STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE

Policy No. DOC 4.5.9	Subject: **CONTINUOUS QUALITY IMPROVEMENT PROGRAM**
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 5
Section 5: Clinical Services	Effective Date: May 1, 1998
Department Director Signature: /s/ Brian Gootkin	Revised: 4/19/2021
Medical Director Signature: /s/ Dr. Paul Rees	
Clinical Services Division Administrator: /s/ Connie Winner	

I. POLICY

The Department of Corrections will monitor and improve health and mental health care delivery through Continuous Quality Improvement (CQI) activities that include monthly monitoring, sentinel events, and data review.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (administrator, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Continuous Quality Improvement (CQI) – A process for monitoring the fundamental aspects of a facility health care system to identify areas that need improvement and to develop and implement remedial strategies or actions.

Continuous Quality Improvement Committee – A multidisciplinary committee consisting of health care staff from various disciplines (medicine, nursing, mental health, dentistry, health records, pharmacy, laboratory) that designs quality improvement monitoring activities, discusses the results, and implements corrective action.

Health Care Staff – Includes qualified health care professionals and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

Health Record Reviews – Systematic review of health records using a standardized form or audit tool to determine whether specific elements related to quality of care provided are adequately documented.

Medical Director – The physician(s) designated by the Clinical Services Division administrator to oversee clinical practice decisions requiring medical judgments for offenders under Department jurisdiction.

Outcome Quality Improvement Study – A study examining whether expected patient care outcomes were achieved.

Process Quality Improvement Study – A study examining health care delivery process

effectiveness.

Responsible Physician – A designated person who holds a physician's license pursuant to *37-3-102 and 37-3-303, MCA* who has the final authority at a given facility regarding clinical issues.

Sentinel Event – A sudden unexpected event in the course of overall care; this may be a system issue or unexpected direct complication. Offender death is always a sentinel event.

Thresholds – The expected level of performance (of aspects of healthcare) established by the quality improvement committee.

IV. DEPARTMENT DIRECTIVES

A. Quality Improvement Committee

1. The responsible health authority will establish a multi-disciplinary quality improvement committee to identify health care aspects to be monitored, implement and monitor corrective action when necessary, and study the effectiveness of corrective action plans.

2. The quality improvement committee will include representatives from the following disciplines:
   a. physician;
   b. nursing staff;
   c. mental health staff;
   d. correctional staff;
   e. facility administration; and
   f. Clinical Services Division administration.

3. Committee membership is fluid based on identified problems.

4. The quality improvement committee meets at least quarterly to:
   a. identify health care and mental health care aspects to be monitored and establish thresholds;
   b. complete health record reviews to ensure that appropriate care is ordered, implemented, and coordinated by the appropriate staff;
   c. design quality improvement monitoring activities;
   d. analyze factors that may have contributed to less than threshold performance;
   e. design and implement improvement strategies to correct the identified health care or mental health care problem; and
   f. monitor performance after implementation of the improvement strategies.

5. When the committee identifies a health care or mental health care problem from its monitoring, the committee will examine the effectiveness of the health care delivery process and examine whether the expected outcomes of patient care were achieved by performing:
   a. a process quality improvement study which includes:
      1) identification of a facility problem;
      2) conducting a baseline study;
      3) developing and implementing a corrective action plan; and

4) restudying the problem to assess the effectiveness of the corrective action plan; or

b. an outcome quality improvement study which includes:
   1) identification of a patient clinical care problem;
   2) conducting a baseline study;
   3) developing and implementing a corrective action plan; and
   4) restudying the problem to assess the effectiveness of the corrective action plan.

6. Meeting minutes will contain detailed information identifying:
   a. problems;
   b. agreed upon solutions;
   c. person responsible for carrying out the corrective action plan;
   d. time frame for the corrective action plan; and
   e. be retained for reference and copies will be made available for and reviewed by all appropriate personnel.

7. Data from the process and outcome quality improvement studies will be maintained by the committee.

8. The responsible physician and medical and mental health bureau chief(s) will actively participate in the CQI program and committee.

9. CQI will include an annual review of deaths and serious incidents involving offenders with mental illness to identify trends and corrective action.

