include Website URL)
13. Maintenance
    a. Service contracts
    b. Inspections, clinical performance, safety and compliance
14. Expected refresh period
15. Quantity
16. Par levels, if any, at warehouse, clinic, medical supply area
17. Special procurement
18. Anticipated annual usage/cost
19. Clinical references

(B) Process for review and change of formulary
1. The HDMEC will review the formulary annually and shall solicit input from the institutions.
2. Items may be added, deleted, or updated at any time by actions of the HDMEC.
3. Formulary shall be maintained electronically.
4. The formulary shall be made available to patients in prison law libraries.
5. Institutions may request that the HDMEC add, delete, or update items.

(C) Formulary request process
1. The provider must complete an order for the DME or medical supply. The order must include priority and if applicable, type, size, quantity, associated supplies, and frequency of use.
2. Formulary items that require UM authorization shall also have a completed Health Care Services Physician Request for Services.

(D) Nonformulary request process
1. The provider must complete an order for the DME or medical supply. The order must include priority and if applicable, type, size, quantity, associated supplies, and frequency of use.
2. Nonformulary items shall have a completed Health Care Services Physician Request for Services.
3. The Chief Medical Executive (CME), or designee, shall approve or disapprove nonformulary requests.
    a. The requests shall be approved or disapproved in a timely manner to ensure the DME is provided within the noted delivery timeframes in Section (e)(6).
    b. The reason for approval or disapproval shall be documented in the health record.
    c. The requesting provider must be informed of disposition by the CME.
    d. If a request is disapproved, the provider must document consideration of alternatives and any action taken.
4. If approved, the Health Care Services Physician Request for Services shall be attached to the purchase request and sent to procurement.
5. The institution DME Committee shall receive a copy of the decision and if approved, procurement shall also receive a copy.
6. A provider may appeal a denial to the HDMEC.

(5) Procurement and Purchasing

(A) DME purchases shall be processed in accordance with standard state procurement processes.

(B) Patients shall not be financially responsible for the cost to purchase medically necessary DME. This does not preclude a patient from financial responsibility for damage pursuant to Section (e)(12)(B)2.

(C) Patients shall not have the option to order DME from third party vendors.

(6) Timeframes for Delivery of Prescribed DME and medical supplies are as follows:

(A) Same day

(B) Expedited - Within five calendar days

(C) High Priority - Within 14 calendar days

(D) Routine - Within 90 calendar days

(E) For patients returning to institutions from hospitals, medically necessary DME shall be available upon arrival at the institution.

(7) Patient Arrival to CDCR with DME from outside of CDCR

(A) All DME arriving with a patient to an institution shall be subject to inspection, review, and acceptance by custody for safety and security concerns and health care staff for medical necessity.

(B) If custody staff determines a safety or security concern with a particular item of DME either generally or in the possession of a particular patient, the CME or designee shall be consulted immediately to determine appropriate action to accommodate the patient's needs.

1. Accommodation may include modifying the DME or providing a suitable formulary replacement item at CDCR's expense when medically necessary.
2. Only under exceptional circumstances will a medically necessary approved DME be removed and an alternate means provided. A subsequent written report memorializing the removal action shall be provided by custody personnel. All such circumstances shall be appropriately documented in the health record.
3. The patient shall be examined by a provider to determine medical necessity of DME arriving with the patient.
    a. If medically necessary, the provider shall place the appropriate DME order in the Electronic Health Record System (EHRS).
    b. Documentation in EHRS indicating the disposition of the DME, per the Primary Care Provider (PCP) order, shall occur by entering the CDCR 7536, Durable Medical Equipment and Medical Supply Receipt.

(8) Patient Transfer with DME within CDCR

(A) Patients transferred from one CDCR institution to another shall be allowed to maintain possession of DME and/or medical supplies if it does not pose a threat to safety and security as determined by custody staff and as supported by documented evidence.

(B) At the receiving institution, all previously prescribed DME and medical supplies shall continue to be provided unless a PCP at the receiving institution re-evaluates the patient and determines the DME or medical supplies are no longer medically necessary to ensure patients have equal access to prison services, programs, or activities.

(C) At the receiving institution, the Receiving and Release Registered Nurse shall be responsible for ensuring that patients are provided with prescribed DME and/or medical supplies upon arrival.

(D) Health care staff shall review the patient's current CDCR 7536 to ensure accuracy and update if necessary to reflect all DME in the patient's possession and document in the health record. A new CDCR 7536 shall be generated if not documented in the health record.

(9) Inspection and Inventory

(A) Patient property, including DME, is subject to search and inspection.

(B) The Durable Medical Equipment and Medical Supply Formulary includes information regarding special circumstances for the inspection of DME.

(C) All DME shall be inspected by custody staff according to current CDCR DOM guidelines. These inspections shall be conducted, minimally, during required cell inspections. DME will be inspected for the following:

1. Misuse
2. Security issues
3. Cleanliness
4. Worn, broken, or missing parts

(D) The Primary Care Team shall reassess patients with DME at least annually.

(E) Custody staff shall conduct and log safety and security inspections on all wheelchairs on at least a monthly basis.

(F) All DME shall be tagged with an identification number. Identifiers may include:

1. CDCR property tag or patient CDCR number.
2. Permanent inscription or engraving of the property number on metal or wood.
3. Property number written in indelible marker on soft materials.

(G) DME issued to patients shall be entered on the patient's property card.

(10) Temporary Loans of DME

(A) Patients may receive a temporary loan of DME when:

1. The permanent DME is not yet available for use (e.g., ordered and not delivered; requiring time for preparation, construction, or fabrication) and an interim accommodation with DME is required.
2. The need for DME is time-limited due to the nature of the condition requiring the need for DME (e.g., crutches during a healing fracture of the leg).
3. Permanent DME is being repaired or maintained.

(B) When the indication for temporary DME on loan no longer exists, the DME shall be returned to CDCR in good working condition with reasonable, expected wear and tear.

(C) Patients shall not be required to pay for temporary DME but shall be held financially responsible for damage to loaned DME that is intentionally caused by the patient.

(11) Patient Receipt/Refusal/Rescinding of Medical Supplies and DME

(A) The CEO shall designate a staff person at his/her respective institution who shall be responsible for tracking DME issuance on the CDCR 7535, DME Order and Delivery Log.

(B) Receipt, refusal, or rescinding of DME and medical supplies shall be documented on a CDCR 7536 and shall be included in the health record.

(C) A separate copy of a CDCR 7536 shall be provided to the patient for each DME or medical supply provided.

(D) If a patient refuses DME, the staff that delivers the DME shall make a referral to the requesting provider for the patient to be seen to determine and provide an appropriate interim accommodation if needed.

(E) Refusal of DME or medical supplies shall also be documented on a CDC 7225, Refusal of Examination and/or Treatment, at the time of the clinical encounter. The CDC 7225 shall reference the CDCR 7536 and shall be included in the health record.

(F) All patients that have been issued DME or medical supplies shall be advised to submit a CDCR 7362, Health Care Services Request Form, to discuss issues regarding the DME or medical supply.

(12) Damage To DME

(A) New DME received from a manufacturer that is found to be defective shall be returned to the manufacturer for replacement or repair in accordance with the manufacturer's warranty. If necessary, DME shall be issued on loan to the patient for the duration of the repair.

(B) Damage caused by the patient to DME

1. CCHCS staff shall determine whether DME should be repaired or replaced.
2. All patients shall be financially responsible for damage caused by personal neglect, misuse, or intentional destruction.
3. Repeated deliberate actions resulting in damage to the patient's DME will be treated as a refusal of that DME.

(C) Damage to DME by another inmate shall be the responsibility of the inmate who caused the damage according to established processes regarding destruction of property.

(D) CDCR shall accept liability for the loss or destruction of DME resulting from employee action as established in departmental policy and procedure.

(13) Maintenance of DME

(A) It is the joint responsibility of CDCR/CCHCS and the patient to maintain all DME in good repair and operation.

(B) When DME is in need of repair or replacement, the patient shall utilize approved CDCR procedures for notifying health care staff of health care needs. Health care staff shall ducat the patient for an appointment and evaluate the condition of the DME.

(C) Once the need for repair or replacement is verified and it is determined that neither staff nor in-prison, staff-supervised workers can appropriately repair the DME immediately, staff shall:

1. Arrange for the DME to be repaired while the patient retains possession, or
2. Issue appropriate replacement DME, or
3. Issue appropriate loaned DME while the patient's owned DME is being repaired, or
4. Provide another adequate accommodation.

(D) The patient shall not be financially responsible for necessary repair and replacement of DME and parts resulting from non-destructive treatment of this item.

(E) CCHCS shall maintain the appropriate service contracts for DME maintenance including wheelchairs.
(F) The CEO shall designate a staff person at his/her respective institution who shall be responsible to log each required wheelchair maintenance and repair request on the CDCR 7534, Wheelchair Maintenance Log.

(14) Change In Security Setting, Patient Misuse and/or Diversion

(A) Patients transferred or assigned to higher levels of security within the institution (Administrative Segregation, Security Housing Unit, Psychiatric Services Unit) shall be allowed to maintain possession of DME if it does not pose a threat to safety and security as determined by custody staff in accordance with applicable rules and regulations.
(B) Any confiscation of DME by custody staff will require notification and approval by the Warden and CEO via the chain of command. The decision to confiscate an item of DME shall be documented in the health record and the Central File.
(C) Custody staff shall inform health care staff of any patients with medically prescribed DME being placed in higher levels of security if there is a security risk with the DME.
(D) DME shall be removed from a patient only to ensure the safety of persons, the security of the institution, or to assist in an investigation and only when supported by documented evidence.
1. DME shall only be removed for as long as the DME continues to pose a direct threat to safety and security.
2. DME shall not be removed from a patient because of the acts of another inmate.

(E) If the DME presents a direct and immediate threat to safety and security, the DME may be removed from a patient immediately by any custody staff.
1. DME shall only be removed for as long as the DME continues to pose a direct threat to safety and security.
2. The decision to remove DME from a patient admitted to the Mental Health Crisis Bed shall include the mental health clinician in accordance with Mental Health Program policy.

(F) When DME is taken away from a patient for reasons of safety and security:
1. The senior custody officer in charge shall immediately consult the CME or designee regarding the patient's need for the DME and reasonable alternative in-cell accommodations.
2. Health care staff shall review the health record to determine if there is a temporary alternative to the DME and shall advise custody staff of any contraindications to removing the DME.
3. The senior custody officer in charge shall inform the Warden or designee of the determination and the alternative means to accommodate the patient.
4. The Warden, or designee, shall decide what course to take regarding the removal of the patient’s DME and shall provide alternative in-cell accommodation.

(G) If custody staff decides to retain the DME, it will be stored in a designated location in the unit and provided to the patient if needed when released from his or her cell for yard, escorts, visits, etc.
1. During the period of alternative in-cell accommodation, health care staff shall regularly observe the patient’s health condition and document observed changes in the health record.
2. If evidence of deteriorating health condition is observed, health care staff shall immediately advise custody staff of a need for medically necessary changes to the in-cell care.
3. Alternative DME or removal of DME shall be documented in the health record.

(15) Patient Release or Parole

(A) The CCHCS shall provide 30 days of prescribed medical supplies upon release or parole. Prescribed medical supplies include, but are not limited to:
1. Glucometer supplies
2. Tracheostomy supplies
3. Colostomy supplies
4. Urinary catheters
5. Material for dressing changes

(B) When DME is patient owned property, it shall accompany the patient upon release or parole.
(C) DME that is loaned or issued to the patient shall accompany the patient upon release or parole, unless a PCP determines at the time of the release or parole that the DME is no longer medically necessary.

(D) Pre-ordered DME received by the institution after the patient is paroled shall be forwarded to the parole unit supervising the parolee. CDCR shall make every reasonable attempt to deliver pre-ordered DME to patients who have been released from CDCR custody.

(16) Transfer to County Facilities or Other Outside Facilities

Medically necessary DME shall accompany patients when transferred to any outside facility for any reason and must accompany the patients upon return.

(f) Institution Local Operating Procedure

Institutions shall establish local operating procedures (LOPs) to implement the statewide procedure. Recommended elements of LOPs are provided in Appendix 1.

