Operating Procedure

Effective Date February 1, 2017	**Number** 701.2
Amended 11/1/18, 12/1/18	**Operating Level** Department
Supersedes Operating Procedure 701.2 (7/1/16)	
Authority COV §53.1-10, §53.1-32	
Subject **HEALTH SERVICES CONTINUOUS QUALITY IMPROVEMENT PROGRAM**	**ACA/PREA Standards** 4-4410, 4-4411, 4-4423; 2-CO-4E-01
Incarcerated Offender Access Yes ☒ No ☐ **Public Access** Yes ☒ No ☐ **Attachments** Yes ☐ No ☒	**Office of Primary Responsibility** Health Services Director

I. PURPOSE

This operating procedure provides guidance for a continuous quality improvement program to monitor and improve health care delivered in all Department of Corrections facilities.

II. COMPLIANCE

This operating procedure applies to all facilities operated by the Department of Corrections (DOC). Practices and procedures shall comply with applicable State and Federal laws and regulations, Board of Corrections policies and regulations, ACA standards, PREA standards, and DOC directives and operating procedures.

III. DEFINITIONS

Continuous Quality Improvement Committee - Health Services Director, Chief Physician, Chief Nurse, Chief Dentist, Chief of Mental Health, Chief Pharmacist, Chief Psychiatrist, Infection Control Coordinator, and Grievance Coordinator tasked with designing quality improvement activities, developing evaluation criteria, discussing the results, approving facility corrective action plans, and improving the delivery of health care for the department.

Health Authority - The individual who functions as the administrator of the facility medical department

Quality Improvement - A formal, internal monitoring program that uses standardized criteria to ensure quality and consistency in the provision of offender health care, the program identifies opportunities for improvement, develops improvement strategies, and monitors their effectiveness.

Quality Improvement (QI) Committee - Facility level representative health staff from various disciplines (e.g. medical, nursing, mental health, dentistry, dialysis, as available and appropriate) who are responsible for monitoring and improving the delivery of health care at the facility through the process of quality improvement studies and outcome improvement measures

IV. PROCEDURE

A. Health Services Unit

1. The mission of the Health Services Unit within the Department of Corrections is to provide adequate, medically necessary, and cost effective health care services to offenders within the correctional system.
2. The Health Services Unit (HSU) is committed to providing quality health care for offenders within the Department of Corrections.
3. The HSU provides services that are responsive to offender's health care needs, while protecting the general public, staff, and other offenders from harm through the provision of quality health care while maintaining a secure environment.
4. The HSU is charged with the responsibility of systematically planning, implementing, monitoring, and assessing a plan for improving organizational performances in which optimal standards of

practice are sought and improved.

B. HSU Goals and Objectives

1. Provide quality and cost efficient health care to offenders.
   a. Monitor and evaluate all chronic care clinics to enhance service.
   b. Ensure all offenders receive appropriate, timely, and confidential services in a safe environment.
   c. Conduct an efficient screening process for all offender transfers.
2. Promote the Continuous Quality Improvement plan to successfully assess processes and enact changes based upon these assessments.
   a. Develop indicators designed to promote improvement in the delivery of service.
   b. Ensure systemic monitoring of the treatment environment.
3. Enhance efficient utilization of resources by monitoring current processes to determine effectiveness and improve as necessary.
4. Assist in credentialing reviews, privilege delineation, and peer review.
   a. Verify licensure through the Virginia Board of Medicine and Query of the *National Practitioner Data Bank.*
   b. Conduct biennial peer review on all licensed providers.
   c. Review and revise criteria for data collection of chronic care clinic to correctly reflect a complete and through evaluation of peer reviews.
5. Maintain facility pharmacy areas in accordance with the Virginia Board of Pharmacy regulations.
   a. Review pharmacy dispensing and medication error reports, facility inspection reports, and respective action plans.
   b. Monitor medication administration documentation records for accuracy and completeness.
   c. Review *DOC Controlled Medication (C II-C V) Administration and Count Sheet* 720_F14 to ensure appropriate management and security of those substances.

C. Continuous Quality Improvement (CQI) Program

1. All levels of the DOC Health Services Unit work together in an ongoing effort to monitor and improve the health care delivered in DOC facilities through an integrated Continuous Quality Improvement (CQI) program. (2-CO-4E-01)
2. The Health Services Director will be responsible for a Department level CQI Plan that is updated annually.
3. The Health Services Continuous Quality Improvement (CQI) Unit will receive, track, investigate, and monitor all inquiries regarding offender health care received at the Central Office and Regional Offices.
   a. Central and Regional Office staff shall forward all incoming letters, emails, and phone calls to the CQI Unit for investigation and resolution.
      i. Emails will be forwarded to the DOC Health Services Complaints mailbox.
      ii. Letters must be scanned and submitted by email to the DOC Health Services Complaints mailbox.
      iii. Phone calls will be forwarded to the Health Services Continuous Quality Improvement Unit at (804) 887-8118.
   b. All letters, emails, and a summary of any phone calls received by CQI staff related to offender health care will be logged into the Correspondence Unit's electronic Correspondence Log.
      i. A unique log number will be assigned along with the offender's name, DOC number, current facility, the name of the staff responsible to take action on the correspondence and a due date for the Health Services Unit.

