NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.48
SUBJECT: **QUALITY MANAGEMENT PROGRAM PLAN** PROPONENT: Robert MacLeod, Admin. Director *Name/Title* Commissioner's Office 271-3707 *Office* *Phone #*	EFFECTIVE DATE 05/15/05 REVIEW DATE 01/01/06 SUPERCEDES PPD# 6.48 DATED 02/01/04
ISSUING OFFICER: *Stephen J. Curry, Commissioner*	DIRECTOR'S INITIALS DATE APPENDIX ATTACHED: YES NO
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
To provide for a performance management and improvement system that identified processes and functions that are key to the organization's success and consistent with its Mission, Vision and Strategic Plan. Such processes are often sizable and complicated and they usually cross all departmental and discipline boundaries.

II. APPLICABILITY:
To all staff

III. POLICY:
It is the policy of the Department of Corrections to value and encourage the unique contributions of each member of the department through the Quality Management Program Plan. Participants include but are not limited to employees, representatives of the criminal justice system, victims, offenders and families. In this endeavor, strengths will be capitalized upon, challenges managed and new initiatives encourage.

IV. DENFINITIONS:
A. Quality is defined as the degree to which health, forensic and related services and/or processes:
   1. Achieve the highest degree of excellence toward which the department is continually striving
   2. Meet or exceed the expectations of stakeholders
   3. Increase the likelihood of desired outcomes
   4. Are consistent with current professional knowledge and "best practices"
   5. Are delivered in a cost-effective and customer-focused manner

B. The processes and outcomes of care need to be measured through cycles of:
   1. Identifying important aspects of care
   2. Identifying indicators of performance

3. Gathering data
4. Analyzing data
5. Disseminating findings

C. The Quality Improvement (QI) program utilizes a team concept to address issues which impact the quality of health care services provided to inmates. This is achieved by establishing standing and *ad hoc* Performance Improvement (PI) Teams that explore opportunities for improvement across key functions, disciplines and departments and report through the Quality Council to the Commissioner.

D. Quality Management refers to a comprehensive approach that focuses on systematic on going monitoring and improvement of performance in clinical, professional and operational practice. Quality management involves the use of principles and methods to design and redesign services and processes of work so that they meet and exceed the needs and expectations of individuals served, while reducing costs. Quality management encourages the use of systems thinking in formal and informal efforts to improve quality and performance. A quality management system encompasses the interrelated processes of quality assurance, quality improvement, utilization review and risk management and occurs at all levels.

E. QI is a systematic and structured process(es) for improving performance, customer satisfaction and employee morale through a collaborative, multidisciplinary approach. The expansion of existing strengths, problem solving and implementing innovative ideas and programs are key components. QI involves the review, analysis and evaluation of aggregate data to understand patterns and trends.

F. QI is not limited to incremental process improvement. Rather it may include significant redesign and restructuring. The goal is to change for the better in structure, process and/or outcome. The scope and depth of the effort may span from a process change in a focused area to a comprehensive design or redesign of a process that crosses many functional boundaries.

G. Key concepts in QI include:
1. Identifying the important aspects of health services and related functions (often high-risk, high-volume, high cost, problem-prone functions)
2. Determining indicators of performance
3. Gathering data
4. Tracking and trending findings
5. Benchmarking against like facilities, when possible
6. Designing
7. Implementing
8. Evaluating changes targeted at improvement

H. PI Teams are brought together on a standing and/or *ad hoc* basis in an effort to identify areas in health care and related systems that need improvement. When such areas are found, the evaluation of data triggers a cycle of analyzing the process or processes under study, identifying potential changes, testing changes and evaluating the impact of those changes on identified measures of success. PI Teams are authorized by the Quality Council and are formed and function to determine appropriate measures of improvement success across a broad perspective including the four dimensions of clinical outcomes, processes, satisfaction and cost.