Appendices

- Appendix 1: Elements of Local Operating Procedure

References

- Code of Federal Regulations, Title 42, Chapter 7, Subchapter XVIII, Part E, Section 1395 x(n), Durable Medical Equipment
- Code of Federal Regulations, Title 45, Parts 160 and 164, Health Insurance Portability and Accountability Act
- California Civil Code, Division 1, Part 2.6, Section 56, *et seq.*, Confidentiality of Medical Information Act
- California Evidence Code, Division 9, Chapter 3, Section 1157
- California Code of Regulations, Title 15, Subchapter 2, Article 6, Section 3162, Legal Forms and Duplicating Services
- California Code of Regulations, Title 15, Chapter 2, Subchapter 2, Article 1, Section 3999.200, Provisions of Care and Treatment Exclusions
- California Code of Regulations, Title 15, Chapter 2, Article 1, Section 3999.98, Definitions
- California Code of Regulations, Title 15, Chapter 2, Subchapter 3, Article 9, Section 3999.395, Artificial Appliances
- California Code of Regulations, Title 22, Section 51160, Durable Medical Equipment
- California Code of Regulations, Title 22, Section 51161, Prosthetic and Orthotic Appliances
- California Code of Regulations, Title 22, Section 51162, Eyeglasses, Prosthetic Eyes, and Other Eye Appliances
- Armstrong Remedial Plan, *Armstrong vs. Newsom*, U.S. District Court of Northern California, Case No. C94-2307 CW, Amended January 3, 2001
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 41, Section 54010.5, Paper, Envelopes, and Stamps for Indigent Inmates
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 43, Inmate Property
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 43, Section 54030.6, Liability
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 43, Section 54030.13.1, Transfers

Revision History

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Appendix 1

Elements of Local Operating Procedure

Each institution shall develop and implement a Local Operating Procedure to incorporate the following sections of this procedure:

1. Section (c)(6), Institution Durable Medical Equipment (DME) Committee
   a. Define the membership of the Committee.
   b. Determine meeting frequency.
   c. Develop a local authorization process.
   d. Define the review process.
   e. Develop a process to forward the approved request to procurement.
2. Section (e)(1), Medical Supplies
   a. Define how medical supplies are requested.
   b. Designate who will distribute the supplies.
   c. Develop a timeframe for distribution of supplies - see Section (e)(6).
3. Section (e)(4), Durable Medical Equipment and Medical Supply Formulary
   a. Develop a local nonformulary request process.
   b. Develop a process for the provider to request nonformulary DME.
   c. Designate reviewers for approval.
   d. Develop an appeal process to the Headquarters DME Committee.
4. Section (e)(5), Procurement and Purchasing and Section (e)(6), Timeframes for Delivery of Prescribed DME and Medical Supplies
   a. Develop a process for ordering, procuring, and furnishing DME to patients.
   b. Determine the method of delivery for prescribed DME for patients returning from hospitals.
5. Section (e)(9), Inspection and Inventory
   a. Develop a schedule for custody to inspect DME on a regular basis.
   b. Custody to inspect wheelchairs monthly.
   c. Define a process for record keeping, including entering DME on patient's property card.
   d. Develop a system for tagging/identifying DME.
6. Section (e)(10), Temporary Loans of DME
   a. Develop a process to ensure loaned DME is returned to California Department of Corrections and Rehabilitation (CDCR) after the indication for the DME no longer exists.
   b. Determine an inspection process for return of loaned DME.
      Develop a process to determine the amount to charge for intentional damages, if any, and a method to convey this information to the inmate trust office.
7. Section (e)(11), Patient Receipt/Refusal/Rescinding of Medical Supplies and DME
   a. CEO to identify staff responsible to deliver DME and medical supplies, complete the CDCR 7536, Durable Medical Equipment and Medical Supply Receipt, and distribute copies appropriately.
   b. Define record keeping processes for the dates DME is issued to, rescinded from, returned by, or refused by patients.
   c. CEO to ensure the CDCR 7535, DME Order and Delivery Log, is maintained.

8. Section (e)(12), Damage to DME
   a. Determine if new DME is returned or replaced when under warranty.
   b. Develop a process to loan DME during repair or replacement.
   c. Develop a process to replace DME if loaned DME is found to be defective.
9. Section (e)(13), Maintenance of DME
   a. Develop a multi-disciplinary process including California Correctional Health Care Services (CCHCS), CDCR, and the patient to maintain DME.
   b. CCHCS to provide the contract for repair of DME or providing services at the institution.
   c. Custody to maintain a ducating system for DME repair.
   d. Develop a process for loaning wheelchairs during repair.
   e. CCHCS to provide the contract for repair and maintenance of wheelchairs.
   f. Custody to maintain a ducating system for wheelchair maintenance and repair.
   g. CEO to ensure the CDCR 7534, Wheelchair Maintenance Log, is maintained.
10. Section (e)(14), Change in Security Setting, Patient Misuse and/or Diversion
   a. Develop a process for custody staff to inform health care of the removal of DME.
   b. Define a procedure for providing alternative DME to the patient, if medically necessary.
11. Section (e)(15), Patient Release or Parole
   a. Develop a system to release patient-owned DME and/or 30 days' worth of prescribed medical supplies with a patient who is released or paroled.
12. Section (e)(16), Transfer to County Facilities or Other Outside Facilities
   a. Develop a system of inventorying and transferring DME with a patient to a county or other outside facility.
   b. Determine the process to ensure the DME returns with the patient to the institution.

Article 7 – Emergency Medical Response

3.7.1 Emergency Medical Response System

(a) Policy

California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) shall ensure that medically necessary emergency medical response, treatment, and transportation is available, and provided 24 hours per day to patients, employees, contract staff, volunteers, and visitors.

(1) It is the responsibility of CCHCS to plan, implement, and evaluate the Emergency Medical Response System (EMRS). The organized pattern of readiness and response services within CDCR is set forth in this policy. CDCR shall collaborate in the implementation of this policy by participating in drills and events.

(2) Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) treatment shall be provided consistent with the American Heart Association (AHA) guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care according to each individual's training, certification, and authorized scope of practice.

(3) BLS and ACLS shall be documented on the CDCR 7462, Cardiopulmonary Resuscitation Record.

(4) Trained CCHCS and CDCR staff or contractors shall perform the functions of First Aid, BLS, and ACLS.

(5) The standard guidelines for responding to emergencies are:

(A) The response time for BLS capable personnel (First Responders) shall not exceed four minutes (the First Responder Response Time).

(B) The response time for health care staff shall not exceed eight minutes (Health Care Staff Response Time).

(b) Purpose

The purpose of this policy is to standardize:

(1) The structure and organization of the CDCR EMRS facilities, equipment, and personnel training.

(2) Procedures for emergency medical response.

(3) Mechanisms for documentation, data management, medical oversight, and quality improvement activities.

(c) Responsibility

The Chief Executive Officer (CEO) and the Warden at each institution are responsible for implementation of this policy.

(d) General Requirements

(1) System Organization and Management

(A) Patients may request medical attention for urgent/emergent health care needs from any CDCR employee. The employee shall, in all instances, notify health care staff.

(B) Direct contact with the patient by a Registered Nurse (RN) or physician, either in person or by telephone, shall be provided for all patients requesting urgent/emergent medical attention or who are referred by staff. The RN or physician on duty shall choose one of the following options for evaluating the patient:

1. Arrange to have the patient brought to the clinic.
2. Arrange to have the patient brought to the Triage and Treatment Area (TTA).
3. Evaluate the patient in his/her housing unit or current location.
4. Talk directly to the patient via telephone, complete a telephone triage, and give direction to the patient for subsequent care.

(C) At least one RN shall be available onsite at each institution 24 hours a day, 7 days a week for emergency health care. During those hours in which a physician is not onsite, the highest priority for the RN shall be emergency care. A Provider On-Call (POC) or Medical Officer of the Day (MOD) shall be available 24 hours a day, 7 days a week to provide consultation and onsite care as necessary.

(D) TTAs, standby licensed emergency departments, and all clinical areas shall be properly staffed and equipped.

(E) Local Operating Procedures approved by the designated management team shall be in place for communications, response, evaluation, treatment, and transportation of patients, staff, and visitors.

(F) Community Emergency Medical Services responders have ready entry and ready exit into and out of the institution through the vehicle sally port and throughout the facility in order to access the patient.

(G) CCHCS shall maintain a system to manage and track physician and mid-level staff ACLS certification requirements.

(2) Facilities and Equipment
(A) Emergency equipment and supplies, emergency medical bags, oxygen and Automated External Defibrillators shall be maintained according to manufacturer's specifications and readily accessible to Health Care Staff in the TTA, all clinic areas, emergency medical response vehicles, and all other areas deemed appropriate by the CEO and the Warden in the institution.
(B) The location of the equipment shall be clearly identified by signage.
(C) The equipment shall be maintained, appropriately secured, and inventoried each shift.
(3) Personnel: Staffing and Training
(A) The CEO is responsible for assuring a system is in place to manage and track clinical staff BLS certification requirements.
(B) All correctional peace officers (custody) shall, within the previous two years, have successfully completed a course in CPR that is consistent with AHA guidelines. Custody staff shall maintain a system to manage and track correctional peace officers CPR requirements.
(C) For allied health care staff who have direct patient contact, BLS certification is recommended but not required.
(D) All health care staff with the exception of dental staff and Licensed Clinical Social Workers (LCSWs) shall, within the previous two years, have successfully completed a health care provider-level course in BLS that is consistent with the AHA guidelines. Psychologists who belong to the organized medical staff at their institutions and who have admitting privileges must also complete this course.
(E) Certification Requirements:
1. Dentists, dental hygienists, and dental assistants must provide proof of BLS certification which meets the requirements of their respective licensing board or committee.
2. Psychologists who do not have admitting privileges and LCSWs are not required to maintain BLS certification, although certification is recommended.
3. All primary care physicians and mid-level providers are required to obtain and maintain ACLS certification and submit proof of certification/recertification to institutional management and the headquarters credentialing unit.
4. Physicians and mid-level providers who are currently certified in ACLS are not required to have BLS certification.
5. Contract specialty consultants who may perform procedures requiring procedural sedation at CDCR institutions shall, within the last two years, have successfully completed a course in BLS that is consistent with the AHA guidelines. Proof of certification/recertification must be received by the CEO and the headquarters credentialing unit prior to the contract specialist's start date and/or prior to the expiration of the contract specialist's BLS certification.
(F) ACLS certification and maintenance of certification is desirable for the Supervising Registered Nurse in charge of the TTA, and TTA RNs.
(G) Nursing staff, based on their level of licensure and training, shall provide emergency care only under patient specific individual orders based on clinical indications. The orders may be given verbally or telephonically when the provider is not present.
(H) Nursing staff, based on their level of licensure and training, shall provide ACLS emergency care requiring cardiac rhythm interpretation only under orders of a provider who is at the scene and directly assessing the patient.
(4) Institutions shall conduct emergency medical response training drills and shall provide access to skills training on an ongoing basis pursuant to the Health Care Department Operations Manual, Section 3.7.2, Emergency Medical Response Training Drill and Nursing Skills Lab.

(e) Procedure Overview

Implementation of this procedure will ensure that medically necessary medical response, treatment, and transportation is available and provided 24 hours per day to patients, employees, contract staff, volunteers, and visitors.

(f) General Instructions

(1) All staff has the authority to initiate a 9-1-1 call for Emergency Medical Services (EMS).
(2) Any individual who encounters a medical emergency is responsible for summoning assistance by the most expeditious means available, e.g., personal alarm device, two-way radio, whistle, shouting, or telephone.

(3) Any patient may request medical attention for an urgent or emergent health care need from any CDCR or CCHCS employee. The employee shall in all instances notify health care staff without unreasonable delay.
(4) To efficiently activate a community EMS response and notify appropriate facility staff of a medical emergency, Local Operating Procedures (LOPs) shall identify a single point of contact for reporting medical emergencies and establish the mechanism to contact appropriate parties.
(5) Activation of the institutional Emergency Medical Response System and the community EMS system shall occur as necessary to ensure the most appropriate level of emergency medical care is available in the shortest time interval.
(6) Preservation of a crime scene shall not preclude or interfere with the delivery of emergency medical care. Preservation of life shall take precedence over the preservation of a crime scene.
(7) Custody requirements shall not unreasonably delay medical care during a medical emergency unless the safety of staff, patients, or the general public would be compromised.
(8) If a patient is unable to be resuscitated, the decision to terminate CPR shall be made by a physician or a mid-level provider, community EMS personnel, or by an RN if CPR was initiated for a patient who exhibits clear signs of death as described in Section (g)(2)(D)1. Pronouncement of death shall only be determined and made by a physician or a mid-level provider per LOP.

