CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 01/02
CHAPTER 1: QUALITY MANAGEMENT	Revision Date(s): 12/12
PROCEDURE 3.1.3: QUALITY MANAGEMENT PROGRAM, INSTITUTION	Attachments: Yes ☒ No ☐

I. PURPOSE

This procedure describes strategies, processes, tools, and a governance structure that institutions use to plan, prioritize, develop, implement, and evaluate performance improvement initiatives and sustain improvements.

II. DEFINITIONS

Performance Improvement Plan: Plan that identifies California Correctional Health Care Services (CCHCS) priority areas for improvement, as well as performance objectives and strategies used to achieve objectives.

Institution Performance Improvement Plan: Plan that identifies the institution priority areas for improvement that are consistent with statewide performance improvement objectives, as well as performance objectives and strategies used to achieve objectives.

Health Care Services Dashboard: A monthly report that consolidates strategic performance information across key health care areas. The Dashboard provides data at both statewide and institution levels and shows trends in performance over time. The primary goal of the Dashboard is to provide CCHCS staff with information that can be used to improve the performance and value of health care services and patient outcomes.

Institution Scorecards: A report updated monthly that shows each institution's individual performance for measures included in the Dashboard.

Patient Registries: A decision support tool that lists patients who may be eligible for specific clinical services or interventions or who have specific clinical conditions.

Quality Improvement: A rigorous approach to managing and improving organizational performance through the objective use of data and statistical tools to evaluate the structures, processes and outcomes of care and using improvement methods to design and test changes to continuously improve the value, quality and safety of health care systems.

Quality Management: A planned, strategic, system-wide approach to defining, evaluating, and improving organizational performance, thereby continually enhancing the quality and value of patient care and services provided and the likelihood of desired outcomes.

Root Cause Analysis: A structured method to analyze, identify, and resolve "root causes" of system and process problems.

Model for Improvement: The Model for Improvement is a framework for structuring a quality improvement project that focuses on answering a set of fundamental questions followed by small but frequent tests of change, using Plan-Do-Study-Act (PDSA) cycles.

Lean Model: An approach that centers on the separation of "value-added" from "non-value-added" work and seeks to improve quality and productivity, reduce inefficiencies, and eliminate waste.

Six Sigma: A measurement-based, data-driven, systematic approach to process improvement and problem solving through the application of tools and techniques with the purpose of minimizing unnecessary variation in processes and eliminating defects.

Focus-PDSA: A methodology that is used to identify improvement opportunities and create a systematic approach to implementing changes. The model is used to learn by doing and experimenting with improvements, examining what is learned and implementing what was learned into further improvement efforts.

Failure Mode and Effects Analysis: A systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change.

Process Flow Diagramming: A way of designing and documenting business processes that illustrates and analyzes the overall flow of activities in providing a service.

Cause and Effect Diagramming: A visual tool used to organize the potential causes of variation in an activity or process.

III. RESPONSIBILITIES

The Institution Chief Executive Officer (CEO) is responsible for implementation of this policy.

IV. PROCEDURE

A. Performance Improvement Plan

1. Integrated Health Care Services Delivery System

   Implementation of an integrated health care services delivery system with a strong primary care foundation has been identified as an overarching strategy for improving care and avoiding unnecessary morbidity, mortality, and costs. Health care staff at each institution are responsible for implementing care processes necessary for a sustainable integrated health care delivery system, including, but not limited to, processes to:

   - Identify the health risk of each patient and ensure that the patient-inmate is placed at an institution and/or treatment setting with the capacity to address his or her health care needs, per an automated Clinical Risk Classification process.

- Establish consistent interdisciplinary care teams that assume primary responsibility for the patients assigned to them.
- Provide care coordination for patients as they move from one treatment setting to another, including transitions between care teams, and across levels of care.
- Ensure that care teams work across disciplines to co-manage each patient as appropriate to his or her health needs.
- Ensure care teams have necessary resources and information, such as updated health records, specialty care reports, discharge summaries, diagnostic study results, and patient registries, to provide planned care for patients.
- Provide evidence-based care that is consistent with current guidelines and community standards.
- Enhance access to services through open access appointments or other scheduling strategies, after-hours care, and effective communication techniques.
- Ensure that patients have timely and consistent access to medications.
- Use patient registries to manage subpopulations with specific health risk factors or chronic disease, including high risk patients and mental health patients that are high utilizers of services.
- Promote patient self-management to improve outcomes.

