CORRECTIONAL MANAGED HEALTH CARE

Quality Improvement Plan

FY 2015

CORRECTIONAL MANAGED HEALTH CARE

QUALITY IMPROVEMENT PLAN

The procedures and guidelines contained in this plan were developed as part of a joint agency effort involving the Texas Department of Criminal Justice, the University of Texas Medical Branch in Galveston, and Texas Tech University Health Science Center. This Quality Improvement Plan has been reviewed and approved by the Correctional Managed Health Care Chairperson, university medical directors and the Division Director for Health Services at the Texas Department of Criminal Justice.

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Chairperson
Correctional Managed Health Care Committee

9-18-14
Date

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CORRECTIONAL MANAGED HEALTH CARE

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I. PREFACE

CORRECTIONAL MANAGED HEALTH CARE DESCRIPTION

Correctional Managed Health Care (CMHC) was established by the Texas Legislature in 1993.

Since 1993, the initial CMHC model the state enacted has further evolved due to various statutory changes. Currently, the direct delivery of health care services to offenders incarcerated within TDCJ correctional facilities primarily involves two state entities: The University of Texas Medical Branch (UTMB) and the Texas Tech University Health Sciences Center (TTUHSC)..

In July, 1995, Michael Warren, M.D., Division Director for TDCJ Health Services convened a committee tasked with developing and leading the implementation of a state of the art Quality Improvement Plan for the TDCJ Correctional Managed Health Care system.

The committee was tasked with developing a plan, which would meet or exceed the standards set by the National Commission on Correctional Health Care.

The plan, contained in this Quality Improvement Program Manual, represents the work of this committee as well as input from the TDCJ Correctional Managed Health Care personnel.

A step by step "how to" process is located in the Procedure section of this manual. The other sections of the manual are designed to be used as a reference, for ideas and guidelines.

II. 2014 CORRECTIONAL MANAGED HEALTH CARE COMMITTEE MEMBERS

Members Appointed by the Governor

Margarita de la Garza-Grahm, M.D., Chairperson, CMHCC
Tyler, Texas

Harold K. Berenzweig, M.D., Member, CMHCC
Executive Vice-President, Clinical Leader SW Zone
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Elizabeth Anne Linder, Ed.D., Member CMHCC
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Ex Officio Member

Patricia A. Vojack, JD, MSN, Ex Officio Member, CMHCC
Deputy Executive Commissioner
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Austin, Texas

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The University of Texas Medical Branch (UTMB)

Ben G. Raimer, M. D., Member, CMHCC
Senior Vice-President for Health Policy
and Legislative Affairs,
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Texas Tech University Health Sciences Center (TTUHSC)

Cynthia Jumper, M.D., Member, CMHCC
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Texas Department of Criminal Justice (TDCJ)

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Division Director for Health Services
Huntsville,Texas

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MISSION/PHILOSOPHY

III. Mission

The CMHCC's mission is to develop a statewide managed health care network to address three key goals:

• providing TDCJ offenders with timely access to care consistent with correctional standards;

• maintaining a quality of care that meets accepted standards of care; and

• managing the costs of delivering comprehensive health care services to a growing and aging offender population.

IV. Philosophy

The correctional managed health care system represents a partnership among several public institutions that share the following values:

Quality: The partnership strives to provide health care services of recognized high quality and deliver them uniformly, promptly and efficiently to the limit of our resources and capabilities.

Integrity: As public servants, the partners work to uphold the public's trust through ethical personal and professional behavior.

Commitment: The partners are dedicated to restoring and preserving the health of our patients and clients.

Teamwork: The partnership accomplishes our mission and goals through teamwork, with each partner contributing to the organization, work and systems, and sharing in its success.

V. POLICY AND STANDARDS

Correctional Managed Health Care Policy (A-06.1), ACA Standard 1-4-4410 Internal Review, NCCHC Standard P-A-06 Comprehensive Quality Improvement Program (Essential) and Quality Assurance (Mandatory).

