State of Connecticut Department of Correction **ADMINISTRATIVE DIRECTIVE**	Directive Number 8.10	Effective Date 05/20/17	Page 1 of 5
	Supersedes Quality Assurance and Improvement, dated 1/1/2008		
Approved By  Commissioner Scott Semple	Title Performance Monitoring of Healthcare and Healthcare Services		

1. Policy. The Department of Correction (DOC) shall monitor the quality of health services provided to inmates.

2. Authority and Reference.
   a. Connecticut General Statutes, Sections 18-81, 21a-262 and 52a-174.
   b. Doe v. Meachum, Civil Action No. H-88-562 (PCD), November 2, 1990.
   c. Lareau v. Manson, Civil Action No. H-78-145, September 17, 1981.
   d. West v. Manson, Civil Action No. H-83-366 (AHN), April 23, 1987.
   e. Smith v. Meachum, Civil Action No. H-87-221 (JAC), August 8, 1989.
   f. American Correctional Association, Standards for Administration of Correctional Agencies, Second Edition, April 1993, Standard 2-CO-4E-01.
   g. American Correctional Association, Standards for Adult Correctional Institutions, Fourth Edition, January 2003, Standards 4-4409 and 4-4424.
   h. American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June 2004, Standards 4-ALDF-7D-25 and 3-ALDF-7D-26.
   i. National Commission on Correctional Health Care, Standards for Health Care in Prisons, 2014, Standard P-A-06.
   j. National Commission on Correctional Health Care, Standards for Health Care in Jails, 2014, Standard J-A-06.
   k. Administrative Directives 1.9, Audits, 8.7, Health Records Management; and 10.11, Addiction Services.

3. Definitions. For the purposes stated herein, the following definitions apply:
   a. Benchmark. Defines the 100 percent mark on the measurement scale to gauge performance on a defined product or service against the best existing products or services of the same type.
   b. Clinical Performance Enhancement Review. The process of having a health professional's work reviewed by another professional of at least equal training within the same general discipline.
   c. Continuous Quality Improvement (CQI). A program model that supports the continuous review and improvement of services and corrective actions related to health care.
   d. Corrective Action Plan. A written detailed response that identifies the responsible party tasked with implementation, the steps that will be taken, and when a resolution will be completed.
   e. Evaluation. A health appraisal of an individual.
   f. Introduction-Situation-Background- Assessment-Request tool (ISBAR). A tool that identifies any area of concern that may impact the provision of healthcare and services to the inmate patient population.
   g. Local QA/QI Committee. A facility based multi-disciplinary team that represents the various types of care provided for that facility (e.g., laboratory, nursing, psychology, custody, etc.).
   h. Monitoring. An ongoing systematically planned collection, organization, compilation and review of collected data.
   i. Monitoring Panel. A multi-disciplinary team composed of DOC employees that monitor the quality of care, develop action plans for improvement based on findings, and assesses the effectiveness of these plans after implementation.
   j. Outcome. The degree to which output meets the needs and expectations of the patient.
   k. Quality. A level of health care service intended to increase the probability of desired treatment outcome and reduce the opportunity of undesired outcome.

l. Quality Assurance and Quality Improvement (QA/QI) Program. A process by which health care delivery is monitored and evaluated to assess the quality and appropriateness of care and to identify features of the health care delivery system requiring improvement. QA/QI Programs shall follow the CQI program model.
m. Statewide QA/QI Committee. A multi-disciplinary team consisting of the members of the Monitoring Panel, members of the Health Services Unit administrators, and least one (1) representative from the Health Services Unit local QA/QI Committee.

4. Quality Assurance and Quality Improvement Program Management. The Chief Operating Officer or designee shall supervise, provide oversight, and have reporting requirements regarding a QA/QI Program for health and addiction services in accordance with the provision of health and addiction services.

5. Components of the Quality Assurance and Quality Improvement Program. The QA/QI Program shall, at a minimum, contain the following components:
   a. Safety. To monitor the safety of the environment for the public, staff and inmates by recommending or implementing safeguards against accidents and injuries.
   b. Consent Decree Compliance. To direct compliance with court ordered consent decrees, identify areas of potential liability, and to make recommendations for corrective action.
   c. Infection Control. To prevent, identify and control infections.
   d. Health Care. To monitor all aspects of health care including admission, screening and evaluations of sick call services, chronic disease services, infirmary care, nursing services, pharmacy services, diagnostic services, psychiatric services, dental services, and adverse patient occurrences.
   e. Critical Incident Case Review. To conduct a review in the event of an inmate death or other serious clinical event as determined by the Chief Operating Officer in order to determine if a pattern of symptoms exist, which if identified during the course of treatment, might have resulted in earlier diagnosis and intervention, and to examine events immediately surrounding each death or other serious clinical event to determine if appropriate interventions were applied.