(g) Procedure

(1) Urgent Response, Treatment, and Transportation

(A) Upon notification or discovery of an urgent health care need, the staff member shall call the designated clinical area.
(B) The requesting staff member shall provide a brief description of the nature of the request to the clinical staff.
(C) Direct contact with the patient by licensed clinical staff shall occur in person or by phone and be provided for all patients requesting urgent medical attention.
(D) An RN, physician, or mid-level provider shall evaluate the patient's request by one of the following options:
1. Arrange to have the patient brought to the clinic.
2. Arrange to have the patient brought to the TTA.
3. Evaluate the patient in his/her housing unit or current location.
4. Talk directly to the patient via telephone and thoroughly document the encounter on Interdisciplinary Progress Note.
(E) The licensed clinical staff members shall document the evaluation in the health record using an appropriate form. Documentation of the encounter must clearly state the disposition and the rationale for the disposition decision.
(F) The RN, physician, or mid-level provider may direct other licensed staff to obtain vital signs and other clinical data and report the information to them.
(G) All urgent encounters resolved in the yard or yard clinic after hours shall be documented on an Interdisciplinary Progress Note, and discussed by the Primary Care Team the following business day.
(H) All dispositions for urgent conditions shall be made at the RN level of licensure or higher.

(2) Emergency Medical Response

(A) A First Responder (FR) shall evaluate the situation and initiate appropriate first aid and/or BLS measures, including establishing airway, breathing, circulation, controlling bleeding, and administering CPR. The FR shall also:
1. Briefly evaluate the patient and situation, then immediately notify health care staff of a possible medical emergency, and summon the appropriate level of assistance.
2. Inform the health care staff of the general nature of the emergency including the general status of the patient. This may include whether the patient is conscious, breathing, bleeding, or other observable patient conditions and complaints.
3. Immediately initiate CPR if appropriate.
4. Initiate community EMS activation if necessary.
5. Clearly document the reason(s) if CPR is not initiated due to the condition of the patient.
(B) Custody Protocol
1. In medical emergencies, the primary objective is to preserve life. All peace officers who respond to a medical emergency shall provide immediate life support until medical staff arrives to continue life support measures. All peace officers must carry a personal CPR mouth shield at all times.

2. The peace officer must evaluate and ensure it is reasonably safe to perform life support by effecting the following actions:
   a. Sound an alarm (a personal alarm or, if one is not issued, an alarm based on the LOP must be used) to summon necessary personnel and/or additional custody personnel.
   b. Determine and respond appropriately to any risk of exposure to blood borne pathogens by adhering to standard precautions.
   c. Determine, isolate, contain, and control the emergency and significant security threats to self or others including any circumstances causing harm to the involved patient.
   d. Initiate life saving measures consistent with training.
3. The responding peace officer shall document on a CDCR 837, Crime/Incident Report, the decisions made regarding immediate life support and actions taken or not taken (Section (g)(2)(D)1), including cases where life support is not initiated consistent with training and/or situations which pose a significant threat to the officer or others.

(C) RN/Licensed Vocational Nurse (LVN)/Licensed Psychiatric Technician (PT) shall:
1. Respond as quickly as conditions permit to the scene of the medical emergency with an emergency medical response bag and Automated External Defibrillator (AED), and initiate and/or assist with CPR if indicated.
2. Make an initial assessment of the situation and determine whether a medical emergency is present.
3. Notify the TTA with relevant clinical information within eight minutes of the initial call for an emergency medical response if an RN is not already at the patient location.
4. The Health Care First Responder (HCFR) shall initiate community EMS activation if needed and not already completed by the FR.

In all cases, an RN or higher level of licensure shall be responsible for determining the disposition of the patient and communicating this information to the HCFR either in person or via radio/telephone.

(D) The HCFR shall begin appropriate medical treatment and assume responsibility for directing any medical care already in progress.
1. The HCFR shall determine if CPR is appropriate and continue CPR in the absence of:
   a. Rigor mortis.
   b. Dependent lividity.
   c. Tissue decomposition.
   d. Decapitation.
   e. Incineration.
2. If one or more of the above signs are present, then the HCFR shall determine the patient to be deceased. The official pronouncement of death is the responsibility of the physician or mid-level provider per LOP.
3. CDCR 7462, Cardiopulmonary Resuscitation Record:
   a. The CDCR 7462, Cardiopulmonary Resuscitation Record, shall be maintained on the emergency/crash cart for immediate access, and be completed by an RN or designee during a respiratory and/or cardiac arrest event.
   b. All drugs administered during the respiratory and/or cardiac arrest event shall be read back and documented by the recorder in the spaces provided on CDCR 7462, Cardiopulmonary Resuscitation Record, at the time of administration.
   c. All other resuscitative measures shall be read back and documented in the spaces provided on the CDCR 7462 as they occur.
   d. Names of the team members involved in the code shall be documented in the space provided. Sections of the CDCR 7462 that are not applicable to a specific patient shall be marked “N/A.”
   e. All team members involved in the code (e.g., Physician, RN, LVN) must sign the CDCR 7462 next to their name under the “Team Member” column.
4. Once started, CPR shall continue until:
   a. Resuscitative efforts are transferred to a rescuer of equal or higher level of training.
   b. The patient is determined by a physician or mid-level provider to be deceased.
   c. Effective spontaneous circulation and ventilation have been restored.
   d. Emergency responders are unable to continue because of exhaustion or safety and security of the rescuer or others is jeopardized.

e. A written, valid Do Not Resuscitate (DNR) order is presented. If there is any suspicion that a patient's cardiopulmonary arrest is not part of a natural or expected death (e.g., the patient's condition is a result of an attempted suicide), resuscitation efforts shall be continued regardless of the existence of a DNR, Physician's Orders for Life Sustaining Treatment, or Advance Directive to the contrary, and resuscitative efforts shall be commenced and continued until other indications to cease are present.
f. An RN determines that obvious signs of death are present (Section (g)(2)(D)1) and may direct that CPR be discontinued.

(3) Definitive Care and Patient Transportation

(A) Based on the patient's clinical condition and emergency situation, the RN and the Primary Care Provider shall be responsible for:
1. The continuation of medical treatment until community EMS responders arrive and assume care and transport the patient.
2. Directing the transportation of the patient to the nearest site equipped and staffed for definitive care.
3. Continuing treatment on location and directing EMS personnel to the scene, if clinically appropriate.

(B) Transportation Requirements
1. Patients shall only assist with transportation if they are part of the fire crew.
2. CDCR 7252, Request for Authorization of Temporary Removal for Medical Treatment, shall be initiated by health care staff and given to the designated custody representative (e.g., Associate Warden of Health Care, Watch Commander) for final completion and approval. After the form is completed it is forwarded to the custody transportation team.
3. The transport of a patient via code three ambulance shall not be unnecessarily delayed in order to complete the CDCR 7252 or to obtain other approvals from custody staff.
4. EMS personnel shall transport the patient to a community emergency facility according to local EMS agency policies and procedures.

(C) Notification
1. During regular business hours (Monday through Friday) the TTA RN shall notify the Chief Medical Executive (CME), or designee, and TTA Supervising RN, or designee, of the medical emergency transport and the circumstances of the transport as soon as possible. The Chief of Mental Health shall be notified of all suicides, suicide attempts, and possible overdoses that require medical emergency transport.
2. During non-business hours on evenings, nights, weekends, and holidays the TTA RN shall notify the institution MOD or POC as soon as possible to inform him or her of the patient status and transport decision. The MOD or POC shall notify the CME, or designee, by the next business day.
3. For patients transferred to a community emergency facility, the TTA provider or RN shall contact the receiving facility and provide a report, including available clinical information.

(4) Documentation

(A) General Requirements
1. The RN shall complete a CDCR 7219, Medical Report of Injury or Unusual Occurrence, for all work-related injuries or per custody requirements.
2. The HCFR shall document his/her findings and interventions on the CDCR 7463, First Medical Responder – Data Collection Tool, and sign this form.
3. In the event of a patient death and if CPR is not initiated by non-health care staff, then non-health care staff shall document the reason(s) on a CDCR 837-A-1, Crime/Incident Report Supplement.
4. The use of an AED shall be documented by a health care staff member. If the AED has download capability, the electronic information record shall be downloaded, printed, and added to the health record.
5. Notice of discharge of an AED shall be reported to the local county EMS utilizing the forms provided by that entity.
6. Documentation of any additional care and treatment provided by other clinical responders at the scene shall be completed on an Interdisciplinary Progress Note.
7. The emergency medical response documentation shall be signed, dated, and timed. All documentation shall be delivered to the TTA RN immediately at the time the patient arrives in the TTA or as soon as possible if the patient was transferred directly to a community emergency department.

8. The TTA RN shall contact the psychiatrist on duty regarding patients who present with self-inflicted injuries.

(B) TTA Documentation Requirements

1. A TTA Log shall be maintained in the TTA at each institution.
2. Care and treatment shall be documented on the CDCR 7464, Triage and Treatment Services Flow Sheet.
3. BLS and ACLS shall be documented on the CDCR 7462.
4. Care delivered pursuant to RN protocols shall be documented on the appropriate RN protocol forms.
5. On arrival at the TTA, the RN shall remain with the patient and continue monitoring the patient's status until any resuscitative efforts are terminated, or until emergency medical service personnel assume patient care. During this time, the RN shall record the following:
   a. Patient identification data (CDCR number, or, if unavailable, other identifying data).
   b. Description of initial events and patient presentation (patient location, position, and witness description of events).
   c. Times various treatments and procedures are rendered.
   d. Name and title of the RN, name and title of the person to whom the patient is transferred, the date and time of the transfer, and the RN's signature.
6. TTA staff shall attach all relevant documentation to the CDCR 7464 for inclusion in the health record.

(C) Transport Documentation Requirements

1. Copies of the CDCR 7464, Triage and Treatment Services Flow Sheet, CDCR 7462 if applicable, and all attachments shall be provided to the emergency medical service transport staff if the patient is sent out of the institution.
2. CDCR 7252.
3. Sally port officers are to maintain a standardized log of all emergency vehicle traffic entrances and exits, including times.

References

- California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 3, Article 6, Section 3999.67, Dental Care
- Health Care Department Operations Manual, Chapter 3, Article 7, Section 3.7.2, Emergency Medical Response Training Drill and Nursing Skills Lab
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 10, Suicide Prevention and Response
- California Department of Corrections and Rehabilitation, Emergency Alarm Response Plan
- American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

Revision History

Effective: 08/2008
Revised: 07/2012

3.7.2 Emergency Medical Response Training Drill Nursing Skills Lab

(a) Policy

California Department of Corrections and Rehabilitation and California Correctional Health Care Services shall maintain a procedure for emergency medical response training drills. Emergency medical response training drills shall be conducted at least quarterly and on each shift. Access shall be provided to clinical skills labs at least quarterly.

(b) Purpose

Implementation of this policy shall ensure:

(1) Institutional staff is properly trained in the management of medical emergencies.
(2) Registered Nurse competency in performance of clinical skills in all applicable nursing protocols.
(3) Identified deficiencies are remedied.

(c) Responsibility

The Chief Executive Officer (CEO) and the Warden are responsible for ensuring staff is properly trained in the management of medical emergencies and emergency medical response drills are conducted at least quarterly.

(d) Frequency of Drills

Emergency medical response training drills shall be conducted at least quarterly and on each shift.

(1) The drills shall address responses to medical emergencies in all areas of the institution and include participation of health care and custody staff.
(2) Emergency medical response program staff shall conduct drills in all dental clinics a minimum of once per year.
(3) The drills may or may not be pre-announced and shall be conducted under varied conditions.
(4) Each form required for medical emergency drills shall be completed.

(e) Procedure Overview

Implementation of this procedure shall ensure:

(1) Institutional staff is properly trained according to emergency medical response guidelines.
(2) Nursing staff is properly trained in nursing skills lab procedures.