2. Priority-Setting Process

   Each year, institutions will review health care areas considered to be high risk, high volume, high cost, and problem-prone, and identify improvement priorities, taking into consideration statewide strategic priorities and customizing the plan for the facility's health care mission, resources, and the needs of the patient population. The annual improvement plan will include the following elements:

   - Priority areas for improvement to be targeted by institution staff in the coming year.
   - Performance objectives for each priority area (generally six to twelve) and associated timeframes.
   - Improvement strategies that will be used to achieve performance objectives.

3. Development of an Annual Performance Improvement Plan

   As a first step in developing an improvement plan, each California Department of Corrections and Rehabilitation (CDCR) institution will evaluate the health care delivery system and identify gaps in areas such as those listed above. Each institution prioritizes areas to be targeted in improvement initiatives, sets measurable performance objectives for each area, and determines which strategies the institution will use to achieve objectives.

   As a condition of licensure, institutions with a General Acute Care Hospital (GACH) are required to complete an annual Medication Error Reduction Plan. Please see the

requirements for this plan in Attachment A. Institutions with a GACH will incorporate the Medication Error Reduction Plan into their annual performance improvement plan.

Upon developing an improvement plan for the year, institution leadership will take steps to inform institution staff about the improvement priorities for the year and help managers, supervisors, and line staff to identify specific ways they might contribute to improvement efforts as part of their current duties. To this end, institution leadership is responsible for:

- Communicating improvement priorities to staff at all levels of the health care system.
- Helping staff understand their role in achieving improvement objectives.
- Guiding the process of strategic alignment, by which managers and supervisors determine how program operations and day-to-day supervision will support performance objectives, and how care teams and other staff incorporate improvement activities for priority areas into their day-to-day work.
- Updating health care staff about any changes to the improvement plan that occur throughout the year.
- Keeping institution staff apprised of progress toward meeting objectives in the annual improvement plan.

B. Performance Evaluation

1. Overview

   As part of the development of an annual improvement plan, each institution will determine performance measures and objectives for each priority area identified in the improvement plan. Progress toward the achievement of improvement objectives should be monitored at least monthly, and regularly conveyed to all health care staff. To make data as useful as possible as a catalyst for change, institutions may consider generating reports that break down performance by:

   - Clinic or care team.
   - Primary care provider, primary mental health clinician, psychiatrist, or dentist.
   - Patient-inmate subpopulation (e.g. high risk or mental health high utilizers), or other meaningful subgroup.

   This may help health care staff determine which locations, staff, or patient-inmates might receive improvement interventions first, and is generally useful in identifying care teams or individual providers who might present best practices.

2. Health Care Services Dashboard

   For the purposes of identifying opportunities for improvement and potential patient-inmate safety concerns, institutions are also required, through Quality Management Committee (QMC) meetings, Quality Improvement Team (QIT) meetings, and other

forums, to monitor the performance of critical clinical and administrative processes monthly through the Health Care Services Dashboard. The Dashboard includes institution-level performance data, trended over time, in the form of Institution Scorecards, trended composites, and other data displays. Some of the Dashboard data is derived from institution reports. To ensure that Dashboard data is as useful as possible in informing management decisions, institutions will take action to ensure accuracy in data reporting, including:

- Ensuring that staff applies standardized methods for data collection, in accordance with statewide policies, procedures, and detailed instructions.
- Ensuring that staff collecting data are appropriately trained.
- Periodic data validation through redundant data collection by an independent reviewer (e.g. for clinical practice reviews) and/or checking database information against another data source, such as patient-inmate charts to double-check accuracy of health care scheduling data.
- Conducting inter-rater reliability analysis for reviewers of qualitative data.
- Use of statistically-valid samples.

3. Performance Reports

   In addition to the monthly Dashboard, CCHCS issues periodic performance reports and special studies, including morbidity and mortality analysis. Institution CEOs are responsible for ensuring that these reports are broadly distributed to health care staff and discussed in various meeting forums, such as staff meetings and quality improvement committee meetings.