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VI. PURPOSE

The purpose of this plan is to provide a streamlined, integrated, clinically driven state-of-the-art Quality Improvement Program, which adds value to the quality of health care services, provided to TDCJ offenders.

The plan demonstrates that quality activities will be consistently/continuously applied and/or measured, and will meet or exceed regulatory requirements.

The Correctional Managed Health Care Committee (CMHCC) strongly endorses and has administrative oversight for implementation of the plan. The agents of the CMHCC and the TDCJ Health Services Division will demonstrate support and participation for the plan.

VII. TRANSITION

This plan reflects the continued transition of the Quality Improvement/Management Program, which was introduced in January 1994. At that time Health Services personnel were exposed to the concept of utilizing a systematic approach to problem identification, data collection, and corrective action.

Development of an effective Quality Improvement Program is a long-range project. The plan must have an ongoing process for monitoring, evaluating, and improving the quality of health care being provided. In addition it must meet the needs of its customers, provide a level of health care consistent with community standards, and be in accordance with ACA and NCCHC standards.

Once formalized, and prior to implementation, training sessions for key personnel were held. The purpose of the training was to solidify the Quality Improvement philosophy and ensure the focus of the program is to improve the quality of services. Staff must continually attempt to redesign the processes by which services are delivered and avoid focusing solely on end product errors. In order to do this; health service providers must view themselves as both customers and suppliers. Another step to improve services requires that departmental barriers be broken down and a team approach utilized (e.g. when reviewing laboratory services, physicians, nurses, laboratory personnel, health records staff, security staff, and patients should be included in the group which reviews the systems in place for obtaining laboratory specimens.) This team approach provides for the creation of a stimulating and rewarding work environment.

Ultimately, all health services staff must be oriented to and be included in the program. The program entails fundamental changes in thinking as well as in individual and group behaviors.

Leaders in health care quality have advised that a full transition from a task to systems oriented organization, especially one of the magnitudes of TDCJ is a 5-10 year process. However, improvements in outcomes should occur during each phase of the program.

VIII. SCOPE

The Quality Improvement program encompasses all aspects of care and services provided by CMHCC, its agents, and the TDCJ Health Services Division. Participating disciplines include:

- Health Records
- Laboratory Services
- Medical Staff
- Nursing
- Nutritional Services
- Respiratory Services
- Radiology Services
- Mental Health Services
- Pharmacy Services
- Dental Services
- Occupational Therapy
- Physical Therapy
- Case Management
- Emergency Medical Services
- Optometry
- Physiatry

Additionally the following functions/activities will be addressed and information data specific to the Quality Improvement Program will be disseminated:

- Infection Control
- Utilization Review
- Pharmacy and Therapeutics
- Operational Review/Contract Monitoring
- Adverse Patient Occurrences
- Medication Errors
- Disaster Drills
- Environmental Inspection Reports
- Offender Grievances
- Patient Liaison Concerns
- Quality Assurance Peer Review
- Morbidity/Mortality
- Specialty Service Quality Control Issues

IX. GOVERNING BODY

A. The Correctional Managed Health Care Committee is responsible for oversight of the entire health care program. All aspects of health care delivery are subject to review by this governing body. The CMHCC will update the Texas Department of Criminal Justice Board as necessary. CMHCC delegates the authority and accountability for the functional operation of the program to the System Leadership Council.

B. At local levels the Facility Health Authority/Medical Director is responsible for maintaining the Quality Improvement Plan and appoints the Facility Leadership Council chairperson and coordinator.

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X. ORGANIZATION

A. Two (2) committees serve as focal points of the Quality Improvement Program. The first is the System Leadership Council and the second is the Facility Leadership Council.