Team members are selected to study a process wherein customer needs are identified, key characteristics reviewed, data collected, evaluations made and actions taken to operationalzied-identified improvements. Team members are responsible for the content and process of team meetings by focusing on the team mission, contributing information, analyzing data, making decisions, managing time and continually contributing to improving the team process.

Team leaders/facilitators are responsible for guiding the team through the meeting processes to achieve their objectives, in addition to providing direction, education and support. They are responsible for keeping meetings focused and moving by preparing for meetings, consulting on tools and techniques, testing for consensus, summarizing key points, providing feedback to the team and documenting the process and products.

I. Quality Assurance (QA) is a structured process established to monitor, evaluate and improve the quality and appropriateness of care to an individual or class of patients. QA involves the review, analysis and evaluation of patient and/or provider-specific data that may indicate the need for changes in systems or procedures that would improve the quality of care. Internal or external standards, thresholds or criteria often trigger the review and may include such activities as root cause analyses, peer reviews, assessing complex cases, reviewing adverse events, etc.

J. Performance indicators are the specific performance expectations and/or structures (policies/plans) or processes that must be in place in order for an organization to provide safe, high quality care treatment and services.

K. At a minimum, indicators will be developed that address Laaman Settlement imperatives, ACA standards, legislatively mandated key processes (i.e. RSA 622:48)(see below) and required statistical reports. The Quality Council will review indicators at least annually to determine their continued relevance.

L. Key Functional Processes and Areas

Standing PI Teams will be formed with a focus on the following key processes/functions:

1. Individual-focused functions
    a. Assessment
        1) Health/mental health biopsychosocial assessment
2. Provision of care/treatment
    a. Continuum of care
3. Medication management
4. Health and wellness education
5. Discharge planning

M. Organizational functions

1. Access to services and programs
2. Performance Improvement Planning
3. Leadership, including utilization and risk management activities
4. Safety and environmental management
5. Staffing effectiveness/sufficiency
6. Information management activities
7. Surveillance, prevention and control of infections
8. Nutritional services
9. Inmate rights and responsibilities

NB. For each key process/important functional area at least one performance indicator **MUST** address *SAFETY* and at least one **MUST** address *COST-CONTAINMENT*.

Through the indicators developed by PI Teams for these and other key processes/functions, the DOC QI Program will monitor the following services and programs:

1. Mental health services
2. Dental services
3. Medical services
4. Nursing services
5. Dietary services
6. Physical therapy services
7. Pharmacy services
8. Medical records

9. Psychiatric services
10. Credentialing of providers in coordination with the Division of Human Resources
11. Other services, as necessary

V. PROCEDURES:

A. The Office of the Commissioner will ensure that the Quality Management Program is system-wide, integrated and comprehensive and that it will systematically and objectively examine, monitor, evaluate, and improve health care and related services within the department through problem prevention, identification and resolution. DOC is committed to achieving higher quality at lower cost by implementing cost-effective performance improvement. By continually monitoring and improving processes and outcomes that are relevant to quality care, staff can reduce waste and costs resulting from system failure or redundancy and streamline data gathering and "paper flow" to eliminate wasteful, inefficient and duplicative procedures. A key component of this effort is to identify the most cost-effective practices and apply these at a consistently high level of performance. Additional goals of the Quality Management Program are to improve resource use at a time when budgets are shrinking, recognize problems early and respond before more serious problems occur, improve communications and teamwork, improve outcomes and satisfaction and substantiate claims about the quality of services provided.

The QI Program also relies on understanding the needs of multiple customers and on collecting appropriate data so that the department can address internal needs, meet or exceed ACA standards and comply with external imperatives, such as the Laaman Settlement.

This plan articulates the expectation that the quality and appropriateness of inmate/patient care and the effectiveness of the health care delivery system will be systematically monitored and evaluated according to RSA 151:13a and other general accepted QI/QA practices and standards.