4. Patient Registries

   CCHCS provides lists of patients with targeted dental, mental health, and/or medical conditions to institution staff, updated at least monthly. Patient registries often include an alert function where patients with abnormal findings or who are missing services required by CCHCS guidelines are highlighted. Institution care teams are required to review registries at least monthly (and more often as appropriate) and take action to follow-up with patients as necessary to improve patient outcomes.

5. Data Integrity

   When an institution determines that there may be a problem with data accuracy, the institution will immediately notify the Quality Management Section and will institute corrective actions to ensure data reliability.

C. Quality Improvement Techniques, Tools and Training

Consistent with health care industry standards, institutions will use improvement processes, techniques, and tools to assist health care staff in establishing and maintaining an integrated

health care delivery system, achieving objectives outlined in annual improvement plans, and regularly evaluating and redesigning health care processes. Institutions will:

- Establish clear and measurable objectives for all improvement projects.
- Re-evaluate critical health care processes on a regular basis and redesign operations to implement an integrated health care delivery system and improve outcomes and efficiency.
- Apply improvement models used widely in the health care and quality improvement industries, such as Root Cause Analysis, the Model for Improvement, Lean Model, Six Sigma, Focus-PDSA, Failure Mode and Effects Analysis, Process Flow Diagramming, and Cause and Effect Diagramming to analyze performance problems, develop solutions, and test and evaluate interventions.
- Use patient registries to identify and manage high risk patients and patients with specific chronic conditions and standardized decision support tools disseminated by the QM Program, such as care guides and quality of care review tools, in the application of improvement processes and techniques.
- Take steps to sustain improvements when an initiative has proven successful, such as memorializing new processes in Local Operating Procedures (LOP) or documenting new staff roles in duty statements.
- Orient and train staff on QM Program structures, processes, and tools, and ensure that staff attends statewide training programs designed to build improvement skills in the field.
- Take actions to promote a culture of teamwork and continuous learning and innovation.

The Cycle of Change described in the Quality Management Program Overview presents a framework for the design and implementation of institution improvement initiatives, incorporating the principles described above.

V. QUALITY MANAGEMENT PROGRAM GOVERNANCE

A. Overview

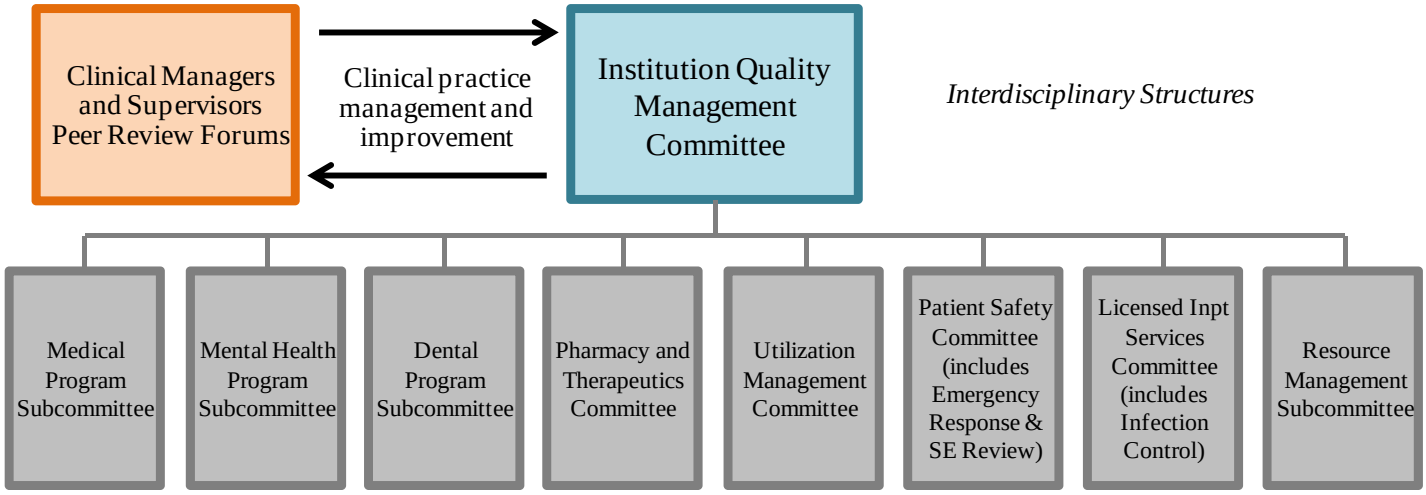
Each institution will maintain an interdisciplinary QM Program structure to monitor and direct performance evaluation and improvement activities. The management structure includes standing committees at two levels:

- An institution QMC that plays a central role in coordinating performance evaluation and improvement activities institution-wide, providing overall strategic direction for the institution quality management system, and communicating performance improvement activities to the statewide QMC, refer to Figure 1.
- Subcommittees that evaluate performance at the program-level, develop program-specific improvement plans, and manage implementation of improvement initiatives. Figure 2 provides a schematic of the management structure overseen by the institution QMC.

Figure 1: The Role of the Institution Quality Management Committee in Leading and Managing Performance Improvement

The institution QMC or any subcommittee may convene a QIT, multi-disciplinary team charged with addressing a particular improvement opportunity. QITs typically exist for the duration of the improvement project and disband upon completion.

Figure 2: Institution Quality Management Program Governance – Standing Committees



Other forums, such as staff meetings, weekly provider meetings, primary care team huddles, and monthly all primary care team meetings, serve as important conduits of performance improvement information and support implementation of improvement initiatives, including, but not limited to:

- Ensuring all staff understand the elements of the integrated health care services delivery system consistent with the Primary Care Model and the quality management system.
- Communicating annual improvement priorities and objectives.
- Reviewing performance data, particularly at the clinic or provider level.
- Disseminating decision support tools and conveying expectations for use.
- Conducting staff development activities consistent with priority improvement areas.
- Developing and implementing improvement initiatives, including process redesign, that align with the institution's improvement priorities and may be specific to a discipline (e.g., health records technicians) or work location (e.g. Yard B).
- Sharing best practices.

B. Institution Quality Management Committee

1. Overview

   In general, the institution QMC provides oversight to local performance improvement activities and ensures that health care programs operate in adherence with applicable laws, regulations, policies, procedures, and standards of care; the institution QMC serves as a hub for change management, collaboration, and coordination across programs and disciplines as activities relate to performance management and

improvement, and serves as a conduit of improvement and patient-inmate safety information from the institution to headquarters.

Among other responsibilities, the institution QMC evaluates the performance of the integrated health care services delivery system at the institution, including CCHCS Primary Care Model, and directs efforts to improve care. The institution QMC sets improvement priorities, regularly evaluates program performance and takes action to make improvements, and coordinates the work of multiple standing committees focusing on particular health care programs or functions. In addition, the QMC ensures that institution staff is trained in quality improvement concepts, processes, and tools, promotes a culture of continuous learning and improvement at the institution.

The scope of the institution QMC is separate and distinctly different from the organized medical staff. The role of an organized medical staff at the institution, if it exists, is peer review and addressing individual clinician practice issues in conjunction with management while the institution QMC oversees organization-wide system performance and improvement activities, which requires involvement of all disciplines and line staff, supervisors and managers. (refer to Figure 2)

2. Committee Actions

   Specifically, the institution QMC takes on the following actions:

   a. Strategic Direction

      - Identifies institution-specific improvement priorities and objectives through the development of an annual performance improvement plan.
      - Aligns institution performance improvement activities with statewide improvement priorities and initiatives.
      - Provides feedback to the statewide QMC on statewide improvement priorities, performance metrics, and initiatives.

   b. Program Evaluation and Improvement

      - Reviews program performance data, including the organizational Dashboard and Institution Scorecards, statewide performance reports, QIT reports, and reports by outside entities, including the Office of the Inspector General, court monitors, and the Prison Law Office, at least monthly.
      - Uses performance data to identify improvement opportunities, evaluate the effectiveness of quality improvement interventions in the Institution Performance Work Plan, and assess the performance of the integrated health care services delivery system, and determine progress toward performance objectives.
      - Takes action when quality or safety problems are identified incorporating new initiatives in the Institution Performance Work Plan, including assigning interdisciplinary QITs to analyze quality problems, select solutions, and implement quality improvement initiatives.