1. SYSTEM LEADERSHIP COUNCIL

a. The System Leadership Council is composed of the following members:

TDCJ Division Director Health Services Division
TDCJ Deputy Director Health Services Division
TDCJ Director, Quality Monitoring and Compliance Health Services Division
TDCJ Public Health Officer, Health Services Division
TDCJ Director, Office Mental Health Services & Liaison
TDCJ Director of Dental Services
TDCJ Chief Nursing Officer/Director Clinical Administration
TDCJ Assistant Chief Nursing Officer/Infection Control
TDCJ Manager IV, Office of Health Services Monitoring
TDCJ Manager IV, Office of Professional Standards
TDCJ Manager IV, Health Services Liaison
TDCJ Nurse IV, Utilization Review Supervisor
TDCJ Manager III, Office of Mental Health Services & Liaison
TDCJ Manager III, Office of Professional Standards
TDCJ Manager III, Health Services Liaison
UTMB Vice President, Offender Care Services
UTMB Director of Mental Health Services
UTMB Sr. Medical Director, Outpatient Services
UTMB Sr. Medical Director, Inpatient Services
UTMB Region 1 Medical Director
UTMB Region 2 Medical Director
UTMB Region 3 Medical Director
UTMB Director of Nephrology & Dialysis
UTMB Medical Director, Estelle Facility
UTMB Medical Director, Young Facility
UTMB Medical Director, Skyview/Hodge Facilities
UTMB Associate Vice President, Outpatient Services
UTMB Associate Vice President, Inpatient Services
UTMB Associate Vice President, Hospital Galveston & Specialty Clinics
UTMB Director of Quality & Outcomes
UTMB Director of Utilization Management
UTMB Director of Pharmacy Services
UTMB Director of Dental Services
UTMB Administrative Director, Mental Health Services

UTMB Assistant Director of Health Information Management
UTMB Chief Nursing Officer, UTMB-CMHC
UTMB Director of Nursing, Inpatient Services
UTMB Region 1 Director of Nursing
UTMB Region 2 Director of Nursing
UTMB Region 3 Director of Nursing
UTMB Nurse Manager, Estelle Facility
UTMB Nurse Manager, Dialysis Services (Estelle and Young Facilities)
UTMB Nurse Manager, Jester IV Facility
UTMB Nurse Manager, Skyview/Hodge Facilities
TTUHSC Executive Medical Director
TTUHSC Executive Director of Correctional Health
TTUHSC Director, Dental Services
TTUHSC Director, Mental Health Services
TTUHSC Northern Region Medical Director
TTUHSC Southern Region Medical Director
TTUHSC Director of Nursing
TTUHSC Director of Quality Improvement
TTUHSC Sr. Director of Utilization Management
TTUHSC Director of Nursing, Allred Facility

b. Annually the Chairperson of the CMHCC will appoint the Chairperson of the System Leadership Council
c. The System Leadership Council will meet, at a minimum, on a quarterly basis. The quarterly meetings may be teleconferenced; annual meetings will be on-site, at a location convenient and agreeable to all members.
d. Functional responsibilities include:

(1). Monitoring major aspects of care across the system.For each aspect of care, a champion(s) will be assigned to implement the monitoring of clinical standards and guidelines.

(2). providing overall philosophical direction by supporting and endorsing the system-wide Quality Improvement Plan.

(3). Using the data provided by representative committees and administrative support services, annually, identifying the most strategically significant 2-4 Aspects of Care (including clinical and administrative) for system-wide improve

(4). Maintaining an information flow with the Facility Leadership Councils via reports.

(5). Receiving, evaluating reports and if indicated, recommending corrective action to the appropriate functional authority.

(6). Maintaining minutes of each meeting which will be located in the TDCJ Health Services Monitoring Office. The following statement will be on each page of the original copy of the minutes: "These minutes are PRIVILEGED and CONFIDENTIAL and are prepared at the request of and for sole distribution to this committee in accordance with Vernon's Annual Civil Statutes, Health & Safety Code, and Chapters 161.032 & 161.033."