(f) Procedure

(1) Emergency Medical Response Training Drills

(A) The Chief Medical Executive (CME), or designee, the Supervising Dentist, or designee, the Chief Nurse Executive/Director of Nursing (CNE/DON), or designee, the CEO, the Health Care Associate Warden, and the Warden, or designee, shall determine the location, time, and scenario of the drill.
(B) The CME, or designee, is responsible for advising and coordinating with the Warden, the Supervising Dentist, and the Chief of Mental Health in advance of the scheduled drill.
(C) The Chief of Mental Health, or designee, is responsible for advising the mental health staff of the impending drill and to ensure staff participation.
(D) The Supervising Dentist, or designee, is responsible for advising the dental staff of the impending drill and to ensure staff participation.
(E) The CEO or Warden, or designee. is responsible for setting up and maintaining control of the proper cardiopulmonary resuscitation mannequins and/or other necessary emergency medical response equipment at the designated drill location.
(F) Institutional staff is required to respond immediately to all emergency medical response drills within their designated area.
(G) Once the drill is initiated and staff is gathered, the CNE/DON, CME, or designee, shall read the drill scenario to the staff participants. The participants shall respond to the scenario as if they are responding to an actual emergency situation.
(H) The custody, medical, or nursing designee shall ensure that the designated supervisor in charge of monitoring the drill utilizes and submits all appropriate forms.
(I) Documentation required in an actual emergency situation shall be completed during the drill scenario.
(J) Immediately following the drill, the drill coordinator shall conduct a debriefing to allow the participants to evaluate their performance, incorporate lessons learned, and discuss any additional steps or components necessary to remedy identified deficiencies.

(K) The drill coordinator shall submit a report to the committee designated to review emergency medical response events. The report shall include, but is not limited to, the following:
1. Synopsis of the event
2. Date and time of the drill
3. Drill location
4. Participants involved
5. Time frames of all elements, e.g., response time from medical/custody
6. Areas identified as positive or appropriate interventions
7. Recommendations on areas needing improvement or training
8. Development of a corrective action plan

(2) Nursing Skills Lab

(A) The nurse instructor shall ensure that emergency medical response skills labs are scheduled on the education calendar and all nurses have the opportunity to participate in the skills training.

(B) A lab facilitator who may be the nurse instructor, supervising nurse, or other identified staff member shall be available during designated lab hours.

(C) Documentation of the skills lab training and/or remedial training provided shall be completed on the in-service training form.

(D) All skills lab training forms, materials, and documentation shall be maintained and tracked by the nurse instructor or designee.

Revision History
Effective: 08/2008
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3.8.7 Tuberculosis Surveillance Program

(a) Procedure Overview

(1) California Correctional Health Care Services (CCHCS) and the California Department of Corrections and Rehabilitation (CDCR) has adopted guidelines for the assessment, screening, treatment, and containment of Tuberculosis (TB) in the correctional setting. These guidelines are consistent with community standards and the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

(2) As required by Penal Code Sections 7570 to 7576, CCHCS has developed this procedure to ensure that all patients receive the required annual TB surveillance, testing, education, and medically necessary treatment consistent with the CCHCS TB Surveillance Care Guide, community standards, and the recommendations of the ATS and CDC.

(b) Responsibility

(1) Statewide

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 TB Surveillance Program is successfully implemented and maintained.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the TB Surveillance Program at the institution and patient panel level. The CEO delegates decision-making authority to the Chief Medical Executive (CME) and the Chief Nurse Executive (CNE) for daily operations of the TB Surveillance Program and ensures adequate resources are deployed to support the system including, but not limited to, the following:

1. Ensuring access to and utilization of equipment, supplies, health information systems, Patient Registries and other patient care tools, and evidence-based guidelines.
2. Ensuring new Care Team members including other health care staff with a role in TB surveillance are adequately prepared to assume team roles and responsibilities in the TB Surveillance Program.
3. Assessing competence of existing Care Team members including other health care staff with a role in TB surveillance.
4. Providing updated procedures, roles, and responsibilities as new tools and technology become available.
5. Ensuring that institutional leadership, in consultation with the CCHCS Public Health Branch (PHB), develops a Local Operating Procedure (LOP) to address the local implementation of the TB Surveillance Program within their institution.
6. Implementing a quarterly review of all patients housed at the institution to ensure that each patient is participating in the TB Surveillance Program.

(B) The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(C) The CNE is responsible for the overall daily operations, oversight, and management of the TB Surveillance Program, processes, and resources including personnel. The CNE shall ensure that the institution's Public Health Nurse (PHN) participates in all aspects of the TB Surveillance Program as described in the procedure below.

(D) The institutional PHN, in conjunction with the responsible local Health Officer and/or designee, shall act as the liaison between the institution and the CCHCS PHB for coordination of implementation and operational strategies, questions, and concerns.

(E) The CNE and CME, or their designees, shall meet to review the Care Teams' performance including the overall quality of TB Surveillance Program services provided and shall utilize Dashboards, Patient Registries, Patient Summaries, and other patient care and decision support tools to address or elevate issues as necessary.

(c) Procedure

(1) Reception Centers

(A) Upon arrival to CDCR, patients shall be evaluated and tested for TB.

1. Patients shall be immediately screened for TB symptoms upon arrival at the Reception Center (RC) as part of the RC screening process using the Initial Health Screening PowerForm and the TB Screening/Evaluation Report PowerForm in the Electronic Health Record System (EHRS). The CDCR 7277, Initial Health Screening (All Institutions), and CDCR 7331, Tuberculin Screening/Evaluation Report, paper forms shall be used during EHRS downtime periods to document symptom screening and health record review.
   a. Either the PHN, Registered Nurse (RN), Licensed Vocational Nurse (LVN), or the Psychiatric Technician (PT) shall:
      1) Question the patient about TB symptoms one at a time.
      2) Listen actively.
      3) Prompt the patient for additional information, if necessary.
      4) Allow time for questions.
      5) Refer to an RN or health care clinician if the patient has any TB disease.
2. Symptoms Present
   Patients with signs or symptoms of TB (regardless of any past Interferon-Gamma Release Assay Test [IGRA] test or TST result) shall wear a surgical mask and be sent to the Triage and Treatment Area (TTA) to be evaluated for active TB disease. The workup shall include a medical evaluation and, if clinically indicated, a chest X-Ray (CXR) and sputum smears and cultures for Acid-Fast Bacilli (AFB) (refer to the current CCHCS Care Guide: Tuberculosis-Surveillance for details).
3. Asymptomatic Patients
   a. Patients with a prior negative IGRA test, negative TST, or unknown or inadequate documentation of TB infection status shall have an IGRA test drawn at the RC.
   b. An IGRA test is not indicated for patients with documented:
      1) History of an IGRA test interpreted as positive.
      2) TST with mm reading interpreted as positive at any time in the past.
      3) TST < 5 mm in the past 30 days; with a high risk condition.
      4) TST < 10 mm in past 30 days; without a high risk condition.
4. HIV Infected
   a. Asymptomatic patients known to be HIV infected shall also receive a CXR within 72 hours of arrival unless their records contain documentation of a normal or stable CXR within the preceding 30 days. The CXR should be read within 24 hours.
   b. Any HIV infected patient with a CXR abnormality that cannot be documented as stable for 60 or more days by previous records (with the exception of an isolated calcified granuloma or apical pleural thickening), shall be isolated and evaluated by a clinician even if asymptomatic.

(B) Workup for Positive Tests

Patients with signs or symptoms of TB shall have a workup as follows:

1. A CXR shall be completed to assess for radiographic evidence of active TB disease within 72 hours for patients with the following:
   a. New positive IGRA test result.
   b. TST 5-9 mm result, with high risk condition.
   c. TST ≥ 10 mm, with or without high risk condition.
2. A High Risk Condition is:
   a. HIV infected or has an unknown HIV infection status.
   b. Has an organ transplant and is on transplant immunosuppression or is otherwise immunosuppressed; examples include, but are not limited to:
      1) Receiving the equivalent of ≥ 15 mg/day of prednisone for ≥ one month.
      2) Chemotherapy for cancer.
      3) TNF alpha antagonists.
3. After TB disease is ruled out by a CXR and a physical assessment by a health care provider, treatment for latent TB infection should be considered.

CXR for Asymptomatic Patient with No Known History of TB disease

TST (mm)	HIGH RISK CONDITION	CXR RECOMMENDATION
0 - ≤ 4 mm	Not applicable	NO
5 - 9 mm	YES	YES
5 - 9 mm	NO	NO
≥ 10 mm	Not applicable	YES

(C) Evaluation for CXR Findings Consistent with Active TB Disease

1. Patients with an abnormal CXR consistent with TB or if the CXR is normal but the patient has symptoms consistent with TB, the patient should wear a surgical mask and be sent to the TTA to be evaluated for TB disease.
2. Treatment for latent TB infection should be delayed until TB disease has been ruled out.
3. Sputum specimens for AFB smear and culture should be obtained even when the radiographic abnormalities appear stable (excluding isolated calcified granulomas and apical pleural thickening).
4. Treatment for latent TB infection should not be initiated until three culture results are documented as negative for TB disease.

(D) Documented Prior Positive IGRA Test or Prior Positive TST

Patients with written documentation of a positive IGRA test or a positive TST with a written record of a mm read and a positive interpretation (≥5 mm with risk factors or ≥10 mm without risk factors) shall:

1. Within 72 hours of arrival at an RC, have a CXR and further workup as clinically indicated to rule-out TB disease before being encouraged to accept latent TB infection treatment.
2. Have a repeat CXR, if the prior CXR was taken more than six months before entry or re-entry into CDCR.
3. Be encouraged to accept treatment for latent TB infection if there is no documentation of treatment or if previous treatment was incomplete or inadequate.

(E) Documented Prior TB Disease

Patients with a history of prior TB disease shall be evaluated by a health care provider, and should have a baseline CXR.

(2) Interfacility Transfers

(A) Patients arriving at a CDCR institution shall immediately receive TB symptom screening pursuant to Section (c)(1)(A)1.a above to evaluate for TB disease as part of the transfer screening process.

1. This includes patients who are transferred between CDCR institutions, who return from out-to-court, who return from a higher level of care, or who are short stay (enroute/layover) patients with no known recent exposure to an active TB patient.
2. All Category "S" patients shall be evaluated and screened for symptoms of TB disease.
3. Patients transferring to/from Department of State Hospitals facilities shall have a symptom screening for TB disease only.

(B) Patients who exhibit signs or symptoms of TB disease during the screening/evaluation process shall wear a surgical mask and be referred to the TTA to be evaluated for TB disease.

(C) The results of the TB symptom screening shall be recorded on the Initial Health Screening PowerForm in EHRS.

(3) Annual and other Periodic Screening

(A) Patients housed in a CDCR facility shall receive a TB evaluation annually. The type of evaluation shall be based on the TB status of the patient. In addition, the patient may receive periodic screenings based on the status of the TB infection treatment of the patient. All patients, regardless of their TB status shall be screened for signs and symptoms of TB disease pursuant to Section (c)(1)(A)1.a above unless they have had a symptom screening for TB disease within the past 30 calendar days.

(B) The following processes shall be used for conducting annual TB evaluations. Each institution shall develop an LOP to implement the tasks below if necessitated by institutional or operational needs (e.g., physical plant, staffing or other factors such as oversight of Fire Camps or Modified Community Correctional Facilities).

1. The PHN or RN shall review the Quality Management (QM) TB registry at least monthly and determine which patients are due or overdue for their annual TB evaluation.
2. The Nursing Supervisor shall coordinate with the Care Team(s) to ensure that all patients who are due or overdue for an annual (or periodic) TB evaluation are scheduled for the appropriate screening (refer to Appendix 1).
   a. An LVN or PT may screen patients who have no history of a TB infection or who have completed a full course of treatment for TB infection. The evaluation consists of a thorough TB symptom screen for TB disease pursuant to Section (c)(1)(A)1.a above.
   b. An RN or PHN shall evaluate patients with TB infections who have not been treated, patients currently on treatment for TB infection, patients currently on treatment for TB disease, and patients who have completed treatment for TB disease.
      1) TB symptom screening and education tailored to the patient's TB status shall be provided.
         a) All patients shall be educated about TB infection and disease.
         b) Patients with untreated TB infection shall be encouraged to initiate and complete treatment for TB infection and encouraged to seek medical attention if they develop symptoms of TB disease.
         c) Patients on treatment for TB infection shall be encouraged to complete the full course of treatment, advised about possible side effects of treatment, and encouraged to seek medical attention if they develop symptoms of TB disease or possible side effects.
         d) Patients on treatment for TB disease shall be encouraged to complete the course of treatment, advised about possible side effects of treatment, and encouraged to seek medical attention if they develop side effects.
         e) Education provided shall be documented in the health record.
      2) If during the patient education session the patient agrees to begin treatment for TB infection, the RN shall notify the PHN of the patient's decision on the same day the decision is made. The patient shall be referred by the RN to the Care Team Primary Care Provider (PCP) within seven calendar days for evaluation and initiation of treatment for TB infection treatment. The PHN shall monitor the patient's care to ensure the referral and evaluation by the Care Team PCP occurs within seven calendar days.
   c. Patients who exhibit signs or symptoms of TB disease during the screening/evaluation process shall wear a surgical mask and be referred to the TTA to be evaluated by a provider for TB disease.
   d. The results of the TB screening shall be documented in the health record.

