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SUBJECT: QUALITY MANAGEMENT PROGRAM

EFFECTIVE DATE: 10/15/2021

I. PURPOSE:

To implement a program that evaluates and improves the quality of health care provided to inmates of the Florida Department of Corrections (FDC).

II. DEFINITIONS:

Central Office Quality Management (QM) Coordinator- the central office employee designated by the Health Services Director or designee to coordinate the planning and implementation of the quality management program.

Comprehensive Health Care Contractor (CHCC)- private health care vendor designated by the Department of Corrections (DC) or Department of Management Services (DMS) to provide medical, dental and mental health services at designated institutions within a particular region. Contractor will be responsible for coordinating the quality management program at these designated institutions. The CHCC will utilize staff that is comparable to the department for the management of the QM program.

Corrective Action Plan- refers to a plan for the correction of a non-compliant finding within a specified review or study within the Quality Management Program.

Regional Quality Management (QM) Coordinator- the designated employee responsible for the quality management program at each region.

Institutional Quality Management (QM) Coordinator- the employee who has been designated to coordinate the quality management program at each institution.

III. PROCEDURE:

A. Responsibilities:

These standards and responsibilities apply to both FDC and CHCC staff. The CHCC is responsible for meeting all requirements utilizing positions of equivalent level identified in this procedure. Prior approval by FDC Office of Health Services (OHS) is required before any modification to this program is instituted by the CHCC.

1. **Office of Health Services**- Responsible for the administration of the quality management program to include:

a) Directing the activities related to the quality management program through:
   1) Development of strategies to ensure a successful program.
   2) Evaluating and improving the quality of health care processes and outcomes.

b) Ensuring corrective action is taken for all agreed-upon findings in various reports and surveys.

c) Acting as a resource for all quality management related issues.

d) Maintaining records of the quality management activities

e) Coordinating the Office of Health Services QM Committee meeting.

2. **Regional QM Coordinator**- the designated employee will:

a) Ensure a quality management program exists in each institution within their region.

b) Act as the liaison between central office and the institutions on QM issues.

c) Conduct reviews at each institution to ensure appropriate continuous operational QM process and clinical QM efforts are being performed.

d) Provide summary of findings and approved corrective action plans. Resources will be included as applicable.

3. **Institutional QM Coordinator**- the designated institutional health services employee will:

a) Coordinate the quality management program at the institution.

b) Participate in the monthly QM Committee and provide reports to their Regional QM Coordinator.

c) Provide quality management orientation and education to health services staff.

d) In collaboration with the appropriate discipline manager will develop corrective action plans.

B. Quality Management Review Process:

To ensure the most efficient and effective health care systems, the review process is an important component of the program. It provides input into the management of resources and personnel and is divided into two sections: 1) continuous operational QM process efforts; and 2) clinical QM efforts.

1) Continuous operational QM efforts are those routinely performed by regional and institutional staff to ensure efficient operations. This includes, but is not limited to: performing routine site visits to monitor and ensure the health care system is working properly, reviewing and analyzing reports and logs to assess appropriate inmate access to health care within and outside the institution, performing problem resolution when necessary, and identifying and assisting with training needs.

2) Clinical QM efforts are those that require specific records review of various clinical functions, such as Chronic Illness Clinics, care review, medication/treatment administration, etc. This will be accomplished through chart reviews.

The quality management review process provides a mechanism to evaluate and identify opportunities for improvement through all aspects of health services. The process is as follows:

1. **Quality Review by the Institutions**

   a) Each discipline will utilize DC4-512A or approved form to perform a bi-annual (June and December) review of their area within health services. When reviewing clinical areas, each discipline will randomly select 10 to 15 records per clinic/category that are eligible to meet an indicator utilizing the OBIS run reports. If there are categories/clinics that are not held at a particular institution, they would be marked as "not applicable".

   b) Each indicator with a score below 90% requires a corrective action plan (DC4-512C or approved form).

   c) The outcomes and improvements/acts are discussed at the QM Committee meetings.

   d) The Institutional Coordinator will submit to the Regional QM Coordinator the bi-annual health services reports with all personal health identifiers removed from the report (DC4-512B or approved form) and any corrective action plans by the 15th of July and January.

e) The Regional Coordinator will submit a bi-annual summary of the health services reports with all personal health identifiers removed from the report to the Central Office QM Coordinator by the 5th of August and February.

2. **Quality Management Review by Regional Team**:

a) Every 18 months, a review will be conducted at each institution by the Regional QM Review Team. They shall use the quality management instrument (DC4-512A or approved form) and randomly select 10 to 15 records per clinic/category. The reviews should be scheduled around CMA and ACA audits, which should prevent an institution from going no longer than twenty-four (24) months without an onsite review. A fiscal year (July 1- June 30) schedule of QM reviews is to be submitted to OHS by the 20th of August, each year.

b) The Regional QM Coordinator is the team leader of the Quality Management Review and is ultimately responsible for the oversight of the process.

c) The team will consist of the following positions (unless otherwise approved by OHS) within each region:

1) Regional QM Coordinator - Team Leader
2) Regional Medical Director
3) Regional Registered Nursing Director
4) Regional Infection Control Registered Nurse
5) Regional Mental Health Director
6) Regional Dental Services Director
7) Pharmacy Manager (Administration or Clinical)

d) The length of the review will depend on the size and complexity of the institution. Each team member will have the flexibility to perform the review at their own pace and submit findings to the team leader by the end of the review week.

e) A preliminary report of major findings will be provided to institutional management during the exit briefing.

f) The Team Leader will be responsible for compiling the final report (which will include all team members' findings) with all personal health identifiers removed from the report on DC4-512D, and is

submitted to the institution and Central Office Coordinator within 20 days after the review.

g) The institution will address each indicator with a score below 90% with a corrective action plan. The Institutional Coordinator will submit the corrective action plan to the Regional Coordinator for approval within 10 days after receiving the preliminary report.

h) The Institutional Coordinator will provide the Regional Coordinator with a monthly corrective action plan report until all corrective action has been completed.

i) Within 6 months from the date of the final report, the Team Leader shall perform a follow-up site visit to ensure corrective action has been completed.