(7). annually, or as indicated, evaluating, and reviewing the system-wide Quality Improvement Program

2. TTUHSC CORRECTIONAL HEALTH CARE:

The TTUHSC Correctional Health Care is composed of the following members:

- Executive Director Managed Health Care
- Director of Field Operations
- Director of Contracted Services
- Executive Medical Director, Health Care Systems
- Director, Dental Services
- Director, Nursing Services
- Southern Regional Medical Director
- Northern Regional Medical Director
- Medical Director Mental Health Services
- Director of Mental Health Services

3. UTMB MANAGED CARE:

A The UTMB Managed Care is composed of the following members:

- Vice President, Offender Care Services
- Director, Dental Services
- Associate Vice President, Inpatient Services
- Associate Vice President, Outpatient Services
- Medical Director, Inpatient Services
- Medical Director, Outpatient Services
- Director, Mental Health Services
- Chief Nursing Officer, UTMB-CMHC
- Director of Pharmacy Services

B. The Facility Health Authority/Medical Director, or his/her designee, will serve as the Chairperson of the Facility Leadership Council.

(1). annually the Facility Health Authority/Medical Director will appoint, from the membership listed in "a" above, a Facility Quality Improvement Coordinator (FQIC) who will be responsible for:

(a). Recording, maintaining and distributing meeting minutes
(b). Preparing meeting agendas
(c). Receiving, maintaining, and distributing appropriate plans and reports (i.e. data collection, corrective action plans, etc.)

C. The Facility Leadership Council will meet monthly.

D. Functional responsibilities include:

(1). Using available data, from their facility, or the SLC and appropriate regions and/or sectors, annually identifying the most strategically significant 2-4 Aspects of Care (including clinical and administrative) for facility improvement.

(2). Monitoring and evaluating major aspects of care.For each aspect of care, a champion(s) will be assigned to implement the monitoring of clinical standards and guidelines.

(3). annually, or as necessary, developing/maintaining a facility Quality Improvement Program to include: Scope of Care, Assigning Responsibility, and Identifying Important Aspects of Care with Identifying Indicators.

(4). Maintaining an informative flow with the System Leadership Council via the appropriate Quality Improvement Resource Office.

(5). Maintaining minutes of each meeting.

(a). One set of minutes will be forwarded, by the 20th of each month following each meeting to the appropriate Health Services Monitoring and University Provider. The following statement will be on each page of the original copy of the minutes: "These minutes are PRIVILEGED and CONFIDENTIAL and prepared at the request of and for sole distribution to this committee in accordance with Vernon's Annual Civil Statutes, Health & Safety Code, Chapters 161.032 & 161.033."

(b). One set of minutes will be located in the Office of the Facility Quality Improvement Coordinator.

(6). annually, or as indicated, evaluating the facility's Quality Improvement Program.

B. Frequency of Meetings

1. Each committee determines the place, time, week and day of the week to meet at the beginning of each calendar year. Meetings are scheduled so that the function and responsibilities of each committee are best accomplished and information flows in a logical order.

XI. TEN STEP PROCESS

The CMHCC, its agents, or the TDCJ Health Services Division does not require adoption of any specific management style; support any particular "school" of Total Quality Management (TQM) or Continuous Quality Improvement (CQI), or use of specific quality improvement tools. However, they will continue to adhere to the Joint Commission on Accreditation of Healthcare Organizations ten step processes for improvement.[1]

Step 1 Assign Responsibility

Step 2 Delineate Scope of Care

Step 3 Identify Important Aspects of Care

Step 4 Identify Indicators

Step 5 Establish Thresholds for Evaluation

Step 6 Collect and Organize Data

Step 7 Evaluate Care

Step 8 Take Actions to Solve Problems

Step 9 Assess the Actions and Document Improvement

Step 10 Communicate Relevant Information to the Organization wide Quality Assurance Program

[1] "The Joint Commission Guide to Quality Assurance," (Chicago: Joint Commission on Accreditation of Healthcare Organizations, 1989)

XII. ASSIGNING RESPONSIBILITY

Monitoring and evaluation functions will be assigned to the individual or individuals that have the most expertise and knowledge regarding the particular Aspect of Care being studied. Each Aspect of Care being studied will be the primary responsibility of individual(s) identified as its "champion."

XIII. IDENTIFYING IMPORTANT ASPECTS OF CARE

Once the data generated by committee members and support staff, has been received, the System Leadership Council and/or Facility Leadership Council will identify what is most strategically significant by determining:

Which Aspects of Care occur frequently or affect large number of patients?