(4) Monitoring and Sustainability

(A) Institution leadership shall designate a standing committee that reports to the local QM Committee for oversight of the TB Surveillance Program activities.

(B) The CEO and institution leadership team shall establish an ongoing monitoring program to periodically assess the quality of the TB Surveillance Program and adherence to this procedure including, but not limited to:

1. Ensuring that each Care Team discusses surveillance program activities in the Population Management Working Sessions at least monthly.
2. Verifying accuracy and efficacy of patient case management and appointment strategies.
3. Monitoring compliance rates with required screening intervals based on patient TB risk levels.
4. Ensuring documentation of TB Surveillance activities and necessary follow-up.
5. Monitoring quality and documentation of patient education.
6. Ensuring inclusion of other team members/disciplines to manage patient care and compliance.
7. Reviewing information flow relative to required screening, referrals, and follow-up visits.
8. Monitoring adverse events linked to TB Surveillance Program processes described in this procedure.
9. Identifying and addressing barriers.

(5) Training and Decision Support

The CEO and institution leadership team shall establish an orientation and training program to ensure that all staff serving as members of a Care Team or supporting Care Team functions, including other health care staff with a role in TB surveillance, fully understand their roles and responsibilities prior to assuming their duties. Requirements of the training program shall include, but are not limited to:

(A) Adhering to expectations in this procedure.

(B) Monitoring national health care industry advances pertinent to the TB Surveillance Program.
(C) Following new information systems or technology that may increase the efficiency or effectiveness of the TB Surveillance Program.
(D) Monitoring updates in clinical practice, including new or revised CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
(E) Identifying and addressing additional training needs.
(F) Specific clinical training shall also include, but is not limited to:
1. Training RNs, LVNs, and PTs to be competent in:
   a. Performing a TB symptom screen of patients and documenting in the Health Record.
   b. Locating IGRA blood test results in EHRS. Patients with a positive IGRA blood test should have LTBI listed on the Problem List in EHRS. Upon LTBI treatment completion, LTBI, Resolved shall be documented on the Problem List in EHRS.
   c. Administering and measuring TSTs for patients in accordance with the CCHCS TB Surveillance Care Guide and documenting the results in the health record.
   d. Administering medication to patients on treatment for TB disease or TB infection.
2. RNs and PHNs shall also be competent in:
   a. Ensuring that patients are screened yearly in accordance with the CCHCS TB Surveillance Care Guide.
   b. Performing record reviews and accurately documenting previous TB testing and TB diagnoses in the health record.
   c. Educating patients regarding the importance of LTBI treatment for TB infection.
   d. Educating patients regarding the importance of treatment for TB disease.

Appendices
- Appendix 1: TB Screening and Evaluation Matrix

References
- California Health and Safety Code, Division 105, Part 5, Chapter 1, Sections 121361-121375
- California Penal Code, Part 3, Title 8.7, Examination of Inmates and Wards for Tuberculosis, Sections 7570-7576.
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79805, Inmate-Patient Health Record Content
- California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Sections 2500-2505
- Centers for Disease Control and Prevention, Division of Tuberculosis Elimination
- Centers for Disease Control and Prevention, Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC (July 7, 2006): https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm
- Centers for Disease Control and Prevention, Tuberculosis Fact Sheets, Tuberculin Skin Testing: https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
- American Thoracic Society: https://www.cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.8, Reception Center
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.9, Health Care Transfer
- CCHCS Care Guide: Tuberculosis-Surveillance
- CCHCS Care Guide: Tuberculosis Diagnosis and Isolation
- CCHCS Care Guide: Tuberculosis Disease
- CCHCS Care Guide: TB Infection Management
- CCHCS Care Guide: TB Contact Investigation

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Appendix 1

TB Screening and Evaluation Matrix

Cohort	TB Risk	Screening Type	Screening Location	Screening Frequency	Staff
Not infected	Low risk	Signs and symptoms review	Yard clinic or preventive care clinic	Yearly	LVN or PT
Infected, Completed LTBI treatment	Low risk	Signs and symptoms review	Yard clinic or preventive care clinic	Yearly	LVN or PT
Completed treatment for active TB	Low risk	Signs and symptoms review Health record review	Clinic	Yearly	RN or PHN
On LTBI or TB treatment	Low risk – if case managed	Case Management:-Signs and symptoms review -TB/LTBI education -TB/LTBI medication administration -Patient assessment -PHN notified at beginning of treatment	Clinic	Depends on treatment regimen	PHN or RN
Remote infection (> 2 years) Not treated	Medium risk	Signs and symptoms review TB/LTBI education	Clinic	Yearly	RN or PHN
Recently infected (≤ 2 years) Not treated	High risk	Case Management: -Signs and symptoms review -TB/LTBI education -PHN notified at beginning of treatment	Clinic	Every month	PHN or RN
		CXR every 6 months x 24 months	Clinic	Every 6 months x 24 months	

3.8.8 Communicating Precautions from Health Care Staff to Custody Staff

(a) Policy

(1) Health care staff shall communicate to custody the appropriate form of precautions to be used when dealing with a single patient or a small cluster of patients who have contracted certain communicable diseases. Staff shall use either the correctional standard precautions or the transmission-based precautions.

(2) When a patient has an infectious disease that is easily transmitted person-to-person but transmission-based precautions are not required (e.g., norovirus or Staphylococcus aureus infections), health care staff shall communicate the need for correctional standard precautions to custody staff.

(3) When a patient needs transmission-based precautions (in addition to correctional standard precautions), health care staff shall communicate the need for transmission-based precautions to custody staff.

(b) Purpose

To ensure both custody and health care staff are appropriately protected from communicable diseases by communicating the type of precautions required when patients have certain communicable diseases.

(c) Responsibility

The Chief Executive Officer and Warden at each institution are responsible for enforcement and implementation of this policy and procedure.

(d) Procedure

(1) Health care staff at California Department of Corrections and Rehabilitation (CDCR) institutions regularly consults with the California Correctional Health Care Services (CCHCS) Public Health Branch (PHB) about the prevention and control of infectious diseases in CDCR institutions. PHB follows national guidelines when consulted about the use of precautions to prevent the transmission of infectious diseases.

(2) PHB recommends categories of precaution for specific diseases and conditions based on Federal Bureau of Prisons (BOP) guidelines. The categories are standard, contact, droplet, and airborne.

(3) The California Department of Public Health recommends that when BOP does not have a precaution guideline for a specific disease or condition, PHB follows the Centers for Disease Control and Prevention, Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. These are evidence-based guidelines developed by an expert panel.

(4) The BOP advises that all correctional institutions follow Correctional Standard Precautions when interacting with all inmates whether or not they have been diagnosed with a specific condition, and when interacting with patients with known bloodborne pathogen infections (e.g., hepatitis B or human immunodeficiency virus infections).

(e) Procedure

(1) **Medical Classification Chrono**

(A) Health care staff shall use the Medical Classification Chrono (MCC) to communicate the need for transmission-based precautions to custody staff.

1. To communicate transmission-based precautions, the Primary Care Provider (PCP) shall revise the patient's MCC in the following manner:
   a. Check the "Temp. Medical Isolation" box.
      1) When the PCP checks the "Temp. Medical Isolation" box, the form will default select the "Temp. Medical Hold", thereby placing the patient on a temporary medical hold.
      2) If the PCP decides a patient who needs transmission-based precautions can move to another institution, the PCP shall:
         a) Deselect the "Temp. Medical Hold" box (which is the default).
         b) Select the "Req. Medical Transport" box.
         c) Indicate the specific type of transmission-based precautions in the non-confidential comments section.
   b. In the non-confidential comments section, indicate the category of transmission-based precautions required for the patient.
      1) Few patients are expected to require all three transmission-based precautions at any one time.
         a) Refer to Appendix 1, Precautions for Frequently Encountered Infectious Diseases in CDCR Adult Institutions, for a list of precautions necessary for the common diseases which occur among patients (based on national evidence-based guidelines).
         b) The information on the table is provided for informational purposes only and is not meant to

be prescriptive.

c) The Chief Medical Executive or the PCP may deviate slightly from this table (e.g., require a higher level of precautions) based on clinical criteria or specific recommendations from either PHB or the local health department.

c. Indicate any change in the level of care based on the type of precaution.

1) PCPs shall select "OHU" or "CTC" for most patients with transmission-based precautions.

2) For patients who need special housing arrangements in general population (e.g., confined to cell, or to a special isolation area for patients with influenza), the PCP shall note the specific housing arrangement in the non-confidential comment section.

2. When the transmission-based precautions are no longer required, the PCP shall revise the MCC by deselecting "Temp. Medical Isolation" box and remove the type of precautions from the non-confidential comments section.

(2) **Notification**

(A) The Chief Executive Officer and the Warden at each institution shall disseminate the following information to clinical and custody staff:

1. Use of Standard Precautions and Transmission-Based Precautions in the Correctional Setting for the General Population (Appendix 2)
2. Contact Precautions Checklist (Appendix 3)
3. Droplet Precautions Checklist (Appendix 4)
4. Airborne Precautions Checklist (Appendix 5)

(B) Custody staff shall place signage regarding the patient's specific transmission-based precautions in the following manner:

a. At the cell door, bunk, or area of the housing unit where the patient is isolated for patients who are housed in general population.
b. In the transportation vehicle for those patients who are transported.

(C) Signage is not needed for correctional standard precautions.

(3) **Transportation Codes**

(A) All precautions link to the transportation coding system used by custody staff. Transportation codes correspond with patients' precaution requirements in the following manner:

1. Code 90 – Patient has not yet been medically assessed in the reception centers or is on a temporary medical hold as indicated on the MCC. This code indicates that staff shall follow transmission-based precautions.
2. Code 91 – Patient is on temporary medical isolation but is not on a temporary medical hold. This code indicates that staff shall follow transmission-based precautions.
3. Code 92 - No transmission-based precautions. This code indicates that staff shall follow correctional standard precautions.

(B) Designated administrative staff (not clinical staff) at each institution shall maintain the transportation codes.

Appendices

- Appendix 1: Precautions for Frequently Encountered Infectious Diseases in CDCR Adult Institutions
- Appendix 2: Use of Standard Precautions and Transmission-Based Precautions in the Correctional Setting for the General Population
- Appendix 3: Contact Precautions Checklist
- Appendix 4: Droplet Precautions Checklist
- Appendix 5: Airborne Precautions Checklist

References

- California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 4, Article 5, Section 1051, Communicable Diseases
- California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 4, Article 11, Section 1206.5, Management of Communicable Diseases in a Custody Setting

- California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 5, Article 8, Section 1410, Management of Communicable Diseases
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 7, Section 3340, Assistance to Inmates for Administrative Segregation Classification Hearings
- California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 2, Section 2520, Quarantine
- Federal Bureau of Prisons, Clinical Practice Guidelines, (Guidelines to Communicable Diseases including Isolation Precautions) http://www.bop.gov/resources/health_care_mngmt.jsp
- Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Revision History
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Appendix 1

Precautions for Frequently Encountered Infectious Diseases in California Department of Corrections and Rehabilitation Adult Institutions

Disease	CCHCS Practice	Number of Cases
1) Methicillin-resistant Staphylococcus aureus (MRSA), covered lesions	Standard for corrections	~18,000 (estimated)
2) MRSA, uncovered lesions or not covered adequately	Contact	unknown
3) Hepatitis C	Standard for corrections	~40,000 in population
4) Tuberculosis, pulmonary suspected	Airborne	~100/year
5) Influenza	Droplet, single cell or cohort	30 outbreaks/year (10-100 cases per outbreak)
6) Norovirus	Contact, single cell or cohort	31 outbreaks/year (20-200 cases per outbreak)
7) Lice/Scabies	Contact for the first 24 hrs of treatment	<10/year
8) Coccidioidomycosis (Valley Fever)	Standard for corrections	900/year
9) Chickenpox and Shingles, disseminated or in an immunocompromised host	Airborne and contact	40/year
10) Shingles, localized	Contact, single cell, but cohorting in a dorm setting permitted, on a case by case basis	80/year
11) Pertussis	Droplet	<5 /year
12) Human immunodeficiency virus	Standard for corrections	~6,000 in population