The plan emphasizes four areas: QI and QA, which are interrelated, but distinct activities and Utilization Management and Risk Management activities.

B. Consistent with the DOC mission, the goals for the QI program are to:

1. Understand the needs of the population provided services
2. Identify opportunities to continuously improve care and the care delivery processes
3. Identify opportunities to continuously improve the performance of practitioners to uniformly achieve a common standard of care, consistent with "accepted" standards of care in the community.
4. Develop and maintain collaborative strategies for managing performance in order to meet the changing health care needs of the offender population.
5. Assist in process improvement activities that focus on clinical and non-clinical key functions and processes, including those that are high-risk, problem-prone, high-cost and/or high-volume.
6. Facilitate the use of a FOCUS-PDCA model to establish a uniform methodology for all QI activities.
7. Select and develop data collection and data management systems that can be adapted to meet the changing needs of internal and external customers and relate to relevant dimensions of performance.
8. Produce information about quality in a form, which enables providers, employees and leadership to assess strengths and weaknesses, establish clear goals and measure the effectiveness of planned change.

9. Provide education and communication to all staff members on continuous QI activities.
10. Develop program evaluation tools based upon precise and current written descriptions of programs and their target populations and use valid and reliable instruments to assess clinical outcomes.
11. Develop and utilize performance indicators for which nationally accepted standards are available to use for benchmarking.
12. Contribute to cost-containment strategies through the reduction of liability, liability potential and misapplication of resources.
13. Support the development of practice guidelines/parameters, programs and new processes by utilizing up-to-date information as the basis for decision-making.

C. Key Principles
1. Quality is essential
2. Customer service - quality is measures as a reflection of our ability to meet or exceed the changing needs of internal and external "customers"
3. Process not people - improvements are most likely to occur from changing how we do things rather than who does them
4. Scientific thinking/strategic approaches - use available information, collect data and make decisions based on the measurement of customers' needs
5. Quality is continuous - the way we do things to change as we continually look for ways to improve
6. Teamwork - QI is the responsibility of everybody. Wherever possible problems or opportunities for addressing QA/QI are to be addressed by the people who identify them, not delegated to another group for solution

D. Key steps
1. Leadership assigns responsibility
2. Leadership, the Quality Council, staff and customers identify important aspects of care/opportunities for improvement
3. PI Teams define performance indicators of care or key characteristics of improvement
4. Scientific methods are employed by departments or teams to establish data for more intensive review or other action
5. Data is collected and organized
6. PI Teams, the Quality Council, standing committees and leadership set priorities and make recommendations based upon the evaluation of data
7. Actions are taken to implement potential improvements through staff consultation and/or other process changes
8. The effectiveness of actions taken is reviewed through continued data collection and/or other process review
9. Findings from review of actions are communicated to affected individuals and groups as necessary, to maintain standards of practice and opportunities to pursue further improvements

E. Quality Improvement Model

The model for process improvement activities shall be FOCUS-PDCA
1. **F**ind a process improvement opportunity
2. **O**rganize a team that knows the process
3. **C**larify the current knowledge of the process
4. **U**ncover the root cause of process variation
5. **S**elect the improvement
    a. **P**lan the improvement and data collection
    b. **D**o make the improvement, perform data collection, do data analysis
    c. **C**heck data for process improvement, review lessons learned
    d. **A**ct to hold the gain. Act to continue improvement

F. Types of reviews

DOC evaluates and makes plans based on five major types of review

1. Process evaluation - PI Teams process improvement activities
2. Outcome evaluation - achieve desired clinical and operational results as measured by valid and reliable tools
3. Root cause analysis (RCA) - clinical and/or administrative review of significant events
4. Administrative/structural evaluation - ensures program organization for leadership, management, operations and support services
5. Annual review of the Secure Psychiatric Unit (SPU) as required by RSA 622:46
6. Practice evaluation - maintain high standards through literature reviews, peer review, consultation, etc.