Which Aspects of Care place patients at risk of serious consequences or deprivation of substantial benefit when the care is not provided correctly, the care is not provided but is indicated, or the care is provided but is not indicated?

3. Which Aspects of Care tend to produce problems for patients and/or staff?
4. Which Aspects of Care are costly?

XIV. IDENTIFYING INDICATORS

Indicators are identified to monitor the quality of important aspects of care. (Indicators which include clinical criteria are sometimes called "clinical standards," "practice guidelines," or "practice parameters.") Indicators are objective, measurable, and are based on current knowledge and clinical experience.

XV. ESTABLISHING THRESHOLDS

The goal for compliance to standards, policies, and protocols is 80%.

XVI. DATA COLLECTION AND ORGANIZATION

Data is available from many sources such as: health records, I-60s, department logs, other statistical reports, occurrence reports, patient liaison correspondence, offender grievances, information provided by staff members, etc. For the monitoring process it is also necessary to determine a sample size i.e. (percentage of population), as well as how the sample is to be selected (i.e. percentage of population), as well as how the sample is to be selected (i.e. random or stratified) and the time parameters (i.e. 30 days, 6 months, 1 year).

XVII. EVALUATING CARE OR SERVICE

After collecting the data, appropriate staff will review the data and identify situations in which an evaluation of the quality of care is indicated. Such evaluations are prompted when: the cumulative data fails to reach the established threshold; patterns and/or trends are determined; the facilities/regions/sectors/system's performance compares poorly with other facilities/regions sectors and/or community organizations ("benchmarking").

When initiated the evaluation of an important aspect of care may include a more detailed analysis of patterns trends in the data and/or peer review.

XIII. ACTION TO IMPROVE CARE AND SERVICES TAKING

When an opportunity to improve, or a problem in the quality of care, is identified, action is taken to improve the care or correct the problem. If appropriate, the action taken may be either the testing of a strategy for improvement on a limited basis (pilot test) prior to full implementation or the immediate implementation of the strategy in all departments or services to which it may apply.

Two common causes of problems are:
Insufficient staff knowledge, which can be improved by clarifying policies and/or procedures, instituting in-service training or conducting educational programs.

System defects, which can be corrected by improving processes or equipment, or by changing operational procedures.

It is important that the corrective action plan be clearly described, including who is responsible for this activity, and is documented. If applicable, multi-disciplinary team members should participate in formulating the corrective action plan.

XIX. ASSESSING ACTIONS AND DOCUMENTING IMPROVEMENTS

Corrective action plans must be monitored to determine their effectiveness. This can be accomplished by continuing to monitor the applicable indicator. This re-monitoring should be performed at a reasonable time interval to determine if the revised process has resulted in improved quality.

XX. COMMUNICATING AND DOCUMENTATION INFORMATION

The findings, conclusions, recommendations, actions taken, and results of the actions taken are documented (i.e. reports, worksheets, meeting minutes, etc.) and reported through established channels (i.e. System Leadership Council, Facility Leadership Council, other committee meetings, staff meetings, newsletters, etc.)

Documentation should be retrievable. In other words there should be a "paper trail" to support each Quality Improvement study.

XXI. PROGRAM EVALUATION

The system-wide plan and its attachments will be reviewed annually by the System Leadership Council and revised and/or updated to reflect current service. This evaluation will be based on analysis of the Quality Improvement Program organization, scope of quality activities, and effectiveness of all monitoring activities. Facility plans will be reviewed accordingly at the appropriate facility.

This evaluation will also include a review of the number and type of significant problems identified and resolved. In addition, any portion of this plan may be modified or amended at any time to maintain compliance with American Correctional Association, National Commission on Correctional Health Care or other defined standards and to improve the effectiveness of the delivery of services.