Appendix 2

Use of Standard Precautions and Transmission-Based Precautions in the Correctional Setting for the General Population[1]

		AND ADD -- TRANSMISSION-BASED PRECAUTIONS		
CONTROL MEASURE	**STANDARD PRECAUTIONS**	**CONTACT PRECAUTIONS**	**DROPLET PRECAUTIONS**	**AIRBORNE PRECAUTIONS**
Application of Precautions	Applies to all patients, regardless of suspected or confirmed infection status.	Applies to organisms spread by direct or indirect contact with patient or the patient's environment. • Infected blood or fluids enter through skin breaks of others; contaminated hands transmit from one patient to another; contaminated equipment and personal protective equipment (PPE) transmit pathogens to others.	Applies to organisms spread through close respiratory or mucous membrane contact with respiratory secretions. • Examples: spread when infected person coughs, sneezes, or talks, and organisms spread to mouth, eye, or nasal mucosa of others.	Applies to organisms (airborne particles) from infected person carried and dispersed over long distances by air currents. • May be inhaled by others who have not had face-to-face contact with infectious person.
Hand Washing	• Perform hand washing after touching blood, body fluids, secretions, excretions, and/or contaminated items; immediately after removing gloves; and between patient contacts. • Hands should be washed with soap and running water for at least 20 seconds when hands are visibly dirty and when there has been contact with blood or other body fluids (even if gloves have been worn). Other than the situations listed above, alcohol-based hand rubs can be used for routine hand hygiene.	• Perform before and after every contact with an infected patient. • Instruct and encourage patient to practice frequent hand washing. • Instruct on respiratory etiquette (e.g., cover your cough).	• Perform before and after every contact with an infected patient. • Instruct and encourage patient to practice frequent hand washing. • Instruct on respiratory etiquette (e.g., cover your cough).	• Perform before and after every contact with an infected patient. • Instruct and encourage patient to practice frequent hand washing. • Instruct on respiratory etiquette (e.g., cover your cough).

[1] **General Population: Refers to all correctional settings except health care settings.**

AND ADD -- TRANSMISSION-BASED PRECAUTIONS

CONTROL MEASURE	STANDARD PRECAUTIONS	CONTACT PRECAUTIONS	DROPLET PRECAUTIONS	AIRBORNE PRECAUTIONS
Personal Protective Equipment				
General Directions	• **Not routinely required**. • PPE is indicated only if contact with blood/body fluids likely (e.g., gloves to protect hands from contact, or mask, face/eye wear, and/or gowns to protect from sprays and splashes.	• **Routinely required.**	• **Routinely required.**	• **Routinely required.**
Gloves	• Use, clean, non-sterile gloves when touching blood, body fluids, secretions, excretions, and/or contaminated items; and for touching mucous membranes (e.g., eyes, nose, mouth, and non-intact skin.)	• Continue Standard Precautions. • Wear whenever touching patients' intact skin or touching contaminated surfaces near patient. Change gloves after contact with infective material. • Remove gloves before leaving patient's area and wash hands.	• Continue Standard Precautions. • Wear whenever touching patients' intact skin or touching contaminated surfaces near patient. Change gloves after contact with infective material. • Remove gloves before leaving patient's area and wash hands.	• Continue Standard Precautions. • Wear whenever touching patients' intact skin or touching contaminated surfaces near patient. Change gloves after contact with infective material. • Remove gloves before leaving patient's area and wash hands.
Gown	• During procedures and patient care activities when contact of clothing to exposed skin with blood, body fluids secretions, and excretions is anticipated.	• Wear whenever clothing will have direct contact with patient or contaminated surfaces.	• Wear whenever clothing will have direct contact with patient or contaminated surfaces.	• Wear whenever clothing will have direct contact with patient or contaminated surfaces.
Mask, eye protection (goggles), face shield	• During procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions; especially suctioning and endotracheal intubation.	• Use if contact with blood or infectious body fluid from sprays or splashes is likely.	• Don mask upon entry into patient room. Don eye protection depending on the organism. • Don eye protection during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions; especially suctioning and endotracheal intubation.	• Until patient is in an Airborne Infection Isolation Room (AIIR), place surgical mask on patient and N95 respirator on staff. • Staff to wear N95 respirator when in AIIR with patient.
Cardio-Pulmonary Resuscitation	• Use mouthpiece, resuscitation bag, other ventilation devised to prevent contact with mouth and oral secretions.	• Continue Standard Precautions.	• Continue Standard Precautions.	• Continue Standard Precautions.

AND ADD -- TRANSMISSION-BASED PRECAUTIONS

CONTROL MEASURE	STANDARD PRECAUTIONS	CONTACT PRECAUTIONS	DROPLET PRECAUTIONS	AIRBORNE PRECAUTIONS
Sharps	• Do not recap, bend, break, or hand manipulate used needles; if recapping is required, use a one-hand scoop technique only; use safety features available; place used sharps in leak-proof, puncture-resistant container.	• Continue Standard Precautions	• Continue Standard Precautions	• Continue Standard Precautions
Soiled Patient-care Equipment	• Handle in a manner that prevents transfer of microorganisms to others (minimum agitation) and to the environment; wear gloves if visibly contaminated; perform hand hygiene.	• Continue Standard Precautions, and safely handle contaminated patient-care equipment to prevent skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments. • Ensure that reusable equipment is decontaminated and reprocessed between each patient use. • Discard all single-use items properly • Promptly decontaminate reusable equipment if contaminated with infectious body fluids or visibly soiled.		
Laundry	• Collect at bedside. • If wet or soiled, handle as little as possible, and bag in a leak-proof bag at the location it was used, in accordance with local guidance on management of contaminated linens. • Machine wash and dry.	• Continue Standard Precautions. • **Linens**: Change linens every other day (more often if visibly soiled). Patient shall bag linen in the cell. Change towels and wash cloths daily. Machine wash and dry.	• Continue Standard Precautions. • Do not shake items or handle them in any way that may aerosolize infectious agents. • Avoid contact of one's body and personal clothing with soiled items being handled. • Contain soiled items in a dissolvable bag and place in a yellow bag prior to sending to laundry.	• Continue Standard Precautions. • Do not shake items or handle them in any way that may aerosolize infectious agents. • Avoid contact of one's body and personal clothing with soiled items being handled. • Contain soiled items in a dissolvable bag and place in a yellow bag prior to sending to laundry.

AND ADD -- TRANSMISSION-BASED PRECAUTIONS

CONTROL MEASURE	STANDARD PRECAUTIONS	CONTACT PRECAUTIONS	DROPLET PRECAUTIONS	AIRBORNE PRECAUTIONS
Sanitation: Environmental Control	• Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas. • Use an Environmental Protection Agency (EPA)-registered disinfectant. Use according to the manufacturer's instructions. All washable (non-porous) surfaces should be cleaned **during** and **after** (terminal) cell occupancy. Correctional workers should conduct sanitation inspections of living and bathroom areas to identify visibly dirty areas. Each institution should designate custody staff and supervisors to attend to this regularly. • Shared equipment, weight benches, or any other surface exposed to sweat should be disinfected *daily* and *routinely* wiped clean between users with a clean dry towel. Patients should use barriers to bare skin, such as a clean towel or clean shirt while using exercise equipment. Inmate work crews should be assigned to do this task regularly after specific training is furnished.	• Routinely clean all countertops, treatable surfaces per local schedule. Emphasis on frequently touched surfaces (i.e., door knobs, bed rails) and after any contamination with blood/body fluids. • Use an appropriate quaternary ammonium (chloride containing) disinfectant. • Ensure that patient care items and potentially contaminated surfaces are cleaned and disinfected after use. Barrier protective coverings, as appropriate, for surfaces touched frequently with gloved hands during patient care or may become contaminated with blood, body fluids, or are difficult to clean.	Routinely clean all countertops, treatable surfaces per local schedule. Emphasis on frequently touched surfaces (e.g., door knobs, bed rails) and after any contamination with blood or body fluids. • Use an appropriate quaternary ammonium (chloride containing) disinfectant. • Ensure that patient care items and potentially contaminated surfaces are cleaned and disinfected after use. Barrier protective coverings, as appropriate, for surfaces touched frequently with gloved hands during patient care or may become contaminated with blood/body fluids or are difficult to clean.	• Continue Standard Precautions.
Housing: Single cell	• **Single cell not routinely required**. • Place potentially infectious patients in a private room (in consultation with medical staff). Consider this for patients with poor hygiene practices. • In an outbreak situation, patients with the same infectious organism may be housed together. • Monitor patient hygienic practices particularly if mentally impaired. • Medical determines the appropriate housing for a patient with infections.	• **Single cell on a case-by-case basis.** • Patients should be kept separated ≥ 3 feet apart. • Continue Standard Precautions. • Patients with skin infections may be housed in general population if the wound drainage can be contained in a dressing and the patient is cooperative. • Patients with wounds that have significant drainage should generally be housed in a single cell.	• **Single room when available especially those who have a productive cough.** • Continue Standard Precautions. • Place together those who are infected with the same pathogen. Separate ≥ 3 feet from each other. • Patient must wear surgical mask upon exiting his/her cell and on transport. • Permit routine showering last.	• **Always single cell in an AIIR.** • Place in AIIR – that provides 6 to12 air exchanges per hour. Direct exhaust to outside; monitor air pressure daily. • When AIIR is not available, transfer to a facility with AIIR. • Patient must wear surgical mask upon exiting his/her cell and on transport. • Permit routine showering last.

AND ADD -- TRANSMISSION-BASED PRECAUTIONS

CONTROL MEASURE	STANDARD PRECAUTIONS	CONTACT PRECAUTIONS	DROPLET PRECAUTIONS	AIRBORNE PRECAUTIONS
Transfers	• Decision to transport on a case-by-case basis with concurrence from medical or public health. • In general, do not transfer patients with infectious diseases who require Contact, Droplet, or Airborne Precautions.	• If transfer is **required** for security or medical reasons the following procedures should be followed: • Wound should be dressed on the day of transfer with clean bandages; • Use contact precautions as described above (hand-washing, gloves if touching wound drainage and safe disposal of dressings) if soiling of security devices likely, use disposable restraints (if feasible), if not, decontaminate after use; and • Place clean sheet on cloth seats in vehicle (not needed if vinyl) and • Decontaminate, if visible contamination occurs.	• Limit transport on patients on droplet precautions to essential purposes, such as diagnostic and therapeutic procedures that cannot be performed in the patient's room. • When transport is necessary, have the patient and staff don a surgical mask. • Staff in close contact (≤3 feet) should wear surgical mask. • Notify healthcare personnel in the receiving area of the impending arrival to prepare for necessary precautions. • For patients being transported outside of the facility, inform the receiving facility and emergency vehicle personnel (transportation team) in advance about the type of Transmission-Based Precautions being used.	• Do not transport while contagious unless medically necessary or for security reasons. • Consult with medical prior to transport. • When transport is necessary, have the patient wear a surgical mask at all times. • Staff must wear a respirator (such as a N95 mask.) • Maximize air flow in the transport vehicle (if possible roll down windows to permit outside air exchange.)

Report to Medical: Correctional and Health Care staff should follow local procedures on reporting infections. Staff with suspected infections should report them to their supervisor.

Appendix 3

Transmission-Based Precautions for Use in the Correctional Setting for the General Population

CONTACT PRECAUTIONS CHECKLIST
The following information is to be used for Patients who require Contact Precautions:

Control Measure	Indicated	Additional Information
Hand Washing	Yes	• After touching blood, body fluids, secretions, excretions, contaminated items, and immediately after removing gloves. • Between patient contact.
Personal Protective Equipment (PPE)	Yes	• Contact Precautions apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. • Don gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. • Don mask and eye protection during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions; especially suctioning and endotracheal intubation.
Single Cell	Yes	• A single patient room is preferred for patients who require Contact Precautions. When a single room or cell is not available, consultation with the Public Health Section is recommended to assess the various risks associated with patient placement options (e.g., cohorting, keeping patient with an existing cellmate). • In dormitory settings ≥3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between infected patients.
Housing	Yes	• See single cell requirements.
Sanitation	Yes	• Instruct and encourage patient to practice frequent hand hygiene. • Implement strict glove use policy for all food preparation. • Increase frequency of cleaning public toilets. • Shower symptomatic patient last and bleach clean shower stalls after use. • When cleaning up vomit or feces: o Wear disposable gown, mask, gloves, and goggles. o Disinfect the contaminated area with an Environmental Protection Agency approved veridical agent or bleach. The contaminated area is a radius of 25 feet of the incident. o Dispose of gown, mask, and gloves in biohazard waste. o Wash hands. o Close or cordon off the contaminated area for at least one hour. o If possible, open windows to allow for thorough air circulation. • For cardiopulmonary resuscitation (CPR), use mouthpiece, resuscitation bag, or other ventilation device to prevent contact with mouth and oral secretions.
Laundry	Yes	• Follow Standard Precautions and handle laundry in a manner that prevents transfer of microorganisms to others and to the environment.
Activities	Yes	• Allow yard time for the sick. • Bleach-clean equipment and other frequently touched surfaces on the yard after use (e.g., water faucets and/or fountains).
Patient Hygiene	Yes	• Instruct and encourage patient to practice frequent hand hygiene.