C. QM Committee Process:

A committee/team shall be established at the institutional, regional, and statewide levels.

1. **Institutional QM Committee**:

a) Each institution will establish a multidisciplinary QM Committee to review quality management issues within their institution. At minimum, the committee will consist of the following positions or Equivalent positions:

1) Health Service Administrator - Chairperson
2) Chief Health Officer/Medical Director
3) Assistant Warden of Programs
4) Director of Nursing
5) Lead Mental Health Clinical Representative
6) Security Staff Representative
7) Infection Control Nurse
8) Other staff as appointed by Chairperson

b) The committee will meet on a monthly basis to discuss findings, make recommendations for improvements, and evaluate the status of corrective actions.

c) The Chair will prepare meeting minutes, which shall be submitted to the Regional QM Coordinator by the 10th of each month.

2. **Regional QM Team**:

   a) The team will meet quarterly and review institutional quality management issues within their respective region.

   b) Utilizing the DC4-512C or an approved form, the team will prepare a quarterly summary that reflects the findings and initiatives made for improvements. This summary shall be submitted to the Central Office QM Coordinator by the 20th day after the end of the quarter along with a copy of the meeting minutes.

3. **Statewide QM Committee:**

   a) The Health Services Director or designee will establish a multidisciplinary QM Committee to review OHS quality management activities.

   b) The Committee will meet at least semi-annually but more frequently if deemed necessary. They will discuss and analyze statewide findings and make recommendations for improvements.

D. Quality Management Annual Studies:

Studies will be conducted at least annually to document performance trends over time, track variation in care, and recommend quality improvements. The Statewide Quality Management Director or designee will be responsible for the initiating, which includes seeking approval prior to implementation, and executing of these studies. These studies will be presented during designated Statewide QM Committee meetings.

Each study must be pre-approved by the Office of Health Services- Quality Management Department. Some suggested areas would include: chronic disease management, preventive services, behavioral care, and high-burden diseases such as diabetes, heart disease, asthma, and depression.

It is extremely important to have the ability to draw similar comparisons, therefore, all studies will be measured with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) unless prior approved to use similar quality standards and performance measures.

E. Correctional Medical Authority (CMA) Health Services Survey Process:

The CMA, as required by Section 945.6031, Florida Statutes, shall conduct a survey at least once every three (3) years at each institution within the Florida Department

of Corrections (FDC). Institutions should be survey ready at all times. The Department and/or CHCC (if applicable) will respond to findings in accordance with OHS directives.

The survey process includes:
(See Attachment #2 *CMA CAP Process for Contracted Partners)*

1. CMA pre-survey questionnaire and coordination of survey arrangements.

2. Exit briefing by CMA team members will present preliminary findings and a final report will be provided to the respective institution.

3. All findings require a CAP (DC4-512C), which shall be submitted by the institution to the Chief of Health Services Administration and the Central Office Quality Management Coordinator within twenty (20) days of the final report date.

4. The Department or CHCC (after the Department's review) shall submit final CAP(s) to the CMA and Central Office QM Coordinator electronically within thirty (30) days of the final report date indicating the actions that will be taken to address deficiencies determined by the authority to exist at an institution. Each plan shall set forth an estimate of the time and resources needed to correct identified deficiencies.

5. Within six (6) months after the initial survey, CMA will determine whether all deficiencies have been corrected. If they determine all corrective action has not been completed, they will request an amended corrective action plan.

E. Additional Program Components:

1. **Credentialing and Peer Review** - Credentialing and Peer Review will be conducted in accordance with Health Services Bulletin 15.09.05, Credentialing and Peer Review Program.

2. **Infection Control** - Infection Control will be conducted in accordance with the "Infection Control Program Manual".

3. **Mortality Review-** Mortality Reviews will be conducted in accordance with Health Services Bulletin 15.09.09, Mortality Review Programs.

4. **Risk Management -** Risk Management will be conducted in accordance with Health Services Bulletin 15.09.08, Risk Management Program.

5. **Utilization Management** - Utilization Management will be conducted in accordance with Health Services Bulletin 15.09.04, Utilization Management Procedures.

6. **Continuing Health Care Provider Education** - Continuing health care provider education is a licensure requirement.
In-Service training needs to improve the quality of services that are identified throughout the quality management program components. Refer to Procedure 208.019, Required Licensure and/or Certification of Staff.

F. Management of Confidential QM Materials:

Any information or documents which are part of the quality management program are confidential and exempt from the provisions of Section 119.07(1), F.S. Refer to Procedure 401.006, Confidentiality of Health Services Record Information for further details.

IV. RELEVANT DC FORMS:

Attachment#1, *Quality Management Activities and Due Dates*
Attachment #2, *CMA CAP Process for Contracted Partners*
DC4-512A, *Quality Management Instrument*
DC4-512B, *Bi-Annual Reports*
DC4-512C, *Corrective Action Plan*
DC4-512D, *Quality Management Review* *Report*

Health Services Director Date

This Health Services Bulletin supersedes: HSB 15.06.11 dated 12/29/08
TI 15.09.01 dated 2/10/03
TI 15.09.07 dated 4/07/03
TI 15.09.10 dated 6/06/06
HSB 15.09.01 dated 1/24/11, 03/28/13, 01/31/14 3/17/15, AND 12/06/17, 10/15/2019