- Approves local improvement initiatives for implementation institution-wide and monitor them through the Institution Performance Work Plan, including development or modification of health care programs, pilot programs, changes to LOPs, training programs, and development or modification of decision support, among other activities.
- Provides oversight during licensing surveys, audits by external stakeholders, and inspections, develops and manages implementation of improvement plans.
- Oversees implementation of policies, evidence-based guidelines and standards of care.

c. Communication and Coordination

- Ensures dissemination of relevant, accurate, and timely performance information to institution management and staff.
- Ensures that QMC, subcommittee, and workgroup activities are appropriately documented.
- Coordinates and reviews subcommittee activities and recommends program changes or further subcommittee activity.
- Ensures effective communication between local improvement committees, especially in areas of interdisciplinary responsibility or system-wide issues.
- Identifies and disseminates best practices.
- Coordinates annual review and approval of institution LOPs.
- Refer issues to other committees or programs, such as the statewide Professional Practice Executive Committee, when they do not fall under the purview of the QMC.
- Reports institution performance improvement plans and activities and recommendations for state-level improvements, to the statewide QMC at least annually.

d. Orientation and Training

- Implements and oversees a local staff development program to orient all health care staff to the QM Program, promote the skills necessary to perform quality improvement work at institutions, and empower staff at all reporting levels to participate in quality improvement.

3. QMC Membership, Meetings, and Reporting

a. QMC Chairperson

The institution CEO will serve as QMC Chairperson. The Chairperson is responsible for ensuring that the QMC meets at least monthly, the committee agenda reflects the responsibilities and actions described in this procedure, program subcommittees report per a designated schedule, and committee decisions are appropriately documented.

b. QMC Members

The institution QMC will include the following voting members:

- Chief Executive Officer
- Institution Chief Quality Officer
- Institution Chief Medical Executive
- Institution Chief Nurse Executive
- Institution Chief Support Executive
- Chief, Mental Health Program
- Health Program Manager III, Dental Program
- Pharmacist-in-Charge
- Associate Warden of Health Care
- Chairpersons of QMC Subcommittees
- Other members as deemed appropriate such as the Director of Nursing, Supervising Registered Nurse II, Correctional Healthcare Services Administrator, Chief Psychiatrist, Supervising Dentist, Nurse Instructor, Public Health Nurse, Health Program Specialists, Standards Compliance Coordinator, etc.

c. QMC Meeting Frequency

It is recommended that the institution QMC meet weekly. However, at a minimum, the committee will meet no less than monthly.

d. QMC Minutes

The Institution QMC shall document each meeting through formal minutes that will be provided to QMC members for review no later than three business days prior to the next QMC meeting.

e. QMC Reporting

The Institution QMC reports to and receives direction from the Statewide QMC. At some institutions, the QMC also reports to a Local Governing Body to meet regulatory requirements, which can serve as an opportunity to promote strategic management of the healthcare system and prison by the Chief Executive Officer, Warden and their leadership.

C. QMC Subcommittees

Each institution will maintain subcommittees to establish and sustain high-quality health care services within a defined program area, consistent with existing policies and procedures, state and federal law, and community standards of care.

A number of standing subcommittees are required by departmental policy or state regulations. Other subcommittees may be established to review and improve performance of a specific program or resource area. Examples of common subcommittees include:

- Medical Program
- Mental Health Program, may include Suicide Prevention and Response (also see Patient Safety)
- Dental Program
- Pharmacy and Therapeutics
- Utilization Management
- Patient Safety
- Licensed Inpatient Services focuses on compliance with Title 22 of the California Code of Regulations including Infection Control and Patient Care Policy Committees
- Resource Management including Human Resources, Health Information Management and scheduling systems, Budgets and Physical Space

Institutions with licensed facilities may also choose to incorporate the functions of a Patient Policy Committee into the QMC if appropriate.