Control Measure	Indicated	Additional Information
Equipment	Yes	• Bleach-clean yard equipment and other touched surfaces after use (e.g., water faucets and/or fountains).
Transports	Yes	• Limit transport for patients on contact precautions to essential purposes such as diagnostic and therapeutic procedures that cannot be performed in the patient's room. • When transport is necessary, use appropriate barriers. • Notify health care personnel in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission. • For patients being transported outside the facility, inform the receiving facility and the emergency vehicle personnel in advance about the type of Transmission-Based Precautions being used.

Appendix 4

Transmission-Based Precautions for Use in the Correctional Setting for the General Population

DROPLET PRECAUTIONS CHECKLIST

Control Measure	Indicated	Additional Information
Hand Washing	Yes	• After touching blood, body fluids, secretions, excretions, contaminated items, and immediately after removing gloves. • Between patient contacts.
Personal Protective Equipment (PPE)	Yes	• Follow Standard Precautions Guideline and: o Don mask upon entry into patient room. o Don eye protection during procedures, and patient care activities likely to generate splashes or sprays of blood, body fluids, and secretions; especially suctioning and endotracheal intubation.
Single Cell	Yes	• Single cell if available, especially those who have a productive cough. • Separate $\geq$ 3 feet from each other.
Housing	Yes	• Place together those who are infected with the same pathogen. • Separate $\geq$ 3 feet from each other.
Sanitation	Yes	• Instruct and encourage patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette. • For cardiopulmonary resuscitation (CPR), use mouthpiece, resuscitation bag, or other ventilation device to prevent contact with mouth and oral secretions.
Laundry	Yes	• Do not shake items or handle laundry in any way that may aerosolize infectious agents. • Avoid contact of one's body and personal clothing with the soiled items being handled. • Contain soiled items in a laundry bag or designated bin.
Activities	Yes	• Patient must wear mask upon exiting his or her cell. • Permit routine showering.
Patient Hygiene	Yes	• Instruct and encourage patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette.
Equipment	Yes	• Follow Standard Precautions and handle in a manner that prevents transfer of microorganisms to others (minimum agitation), and to the environment; wear gloves if there is visible contamination and perform hand hygiene.

Control Measure	Indicated	Additional Information
Transports	Yes	• Limit transport for patients on Droplet Precautions to essential purposes, such as diagnostic and therapeutic procedures that cannot be performed in the patient's room. • When transport is necessary, patient and staff must don a surgical mask. • Staff in close contact (≤3 feet) should wear surgical mask. • Notify health care personnel in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission. • For patients being transported outside the facility, inform the receiving facility and the emergency vehicle personnel (transportation team) in advance about the type of Transmission-Based Precautions being used.

Appendix 5

Transmission-Based Precautions for Use in the Correctional Setting for the General Population

AIRBORNE PRECAUTIONS CHECKLIST

Control Measure	Indicated	Additional Information
Hand Washing	Yes	• After touching blood, body fluids, secretions, excretions, contaminated items, and immediately after removing gloves. • Between patient contacts.
Personal Protective Equipment (PPE)	Yes	• Gloves when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. • Patient should wear surgical mask and staff should wear N95 respirator or powered air purified respirator.
Single Cell	Yes	• Always single cell in an airborne infection isolation room.
Housing	Yes	• Always single cell in a protective environment.
Sanitation	Yes	• Instruct and encourage patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette. • Use mouthpiece, resuscitation bag, or other ventilation device to prevent contact with mouth and oral secretions.
Laundry	Yes	• Do not shake items or handle laundry in any way that may cause infectious agents to become airborne. • Avoid contact of one's body and personal clothing with soiled items. • Contain soiled items in a laundry bag or designated bin.
Activities	Yes	• Patient must wear surgical mask upon exiting his or her cell.
Inmate Hygiene	Yes	• Instruct and encourage patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette.
Equipment	Yes	• Follow Standard Precautions and handle in a manner that prevents transfer of microorganisms to others (minimum agitation), and to the environment; wear gloves if visible contamination, and perform hand hygiene.
Transports	Yes	• Limit transport for patients on Airborne Precautions to essential purposes such as diagnostic and therapeutic procedures that cannot be performed in the patient's room. • When transport is necessary, use appropriate barriers on the patient. • Notify health care personnel in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission. • For patients being transported outside the facility, inform the receiving facility and the emergency vehicle personnel in advance about the type of Transmission-Based Precautions being used.

4.1.4 Foreign Body Examination

(a) Policy

California Correctional Health Care Services (CCHCS) medical providers shall order a medical imaging foreign body examination when medically necessary. Medical imaging staff shall use approved protocols corresponding to the anatomical area where the foreign body is suspected to be located.

(b) Purpose

To provide guidance to both medical and custody staff regarding how medical imaging examinations are to be ordered and performed in the event of a suspected foreign body.

(c) Responsibility

The Chief Executive Officer, or designee, is responsible for the implementation, monitoring, and evaluation of this policy.

(d) Procedure

(1) Prior to Examination

(A) The ordering medical provider shall create an order in the health record to request a foreign body examination. The order shall identify the anatomical area where the foreign body is believed to be located, a brief explanation of the item suspected, and circumstances of its insertion/ingestion.

(B) CDCR custody officers shall escort the patient to the local Medical Imaging Services department.

(2) Performing the Examination

(A) All clothing (except shorts) and jewelry shall be removed from the patient.

(B) The Radiologic Technologist (RT) shall place the patient onto the x-ray table according to the examination protocol for the suspected anatomical area.

(C) The RT shall perform the examination following the examination protocol and mark the examination as a STAT in the Radiology Information System and Picture Archiving Communication System (RIS/PACS).

(D) A patient may refuse a medical test (e.g., x-ray for contraband) when ordered or recommended by a medical provider. The refusal shall be documented in the health record.

(E) Custody staff may seek a court order for the patient to comply with the examination if the patient refuses the examination recommended by the medical provider or an examination was not ordered by a medical provider due to the absence of a medical indication for the study.

(F) Upon receipt of a copy of the court order for the examination, the CCHCS medical provider will order the requested examination.

(G) Refusal to comply with a court-ordered examination will be managed by custody staff. Medical staff will not perform a radiologic examination without the cooperation of the patient.

(3) Examination Interpretation

(A) Since the examination is marked as a STAT, the Radiologist shall have a final report available in the RIS/PACS within two business hours (between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday).

(B) In the event that the examination is performed outside of the Radiologist's business hours or an immediate interpretation is needed, the ordering medical provider shall provide a preliminary interpretation and complete a CDCR 7537, Preliminary Interpretation/Discrepancy Report.

(C) The ordering medical provider shall give a preliminary interpretation to the requesting custody staff, especially in cases where the patient has been detained (i.e., confined to a cell, placed in restraints), pending the Radiologist's interpretation.

(D) Any questions concerning the interpretation of the examination prior to the Radiologist's review must be directed to the reviewing medical provider. (No other staff member is authorized to provide an interpretation of the examination).

References

- California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 2, Article 2, Section 3999.210, Refusal of Treatment
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 19, Section 52050.20, Degrees and Types of Searches

- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 19, Section 52050.21, X-ray Examination
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 19, Section 52050.22, Forcible Retrieval
- Health Care Department Operations Manual, Chapter 4, Article 1, Section 4.1.5, Contraband Surveillance Watch

Revision History
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EXHIBIT 15

Governor's budget and provide a means to identify authorized staffing at the institution level.

Once completed the guidelines and institutions for use shall be distributed to each institution. Some training of users is anticipated.

51050.16 Revisions

The Deputy Director, Institutions Division, or designee, shall ensure that the contents of this section is accurate.

51050.17 References

PC § 5054.

ARTICLE 6 — DAILY ACTIVITY REPORT

Revised May 20, 1993

51060.1 Policy

Each Warden shall maintain a chronological log of unusual or significant occurrences regarding inmates and staff or other events about which facility management should be informed.

51060.2 Purpose

The purpose of this procedure is to establish guidelines for a comprehensive compilation of occurrences within the facility for review by administrative staff.

51060.3 Responsibility

The logging of all pertinent information shall be delegated to Watch Commanders on each shift.

51060.4 Recording Methods

Activities and events that are not otherwise recorded and readily available for review by administration and other staff, shall be recorded on the Daily Activity Report (DAR).

All staff working a particular shift or watch shall report through the chain of command all significant information pertaining to their assignment. This information shall be assembled on one report by watch, first watch through second and third watches.

51060.4.1 Content

Each facility/parole region shall develop a daily activities report form that will supply the information relative to their needs.

- Routine information that is readily available through log, records, etc., that can be obtained swiftly need not be included.
- Any information of unusual or significant events/actions shall be included.

The following items are examples of content only:

- Delays in count.
- Population changes.
- Accidents (any type).
- Any felony or serious misdemeanor occurrence.
- Delays in serving meals.
- Injuries to staff, visitors, or inmates.
- Sick leave usage (numbers of staff).
- Overtime usage.
- Inspection report.

51060.5 Distribution of Report

The Watch Commander shall prepare the DAR and adequate copies for distribution. The original report shall be retained in the Watch Office as a permanent log. A copy shall be forwarded to the Captain or the Associate Warden—Custody, and a copy shall be delivered to the Warden and Chief Deputy Warden. Other copies may be provided to staff based on the need of the facility.

The Captain or Associate Warden shall take whatever follow-up action is indicated in reference to items reported and shall report such actions to the Warden by 9:00 a.m. on the first day following the recording except on weekends and holidays.

The Watch Commander shall report significant occurrences to the Warden at any time through the normal chain of command or through the Administrative Officer-of-the-Day.

51060.6 Revisions

The Deputy Director, Institutions Division, or designee shall be responsible for ensuring that the contents of this article are kept current and accurate.

51060.7 References

PC §§ 5054 and 5058.

ARTICLE 7 — INMATE DEATHS, SERIOUS INJURY, OR ILLNESS NOTIFICATION

Revised September 8, 2008

Updated September 6, 2013

51070.1 Policy

The Department shall treat the death, serious injury, or serious illness of an inmate or parolee with dignity and respect as is regularly accorded persons who are not incarcerated or on parole. The procedures to be followed after death, serious injury, or illness shall comply with the requirements of all applicable laws.

51070.2 Purpose

The purpose of this Section is to outline the duties of all staff involved when a death, serious injury, or illness of an inmate/parolee occurs. For purposes of this Section, parolee is defined as: a parolee currently incarcerated in a CDCR facility pending a revocation action by the Board of Parole Hearings, or in a CDCR facility based substance abuse treatment program.

51070.3 Possible Death

An employee discovering a possible inmate/parolee death shall immediately summon medical assistance. Pending arrival of medical assistance, the employee shall make every effort to preserve life.

This may include first-aid, Cardio Pulmonary Resuscitation (CPR), and other life-saving measures for which the employee is trained. Life support measures shall be continued until the medical personnel arrive.

Medical personnel will continue life saving efforts unless one or more of the following signs of death are present. If one or more sign is present, the physician will determine if patient is deceased.

- Rigor mortis/dependent lividity.
- Tissue decomposition.
- Decapitation.
- Incineration.

Once started, CPR shall continue until:

- Resuscitation efforts are transferred to a rescuer of equal or higher level of training.
- The patient is determined to be deceased by an MD.
- Effective spontaneous circulation and ventilation have been restored.
- Emergency responders are unable to continue because of exhaustion or safety and security of the rescuer or others is jeopardized.
- A written valid Do Not Resuscitate order is presented.