10. The CQI program will be evaluated annually by the quality improvement committee which will include a review of:
    a. CQI studies;
    b. minutes of quality improvement committee meetings;
    c. minutes of administrative and/or staff meetings related to health care; and
    d. other pertinent written materials.

B. Service Areas

1. The CQI program will evaluate each of the following service areas annually:
   a. intake processing;
   b. acute care (sick call for both general population and restrictive housing);
   c. medication services;
   d. chronic care services;
   e. intra-system transfer services;
   f. scheduled off-site services (consultations and procedures);
   g. unscheduled on-site and off-site services (urgent/emergent care);
   h. mental health services;
   i. dental services;
   j. ancillary services (lab and x-ray);
   k. dietary services; and
   l. infirmary services.

C. Performance Measures

1. Each service area reviewed will include one or more of the following performance measures:
   a. accessibility (unimpeded access to health care services);
   b. appropriateness of clinical decision making by:
      1) record of current license and credentials status;
      2) documentation of continuous education training;
      3) documentation of required certifications;
      4) regular review of clinician performance which includes feedback to increase the probability of clinically appropriate decision making;
   c. continuity:
      1) pre-existing conditions are identified and addressed during the intake process;
      2) follow-up of on-site and off-site services, scheduled and unscheduled;
         i. evaluate time between complaint, referral, and response;
         ii. timeliness of the follow-up encounter with designated health care professional;
         iii. timeliness of receipt of applicable service reports;
      3) consistent receipt of services without breaks in service;
   d. timeliness:
      1) time between health services requests being retrieved and the face-to-face encounter with the qualified health care professional;
      2) time between initial diagnosis of chronic illness and the first chronic care visit;
      3) time between the ordering of a critical medicine and its receipt by the patient;
      4) time between contact with emergency services regarding a patient emergency and the arrival at the emergency room or infirmary;
   e. effectiveness:
      1) clinical outcome measures for certain common chronic diseases (e.g. A 1c levels due to diabetes, Hep C viral load, etc.);
      2) clinical outcome measures for certain mental illnesses (e.g. schizophrenia, Bipolar, etc.);
   f. efficiency:
      1) utilization of available resources;
      2) cost of care;
      3) continuity of care;
   g. quality of clinical-patient interaction:
      1) patient satisfaction surveys;
      2) number and type of health care grievances;
   h. safety:
      1) physical environment:
         i. incident reports;
         ii. evidence of inspection;
         iii. self-harm;
         iv. suicide;
      2) adherence to custody safety and security requirements; and

3) investigating and performing root cause analysis for all offender deaths as well as other adverse events.

D. Clinical Performance Enhancement

1. The responsible health authority or designee will ensure that health care staff meet clinical performance thresholds on an annual basis.

2. Documentation of clinical performance enhancement will be confidentially maintained for each health care employee and will contain the following elements::
   a. name and credentials of the individual being reviewed;
   b. date of the review;
   c. name and credentials of the reviewer;
   d. summary of the findings and corrective action, if any; and
   e. confirmation that the review was shared with the individual being reviewed.

3. Health staff responsible for guiding the CQI program should be given training opportunities to enhance their skills and the program's effectiveness.

4. Clinical performance enhancement reviews are conducted on all full-time, part-time, and per diem providers, RNs, LPNs, psychologists, Licensed Clinical Social Workers, and dentists.

5. A log is maintained that lists the names of individuals reviewed, dates of their reviews, and is made available to the appropriate staff.

E. Reports

1. Quarterly CQI reports will be developed and presented at each quarterly quality improvement committee meeting with copies to the responsible health authority or designee and facility administrator

2. Annual CQI reports will be developed and presented at the annual CQI program review meeting with copies sent to the responsible health authority or designee and facility administrator.

F. Release of Information

1. Information including CQI data, analysis, findings, recommendations, conclusions, and actions developed by or for health care staff, health services, or other individual committees performing CQI assessments or similar functions will not be available to unauthorized persons or organizations or used for other than intended purposes as allowed for under state and federal law.

V. CLOSING

Questions concerning this policy should be directed to the Clinical Services Division administrator.

VI. REFERENCES

A. P-A-06, P-C-02; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018

B. MH-A-06, MH-C-02; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015

C. Y-A-06, Y-C-02; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2015

VII. ATTACHMENTS

None