XXII. FORMS

The following forms have been designed for use by the Facility Leadership Council:

HSA-61	ANNUAL PLAN
HSA-62	QUALITY IMPROVEMENT MONITORING & EVALUATION PLAN
HSA-63	QUALITY IMPROVEMENT PROGRAM CALENDAR
HSA-64	QUALITY MANAGEMENT MONTHLY ANALYSIS
HSA-65	QUALITY IMPROVEMENT PROGRAM MEETING MINUTES
HSA-66	QUALITY IMPROVEMENT PROGRAM MEETING MINUTES (CONTINUED)
HSA-67	FACILITY QUALITY IMPROVEMENT PROGRAM EVALUATION
HSA-67	FACILITY QUALITY IMPROVEMENT PROGRAM EVALUATION
HSA-96	QUALITY IMPROVEMENT REPORTING SCHEDULE

Blank forms as well as a sample of each completed form are located in this section. Instructions for completing the forms are located in the PROCEDURE section. These forms can be ordered via facility formulary. The supply clerk at each facility can provide assistance if needed.

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XXIII. GLOSSARY OF TERMS

1. ACA- the American Correctional Association is a private, nonprofit organization that administers the only national accreditation program for all components of adult and juvenile corrections. It's purpose is to promote improvement in the management of correctional agencies through the administration of a voluntary accreditation program and the ongoing development and revision of relevant, useful standards.

2. Aspect of Care- Care activities or processes which occur frequently or affect large numbers of patients; that place patients at risk of serious consequences if not provided correctly, if incorrect care is provided, or if correct care is not provided; that tend to produce problems for patients or staff; and/or are costly. Such activities or processes are deemed most important for purposes of performance improvement activities.

3. Indicator-a tool use to measure, over time, an organization's performance of functions, processes, and outcomes.

4. Scope-inventory of processes that make up a specified function, including activities performed by governance, managerial, clinical, and/or support personnel.

5. Standard-a statement of expectation that determines the structures and processes that must be in place in an organization to improve the quality of care.

6. Threshold-the point or level at which a stimulus is strong enough to signal the need for organization response to indicator data and the beginning of the process for determining why the organization has not reached the pre-established level.

7. Customer-recipient of services, information and/or materials from others. They may be from inside or outside of your organization.

8. Supplier-provider of services, information and/or materials to others. They may be from inside or outside of your organization.

9. NCCHC-the National Commission on Correctional Health Care is a not-for-profit organization working towards improving health services provided by the nation's jails, prisons, and juvenile detention and confinement facilities.

10. System Leadership Council (SLC)-refer to Organization section.

11. Facility Leadership Council (FLC)-refer to Organization section.

12. Champion-the person assigned primary responsibility for the monitoring and evaluation functions of a particular Aspect of Care.

13. Facility Quality Improvement Coordinator (FQIC)-a member of the FLC who is responsible for the operational functions of the FLC as described in the Organization section.

14. Quality Improvement Resource Office-refer to Resources Section.

15. Benchmark-a point of reference that serves as a standard by which others may be measure.

XXIV. RESOURCES

Policies

The following TDCJ Health Services policies provide guidance for the implementation of this Quality Improvement Program:

A-01.1	Access to Care
A-04.2	Health Services Statistical Report
A-13.1	Physician Peer Review
A-06.2	Professional and Vocational Nurse Peer Review Process
A-11.1	Procedure in the Event of an Offender Death
A-07.1	Emergency Plans and Drills
A-12.1	Grievance Mechanism
A-12.2	Patient Liaison Program
B-14.2	Infection Control Committee
B-15.1	Environmental Inspections
E-36.5	Dental Utilization/Quality Review Committee

Procedures

The following department procedures provide guidelines for the implementation of this Q.I. Program:

Pharmacy Policy and Procedure Manual
05-05 TDCJ Medication Formulary
05-10 Non-Formulary Drugs

Executive Directives

The following Executive Directives provide guidelines for the implementation of this Q.I. Program:

ED-02.92 Establishment and Administration of TDCJ Monitoring systems for Facility Compliance with Departmental Policies and Procedures, and with the Ruiz Final Judgment.

Miscellaneous

Pharmacy and Therapeutics Committee minutes: "The Committee also decided that medication Errors and Adverse Drug Reactions should be added to unit based Quality Assurance Meeting Agenda."