If a medical officer is not present when the inmate dies, the medical personnel will, in addition to the above:

- Notify the Chief Medical Executive (CME), staff medical officer, or the Medical Officer-of-the-Day (MOD) as appropriate.
- Notify the supervising nurse on duty, or on call.
- Notify the senior custody officer on duty.

A physician shall examine the patient at the earliest possible moment to determine if the patient has expired.

51070.4 Pronouncement of Death

Only a doctor of medicine shall pronounce a person dead.

51070.5 Responsibility of Warden/Regional Parole Administrator (RPA)

The Warden/RPA or their designees shall:

- Effect all medical and legal requirements as soon as practicable.
- Ensure that all necessary requirements for care and maintenance of remains and artificial appliances following death are accomplished in accordance with instructions dictated by the appropriate coroner's office and this manual.

51070.6 Chief Medical Executive

Revised September 6, 2013

The CME or MOD on duty shall:

- Notify the watch commander or senior custody officer in the area of occurrence that the patient/victim has expired stating the time of death.
- Notify the coroner of the death and request their inquiry or release of the body.

A Master Pass List shall be prepared, audited, signed, and published from these requests by the Inmate Assignment Lieutenant.

52020.8.6 CDC Form 129, Inmate Pass

Staff shall ensure that all inmates listed on the master pass list receive a CDC Form 129, Inmate Pass. This pass shall be issued to individual inmates to authorize movement to specified locations at designated times.

Each institution/facility shall develop precautionary procedures to ensure blank CDC Form 129s are secured in areas not accessible to inmates.

Issuance to Inmates

CDC Form 129s shall be issued to inmates by housing unit staff by 2200 hours the day prior to the effective date on the pass. The CDC Form 129 shall contain the following information:

- Inmate's name and CDC number.
- Inmate's assigned housing.
- Date scheduled.
- Time scheduled.
- The destination.
- The arrival and departure time.
- The reason for the pass.

All non-priority pass forms shall be printed on plain white paper.

When unscheduled inmate movement is necessary, staff shall issue inmates a CDC Form 129 prior to allowing inmates to proceed without staff escort (i.e., medical/dental, authorized attorney visit, disciplinary hearing, or to complete Receiving & Release necessities, etc.). Staff shall call to inform other staff if an inmate(s) is expected to arrive at their location.

Scheduling Priority Appointments

Except for emergencies, medical services, and casework needs (priority ducats) passes shall not be scheduled during work/program hours. Pass scheduling shall comply with the work incentive law.

- When it is necessary to make casework contacts during an inmate's work hours, a "Priority Ducat Request" shall be initiated including only those inmates who will be on scheduled work assignments. This shall be done separately from nonpriority request.
- The priority request shall require either the approval of the chairperson of a properly constituted classification committee, or the approval of the originator's immediate supervisor. All priority passes shall be distinguished in accordance with DOM 53130.9.2, Priority Ducat System.

52020.8.7 Movement During Nonworking Hours

Inmates may participate in leisure activities during nonworking hours. Participation is based upon the inmate's privilege group. Movement to inmate activities shall be coordinated by the Watch Commander. Nonworking hour's activities include, but are not limited to, the following:

- Self-help groups.
- Recreational functions.
- Library.
- Canteen.
- Hobby programs.
- Entertainment from the outside community.

52020.8.8 Lockdown Movement

All movement of inmates during a lockdown shall be coordinated by the Watch Commander. Movement shall be restricted to those inmates cleared to perform essential or emergency services. Inmate movement shall be under direct staff supervision and/or escort.

Feeding

If controlled feeding is initiated during lockdown conditions, inmates shall be released in small manageable groups and shall be under constant supervision to and from dining halls.

Medical Appointments or Care

Inmates who require medical care, or have scheduled medical appointments, shall be under direct staff supervision and/or escort.

Daily Procedures

Daily institution/facility procedures governing movement of staff and inmates during lockdown conditions shall be published and distributed to all affected areas.

52020.8.9 Controlled Movement/Close Custody Movement

Inmates, designated as close custody, shall be supervised in accordance with CCR 3377.1.

Inmate Escorts

Inmate escorts shall be conducted as security and custody classification dictate. The following are examples to be used as guidelines for escorting inmates:

- The escorting staff member should be approximately 12 to 18 inches diagonally behind the inmate or inmates.
- The inmate may be in restraints (depending on custody classification and behavior).
- The escorting staff member may hold on to the restraints of the inmate (depending on the inmate's behavior or history of behavior).
- The escorting staff member may draw his/her baton for escorting restrained inmates in a general population setting if the staff member deems it necessary.
- For mass escorts, the first escorting staff member should be positioned beside the inmates being escorted, while the second escorting staff member is positioned 12 to 18 inches diagonally behind the last inmate being escorted.

52020.9 Revision

The Director, DAI, or designee shall ensure the contents of this Section are reviewed annually and make changes as necessary.

52020.10 References

PC § 2079.

CCR § 3274.

ACA §4-4188 and 4-4189.

ARTICLE 17 — CONTROL OF DANGEROUS AND TOXIC CHEMICALS

Revised January 26, 2015

52030.1 Policy

All units of the Department shall meet or exceed the requirements of all rules, regulations and laws applicable to identification, training, use, storage, handling and disposal of hazardous chemicals; including those established in the Guidelines for the Control and use of Flammable, Toxic and Caustic Substances, and the Hazardous Substances Information and Training Act, Labor Code, Division 5, Chapter 2.5.

The Department shall provide a working and living area that is as free as possible from unsafe and unhealthy exposure which could lead to personal injury or illness.

52030.2 Purpose

This policy shall establish a method for the identification, receipt, training, issue, handling (or use), inventory and disposal of hazardous chemicals, which is in compliance with all federal, state, and local laws or ordinances.

52030.3 Definitions

The following sections shall define language usage in this section.

52030.3.1 Access

The right and opportunity to examine and/or copy.

52030.3.2 Legislative Act

Hazardous Substances Information and Training Act, Chapter 2.5 commencing with § 6360 of Part 1 of Division 5 of the LC.

52030.3.3 Acute Health Effects

Health effects which are manifested immediately or shortly after, and as a result of, an exposure to a hazardous substance.

52030.3.4 Analysis Using Exposure or Medical Records

Any compilation of data, or any research, statistic or other study based at least in part on information collected from health insurance claims records, provided that either the analysis has been reported to the employer or no further work is currently being done by the person responsible for preparing the analysis.

52030.3.5 Chemical Abstract Service (CAS) Number

The unique identification number assigned by the Chemical Abstract Service (CAS) to specific chemical substances.

52030.3.6 Caustic

EXHIBIT 16

BRIEFING ROOM

Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees

SEPTEMBER 09, 2021 • PRESIDENTIAL ACTIONS

By the authority vested in me as President by the Constitution and the laws of the United States of America, including sections 3301, 3302, and 7301 of title 5, United States Code, it is hereby ordered as follows:

Section 1. Policy. It is the policy of my Administration to halt the spread of coronavirus disease 2019 (COVID-19), including the B.1.617.2 (Delta) variant, by relying on the best available data and science-based public health measures. The Delta variant, currently the predominant variant of the virus in the United States, is highly contagious and has led to a rapid rise in cases and hospitalizations. The nationwide public health emergency, first declared by the Secretary of Health and Human Services on January 31, 2020, remains in effect, as does the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) declared pursuant to the National Emergencies Act in Proclamation 9994 of March 13, 2020 (Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak). The Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services has determined that the best way to slow the spread of COVID-19 and to prevent infection by the Delta variant or other variants is to be vaccinated.

COVID-19 vaccines are widely available in the United States. They protect people from getting infected and severely ill, and they significantly reduce the likelihood of hospitalization and death. As of the date of this order, one of the COVID-19 vaccines, the Pfizer-BioNTech COVID-19 Vaccine, also known as Comirnaty, has received approval from the Food and Drug Administration (FDA), and two others, the Moderna COVID-19 Vaccine and the Janssen COVID-19 Vaccine, have been authorized by the FDA for emergency use. The FDA has determined that all three vaccines meet its rigorous standards for safety, effectiveness, and manufacturing quality.

The health and safety of the Federal workforce, and the health and safety of members of the public with whom they interact, are foundational to the efficiency of the civil service. I have determined that ensuring the health and safety of the Federal workforce and the efficiency of

the civil service requires immediate action to protect the Federal workforce and individuals interacting with the Federal workforce. It is essential that Federal employees take all available steps to protect themselves and avoid spreading COVID-19 to their co-workers and members of the public. The CDC has found that the best way to do so is to be vaccinated.

The Safer Federal Workforce Task Force (Task Force), established by Executive Order 13991 of January 20, 2021 (Protecting the Federal Workforce and Requiring Mask-Wearing), has issued important guidance to protect the Federal workforce and individuals interacting with the Federal workforce. Agencies have also taken important actions, including in some cases requiring COVID-19 vaccination for members of their workforce.

Accordingly, building on these actions, and in light of the public health guidance regarding the most effective and necessary defenses against COVID-19, I have determined that to promote the health and safety of the Federal workforce and the efficiency of the civil service, it is necessary to require COVID-19 vaccination for all Federal employees, subject to such exceptions as required by law.

Sec. 2. Mandatory Coronavirus Disease 2019 Vaccination for Federal Employees. Each agency shall implement, to the extent consistent with applicable law, a program to require COVID-19 vaccination for all of its Federal employees, with exceptions only as required by law. The Task Force shall issue guidance within 7 days of the date of this order on agency implementation of this requirement for all agencies covered by this order.

Sec. 3. Definitions. For the purposes of this order:

(a) The term "agency" means an Executive agency as defined in 5 U.S.C. 105 (excluding the Government Accountability Office).

(b) The term "employee" means an employee as defined in 5 U.S.C. 2105 (including an employee paid from nonappropriated funds as referenced in 5 U.S.C. 2105(c)).

Sec. 4. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) If any provision of this order, or the application of any provision to any person or

circumstance, is held to be invalid, the remainder of this order and the application of any of its other provisions to any other persons or circumstances shall not be affected thereby.

JOSEPH R. BIDEN JR.

THE WHITE HOUSE,
September 9

EXHIBIT 17

ORANGE COUNTY
SHERIFF'S DEPARTMENT

INTERNAL MEMO

To: All Department Personnel
From: Sheriff Don Barnes
Date: September 7, 2021
RE: Updated State Public Health Order Requirements

On August 19, 2021, the California Department of Public Health (CDPH) issued a new State Public Health Officer Order (State Order). The new State Order directly impacts our Department as it applies to employees working in high-risk congregate settings, which includes correctional facilities where health care is provided. The order mandates select employees that work in such facilities where health care is provided be fully vaccinated by October 14, 2021. Information regarding the new State Health Order can be found here: Order of the State Public Health Officer Correctional Facilities and Detention Centers Health Care Worker Vaccination Order

The August 19, 2021 order applies to all Deputy Sheriffs, Investigators, Sergeants, Lieutenants, Captains and Commanders who work within correctional facilities as identified below:

- Central Jails
- IRC/Transportation
- Theo Lacy Facility

Employee Health Services is leading County efforts in collecting vaccination records of employees that fall under this new order. Employees falling under the order will receive a series of email notifications starting the week of September 6, 2021, informing impacted employees of the new State Order and reiterating requirements of either submitting full COVID-19 vaccination status to Employee Health Services or options to obtain the COVID-19 vaccination.

The Department is required to be in full compliance with the new August 19, 2021 State Health Order by October 14, 2021. Therefore, employees impacted by the order are directed to monitor their emails for external EHS notifications (these could be from a CORITY external system) and take prompt action in meeting the requirements of either submitting proof of full vaccination status from COVID-19 to EHS or scheduling a COVID-19 vaccination. It is imperative that each employee impacted by the order comply as outlined within this communication.

Some employees may be exempt from the vaccination requirements based on their religious beliefs or excused due to qualifying medical reasons. The appropriate forms to request exemption can be found on MY18 under COVID-19 Vaccine Religious Accommodation or COVID-19 Vaccine Medical Exemption. Employees can submit completed forms to Janet South at jsouth@ocsheriff.gov for review.

The July 26, 2021 State Order (Order of the State Public Health Officer Unvaccinated Workers In High Risk Settings (ca.gov)) is still in effect for those employees who work in correctional facilities or detention centers but are not in health care settings. Those employees who fall under the July 26, 2021 order but do not fall under the new August 19, 2021 order are still required to test 1x weekly if they are not fully vaccinated.

Should you have any questions regarding the requirements of this order, please contact your assigned HR Analyst or send an email to PSDEmployeeRelations@ocsheriff.gov.