G. Data sources

1. Available statistics/data collected for administration/management information
2. Results of DOC quality assessment and review activities
3. Employee suggestions
4. Offender/family satisfaction surveys and other communications
5. Offender grievances
6. External reference databases
7. Standards/practice guidelines
8. Benchmarking
9. Results of accreditation/regulatory reviews
10. Provider credentialing materials

H. Confidentiality

All participants in DOC QI activities shall assure that appropriate confidentiality is maintained, consistent with professional responsibility and applicable Federal and State laws and regulations. To permit candor and open and honest discussion, ***QA information is deemed confidential and protected from legal discovery.*** The privilege to protect this information is granted by RSA 151:13a. The statute defines QA records as "Confidential records generated in a formal program to monitor and evaluate the quality and appropriateness of care…" QA records document the process of reviewing, analyzing or evaluating the care provided rather than the process of providing the care in the first place.

I. Authority and Responsibility

1. The Office of the Commissioner

   The Commissioner retains the ultimate authority for all PI activities and authorizes the establishment of a centralized multi-disciplinary approach for providing on-going comprehensive review of the performance of key functions and/or processes, with the overall goal of continuous improvement. The Commissioner delegates specific functions to key facility leadership and Division, Bureau and office personnel and health care and forensic providers. The Commissioner delegates the authority and responsibility for implementing a comprehensive QI plan to the director of Quality Improvement.

2. Senior Leadership

   The Commissioner's Office meets with senior manager as an Executive Committee. These managers are responsible and accountable to the Commissioner's Office for the overall security, administrative and clinical supervision of the program/service areas to which they are assigned. Managers provide administrative supervision directly or by delegation to all personnel, employed or contracted, who provide care and programming within their areas.

   The process of leadership involves building a clear mission, achieving accountability at every level in the organization and communicating in a manner that develops a culture committed to performance improvement. The Commissioner's Office and the

Executive Committee, in collaboration with the Director of Quality Improvement and the Quality Council shall:

a. Prioritize improvement activities
b. Allocate the necessary resources
c. Analyze and assess the effectiveness of those activities
d. Authorize and ensure that QA reviews are conducted when appropriate
e. Evaluate the effectiveness of the QI Program

3. Division, Bureau and Office Managers
   All clinical and support service departments are delegated responsibility for managing departmental and individual performance. The manager of each department is responsible for effectively implementing ways to monitor important aspects of care and the clinical performance of members of their department. Managers are responsible for taking action to resolve identified problems using the principles of ***Continuous Quality Improvement***. Managers develop facilitation skills in order to provide the best possible leadership for their employees and QI activities that are summarized, in writing, for the Quality Council.
4. Medical and Forensic Services
   The staff of Medical and Forensic Services is responsible for the implementation of efficient and effective mechanisms to monitor and evaluate the processes and quality of patient care and the clinical performance of designated providers and contracted services. These mechanisms shall include, but not be limited to peer review, discipline-specific evaluation and supervisory oversight. All review activities shall establish a credible, thorough and timely dialogue between reviewers, providers, consultants and others. When and if opportunities to improve the processes and outcomes of care (key functional areas) are identified, the health services staff shall develop written action plans in collaboration with other disciplines, as appropriate.
5. All Staff
   Individual staff works with others to provide the best possible care and programming to offenders. Employees are given training such that they understand the intent of continuous QI activities and can provide creative innovative ideas.
6. Quality Council
   With authority from the Commissioner and Executive Committee, the Quality Council shall oversee and ensure the effectiveness of improvement efforts, especially as they relate to new or substantially revised processes. As its mission, the Quality Council shall seek to ensure an optimum level of services/care by coordinating and facilitating efforts that improve the delivery of customer focused health, forensic and programmatic services.
7. Strategic functions and activities of the Quality Council shall include leadership, organization, facilitation/support, recommendations for resource allocation, assessment and evaluation, overseeing the operationalizing of improvements and coordinating the flow of information and communication among stakeholders.
8. The Quality Council shall meet monthly with an agenda that addresses follow-up on improvement initiatives, consideration of new opportunities for improvement, important process review activities, staff education and staff recognition efforts.
9. Overall, the Quality Council functions are to:
   a. Assist in translating the DOC Mission, Vision and Values into a QI Plan and targeted improvement initiatives
   b. Serve as a resource to the Commissioner's Office to set and drive priorities for clinical improvement, QA, utilization management and risk management
   c. Monitor and improve the delivery of adequate health care, programmatic and related services
   d. Review and approve new PI initiatives
   e. Review all PI reports