Each Subcommittee Chairperson serves as a member of the QMC and is responsible for reporting subcommittee program performance improvement activities, such as development and implementation of initiatives and improvement projects, to the institution QMC on a routine basis through appropriate documentation (e.g. minutes) and verbal reporting.

All subcommittees will meet as frequently as required in existing policy or state law, and meeting minutes shall be completed and readily available for review.

D. Quality Improvement Teams (QITs)

All standing performance committees and subcommittees have the capacity to form Quality Improvement Teams (QITs), which are time-limited, multi-disciplinary teams convened to analyze and address a particular program or process performance problem.

QITs will provide regular updates to the committee that chartered them and a final report at the close of the improvement initiative.

REFERENCES

- California Code of Regulations, Title 22, Division 5, Article 5, Section 79781, Required Committees
- Inmate Medical Services Program Policies and Procedures, Volume 1, Chapter 6B, Utilization Management Program Procedure
- Inmate Medical Services Program Policies and Procedures, Volume 9, Chapter 4, CDCR System-wide Pharmacy and Therapeutics Committee and Pharmaceutical Care Committee
- Inmate Dental Services Program Policies and Procedures, Chapter 4.4, Dental Program Subcommittee
- Mental Health Services Delivery System Program Guide, Chapter 10, Suicide Prevention and Response

ATTACHMENT A

Requirement that GACH facilities complete an annual Medication Error Reduction Plan:

CALIFORNIA HEALTH AND SAFETY CODE
SECTION 1339.63

1339.63. (a) (1) As a condition of licensure under this division, **every general acute care hospital**, as defined in subdivision (a) of Section 1250, special hospital, as defined in subdivision (f) of Section 1250, and surgical clinic, as defined in paragraph (1) of subdivision (b) of Section 1204, **shall adopt a formal plan to eliminate or substantially reduce medication-related errors.** With the exception of small and rural hospitals, as defined in Section 124840, this plan shall include technology implementation, such as, but not limited to, computerized physician order entry or other technology that, based upon independent, expert scientific advice and data, has been shown effective in eliminating or substantially reducing medication-related errors.

(2) Each facility's plan shall be provided to the State Department of Health Services no later than January 1, 2002. Within 90 days after submitting a plan, the department shall either approve the plan, or return it to the facility with comments and suggestions for improvement. The facility shall revise and resubmit the plan within 90 days after receiving it from the department. The department shall provide final written approval within 90 days after resubmission, but in no event later than January 1, 2003. The plan shall be implemented on or before January 1, 2005.

(b) Any of the following facilities that is in the process of constructing a new structure or retrofitting an existing structure for the purposes of complying with seismic safety requirements shall be exempt from implementing a plan by January 1, 2005:

(1) General acute care hospitals, as defined in subdivision (a) of Section 1250.
(2) Special hospitals, as defined in subdivision (f) of Section 1250.
(3) Surgical clinics, as defined in paragraph (1) of subdivision (b) of Section 1204.

(c) The implementation date for facilities that are in the process of constructing a new structure or retrofitting an existing structure is six months after the date of completion of all retrofitting or new construction. The exemption and new implementation date specified in subdivision (b) and this subdivision apply to those facilities that have construction plans and financing for projects in place no later than July 1, 2002.

(d) For purposes of this chapter, a "medication-related error" means any preventable medication-related event that adversely affects a patient in a facility listed in subdivision (a), and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

(e) Each facility's plan shall do the following:

(1) Evaluate, assess, and include a method to address each of the procedures and systems listed under subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.

(2) Include an annual review to assess the effectiveness of the implementation of each of the procedures and systems listed under subdivision (d).

(3) Be modified as warranted when weaknesses or deficiencies are noted to achieve the reduction of medication errors.

(4) Describe the technology to be implemented and how it is expected to reduce medication-related errors as described in paragraph (1) of subdivision (a).

(5) Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.

(6) Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, and administration, to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.

(7) Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate. Failure to meet this criterion shall not cause disapproval of the initial plan submitted.

(f) Beginning January 1, 2005, the department shall monitor the implementation of each facility's plan upon licensure visits.

(g) The department may work with the facility's health care community to present an annual symposium to recognize the best practices for each of the procedures and systems listed under subdivision (d).