ii. Whenever possible, CQI staff will preserve an electronic copy or scan of the correspondence in the electronic Correspondence Log.

c. If the offender is housed in an institution, CQI staff will submit an *Informal Complaint* in VACORIS on behalf of the offender.

i. CQI staff will conduct the investigation in consultation with institutional medical staff and provide the offender with an appropriate response within 15 calendar days in accordance with Operating Procedure 866.1, *Offender Grievance Procedure*.

(a) If the issue was adequately addressed through the *Offender Grievance Procedure* and an appropriate response was provided, CQI staff will advise the offender that the *Informal Complaint* is repetitive and provide the corresponding VACORIS log number(s) in the response.

(b) When CQI staff determine that the issue was not adequately addressed, CQI staff will conduct the investigation in consultation with institutional medical staff and provide an appropriate response.

ii. A copy of the *Informal Complaint* with reasons for the response clearly stated will be mailed to Institutional Ombudsman/Grievance Coordinator for delivery to the offender.

d. For Community Corrections offenders, CQI staff will conduct an investigation in consultation with facility medical staff and provide a written response directly to the offender with a copy to the Facility Unit Head

4. The Health Services Unit will maintain a Department level CQI committee to be known as the HSU CQI Committee. The following disciplines within the HSU Continuous Quality Improvement Committee will monitor, and evaluate their respective area of service.

a. Mental Health Services
b. Dental Services
c. Infection Control
d. Grievances
e. Pharmacy Services
f. Medical
g. Psychiatry

5. The Chairperson of the HSU CQI Committee (Chief Physician) will be responsible for overseeing and coordinating the program. Specific responsibilities include:

a. Be responsible for the day-to-day operation of the program, including serving as custodian of all documents.
b. Assist all facilities/disciplines in developing, implementing, and reviewing all quality improvement plans.
c. Assign members of the HSU CQI Committee to assist in developing training programs to enhance process improvement.
d. Ensure that minutes of meetings contain pertinent information on progress in implementing quality improvement initiatives.
e. Provide input, advice, and consultation to the Health Services Director or Regional Healthcare Administrator/Contract Monitor Manager, and/or facility QI Committee concerning quality improvement activities in order to improve organizational performance.
f. During the last quarter of the calendar year, the HSU CQI Committee will review the effectiveness of the program and report these results to the Health Services Director.

D. Facility Quality Improvement (QI) Plan

1. The Health Authority at each facility (including all contracted medical services facilities) and on-site Dialysis providers will be responsible for a facility QI Plan that is updated annually and scaled to the health care services provided at that facility. (4-4410)

2. The QI Plan shall conform to the *Quality Improvement Plan* 701_F9 which is based on the information required in the *Department CQI Plan*.
3. The Health Authority at each facility (including all contracted medical services facilities) will maintain a QI Committee with representation from each health care discipline practicing at the facility. As needed, the QI Committee should work closely with the Department or facility administration through regular meetings or administrative representation on the QI Committee. (4-4410)
4. The responsibilities of the facility QI committee are as follows: (4-4410)
   a. Monitor, review, and continuously improve the internal review and QI Plan.
   b. Collect, trend, and analyze data combined with planning, intervening, and reassessing.
   c. Evaluate defined data, which will result in more effective access, improved quality of care, and improved utilization of resources.
   d. Meet at least quarterly to review and evaluate the activities of the components of the program
   e. Evaluate on-site monitoring of health care outcomes at least quarterly through:
      i. Chart reviews
      ii. Review of prescribing practices, administration of medications, prescribing errors, and medication errors
      iii. Investigation of complaints and grievances
      iv. Monitoring corrective action plans
   f. Identify significant patterns that may be a potential for harm or an opportunity to improve services.
   g. Incorporate findings of internal review activities into the organization's education and training activities.
   h. Implement measures to address and resolve important problems and concerns identified by any corrective plan of action.
   i. Reevaluate problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired results.
   j. Document findings, actions, and follow-up through committee minutes on Attachment 1, *Quarterly Multidisciplinary Meeting Minutes*.
   k. Communicate findings to appropriate staff to improve services.
   l. Communicate findings and actions quarterly to the HSU CQI Committee or Regional Healthcare Administrator/Contract Monitor Manager and Facility Unit Head.
   m. Ensure confidentiality of records.
   n. Review all deaths in custody, suicide or suicide attempts, and illness outbreaks.
5. The Chairperson of the facility QI Committee will be responsible for annual completion of the *ACA Health Care Outcome Measures Worksheet*.
6. The facility QI Committee shall work with the HSU CQI Committee to implement a comprehensive performance improvement plan that will yield a uniform level of excellence throughout health services.