f. Review the analysis of aggregate statistical data
g. Review findings of external regulators and/or licensing authorities
h. Identify trends, problems and additional opportunities for improvement
i. Prioritize problems
j. Review the findings of Root Cause Analyses
k. Consider options for solutions that resolve or minimize the impact of problems
l. Recommend corrective action
m. Evaluate the process and effect of an action
n. Determine the adequacy of care and services
o. Make written recommendations to improve quality of care and effectiveness of services
p. Report findings, recommendations and actions taken to the Commissioner through the Director of QI

10. Quality Council Membership

The standing membership of the Quality Council will be approved and appointed by the Commissioner and will include the Warden from each facility, Security, the Division of Medical and Forensic Services, the leaders of the PI teams and an outside (non-DOC) member.

The chairs of various standing committees (if not included above) and others will be invited to participate, as appropriate.

11. Office of QI

The Director of QI shall be responsible for the overall coordination of DOC QI activities. These activities include planning, establishing and maintaining standardized reports, consultation, data collection, data integration, data trending analysis and reporting. The Director of QI reports findings and recommendations directly to the Commissioner and others as appropriate.

12. The duties of the Director of QI include, but are not limited to:
    a. Providing consultation in QI principles and methodologies
    b. Monitoring adherence to plans for improvement
        1) Receiving, maintaining and analyzing corrective action plan reports
        2) Receiving and maintaining related documentation to track all QI activities.
    c. Conducting investigations to assist in determining causes/rationale
    d. Coordinating all QI activities
        1) Presenting summaries to QI Committee
        2) Compiling summary reports at least quarterly and producing an Annual QI Report
        3) Submitting reports to the Commissioner
        4) Maintaining QI files that track the development of QI initiatives, results and activities
        5) Chairing the Quality Council
        6) Maintaining membership on other committees:
            a) Infection Surveillance, Prevention and Control
            b) Pharmacy and Therapeutic Committee
            c) Medical Records Committee
        7) Attending the following meetings:
            a) Executive Staff Meeting, as appropriate
            b) Division of Medical and Forensic Services Staff meeting
        8) Conducting focused investigations and studies as requested by the Commissioner

J. Reporting

1. The implementation of the QI program shall be evidenced in a variety of documents, reports, action recommendations, action plans and memos. In addition, accurate minutes shall reflect the proceedings of the PI Teams, Committees and Quality Council. Minutes of the Quality Council meetings shall be distributed as follows:
   a. Commissioner
   b. Assistant Commissioner
   c. Warden of each facility
   d. Division, Bureau and Office Directors
   e. PI Team Leaders
   f. Chairs of standing committees
2. Minutes shall be kept in a notebook labeled "Quality Council Minutes" located in the Commissioners Office and at each facility.

   Reports and minutes shall document conclusions, recommendations, actions and follow-up as they relate to identified topics. A written executive summary of The Executive Committee shall be prepared on a quarterly basis for review The Quality Council shall review the QI Plan, at a minimum, annually and revise as necessary.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards
4-4410 thru 4411

Standards for Adult Probation and Parole Field Services
Third Edition Standards

Standards for Adult Community Residential Services
Fourth Edition Standards

Other:
RSA 151:13a

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