E. Quality Improvement Plan Development and Implementation Steps

1. Assign responsibility - The Health Authority or discipline head shall be responsible for the development, monitoring, and evaluation of the QI Plan within their scope of service.
2. Delineate scope of service - The facility or service area will delineate the scope of services or care that each area provides.
3. Prioritize aspects of care in service area - The service area prioritizes the aspect of care and/or services that are to be the focus of quality improvement activities.

4. Identify indicators - At least two indicators of quality are identified for each prioritized aspect of care. Indicators can be related to the process or the outcome of care or service. Process indicators are staff activities in the provision of care or service. Outcome indicators are the results of the care or service given. (4-4423)
5. Established thresholds of evaluations - A threshold determines when more extensive evaluation or care or service needs to occur. The types of thresholds include sentinel, rated, or pattern.
   a. Sentinel threshold is any single clinical event that automatically triggers a thorough evaluation of the event.
   b. A rated threshold is a specific percentage of events that occur prior to a thorough evaluation of the event.
   c. A pattern threshold is when specific patterns are observed over a period of time that triggers a more thorough evaluation of events.
   d. Thresholds should be set based on specific sources of information that may include professional experience, professional literature, standard practice guidelines, and regulatory standards.
6. Collect and organize data - For each indicator, data is collected and organized so that thresholds can be applied to determine when future evaluation is required. The source of the data is identified, such as medical records, laboratory reports, incident reports, medication administration records, or direct observation.
7. Evaluation - The individual responsible for applying thresholds for further evaluation should review the statistical data. In order to evaluate the outcomes, it is necessary to organize the data, compare the data, and identify opportunities for improvement. Once the data has been organized, the data should be compared against the source of information that established the threshold; for example, professional experience, professional literature, standards of practice or regulatory standards. After the data has been compared, opportunities should be apparent for improvement in the process or outcome. (4-4423)
8. Actions to improve care or service - Once the evaluation identifies an opportunity for improvement, actions should be recommended and then taken. Opportunities may address a system problem, knowledge deficit, or behavioral problem. Actions may require a change in communication, process, or organizational structure. Resolution of knowledge problems may include continuing education, circulating information, or in-service education program. Resolution of behavioral problems may include use of the employee disciplinary process (Operating Procedure 135.1, *Standards of Conduct*). (4-4423)
9. Assess the effectiveness of action to improve care or service - Once actions to improve care or service are implemented, it is necessary to monitor and evaluate the effectiveness of the plan or recommended action. Ongoing and follow-up monitoring will assist in deciding if the action plan was successful in improving care or service. If it is successful, it is no longer necessary to continue to monitor the action plan to improve the care or service. If the action plan to improve care or service was not successful, it may be necessary to reanalyze the evaluation of outcomes to determine if the analysis of data was accurate. In some cases it may be necessary to redesign the plan for quality improvement regarding the specific aspect of care or service.
10. Communication - Recommendations, conclusions, actions, and follow-up shall be reported to staff through monthly staff meetings minutes and quarterly to the members of the HSU CQI Committee. Results may also be used to evaluate staff performance and should be used in completing interim and annual performance evaluations of staff.

F. Peer Review Program (4-4411)

1. The Chief Physician, Chief Psychiatrist, Chief of Mental Health Services, and the Chief Dentist will manage a peer review program for DOC medical, psychiatric, mental health, and dental staff. Contracted medical services facilities will be responsible for implementing the Peer Review Program at their facilities.

2. A documented external peer review program will be utilized for all physicians, psychologists, and dentists every two years.
3. An immediate review may be initiated by the DOC Chief Physician, Chief Psychiatrist, Chief of Mental Health Services, or the Chief Dentist in response to perceived problems of practice. Contract medical providers may initiate an immediate review for contract medical facilities.

V. REFERENCES

Operating Procedure 135.1, *Standards of Conduct*

Operating Procedure 866.1, *Offender Grievance Procedure*

VI. FORM CITATIONS

ACA Health Care Outcome Measures Worksheet

Quality Improvement Plan 701_F9

DOC Controlled Medication (C II-C V) Administration and Count Sheet 720_F14

VII. REVIEW DATE

The office of primary responsibility shall review this operating procedure annually and re-write it no later than three years from the effective date.

The office of primary responsibility reviewed this operating procedure in February 2018 and no changes are needed at this time.

Signature Copy on File *12/20/16*

N. H. Scott, Deputy Director of Administration Date