6. Local Quality Assurance and Quality Improvement Committee. Each facility shall establish a QA/QI Committee to ensure that the provisions established by the QA/QI Program are adhered to in accordance with this Directive.
   a. Committee Members. Committee members shall include a designee(s) as determined by the Unit Administrator. Committee members from the Health Services Unit shall include a representative from various health disciplines and/or facility specific programs.
   b. Committee Duties. The local QA/QI Committee shall:
      i. meet regularly, but quarterly at a minimum;
      ii. ensure regular development and revision of the local QA/QI Program;
      iii. review and assess collected data to identify patterns or trends within a given facility or facilities;
      iv. plan for corrective action;
      v. monitor the resolution of identified problems;
      vi. evaluate the effectiveness of the QA/QI Program;
      vii. document QA/QI Program activities; and,
      viii. participate in Statewide QA/QI Committee activities as needed.
         1. The local committee shall convene at least quarterly and submit minutes to the Chief Operating Officer or designee.

7. Statewide Quality Assurance and Quality Improvement Committee. The Chief Operating Officer shall ensure that a Statewide QA/QI Committee is established as follows:
   a. Committee Members. Committee members shall include representatives from the Monitoring Panel, members on the Health Services Unit, and ad hoc members as necessary.
   b. Committee Duties. The QA/QI Committee shall:

i. oversee and direct the overall QA/QI Program;
ii. review standards and monitoring systems;
iii. identify quality of care standards;
iv. review and assess collected data to identify patterns or trends;
v. identify needs for corrective action;
vi. monitor the resolution of identified problems;
vii. evaluate the effectiveness of the QA/QI Program; and,
viii. document QA/QI Program activities and serve as a resource to local QA/QI Programs.

1. The statewide committee shall convene at least quarterly and submit minutes to the Chief Operating Officer or designee.

8. Accountability.
   a. On January 15th and July 15th of each year, the statewide QA/QI committee shall submit a report of QA/QI Program activity and outcomes to the Chief Operating Officer.
   b. The CQI program shall be consistent with the quality standards established by the National Commission on Correctional Health Care (NCCHC).
   c. A local QA/QI Committee corrective action plan shall be developed, agreed upon and signed off by at least three (3) people from the local QA/QI Committee and submitted for review to the Chief Operating Officer or designee.
   d. Continuous QA/QI studies shall be conducted in all facilities where health and addiction services are provided. Each facility may decide the necessary studies to provide quality care in that facility. QA/QI studies shall relate to the scope of services set forth in Chapter 8 of the Administrative Directives and with Administrative Directive 10.11, Addiction Services.

9. Clinical Performance Enhancement Reviews. The Health Services Unit shall conduct annual clinical performance enhancement reviews based on current NCCHC standards of all providers, which include but are not limited to psychiatrists, physicians and advanced practice registered nurses. These clinical performance enhancement reviews shall be submitted to the Chief Operating Officer quarterly.

10. QA/QI Audits Health service audits shall be conducted in accordance with the following:
   a. Audit Requirements. The Health Services Unit shall appoint a QA/QI liaison to work with the DOC Monitoring Panel to develop and/or improve compliance audit tools. Performance thresholds shall be established for each category.
      i. Performance-based measures shall be conducted annually and may include any health care item from the scope of services that can be measured against nationally known evidence-based practices or internally developed benchmarks
      ii. The Health Services Unit shall pilot test 'new' quality improvement instruments before use, including data collection, staff impact, sample size and feasibility of the data collection itself. The Health Services Unit shall train all staff performing QA/QI studies on the use of each instrument and shall provide the results of all pilot tests and proof of training to the Statewide QA/QI Committee and the DOC Chief Operating Officer as requested.
   b. Audit Process. All relevant health information must be available in the health record on the day of the audit. Only approved DOC and/or Health Services Unit forms shall be permitted in the health record. Issues of legibility shall be addressed and documented on a case-by-case basis. Each site shall have a grace period of 14 days to resolve or correct service or documentation problems identified with any inmate health record. All documented corrections, alterations and late entries shall be consistent with the Health Services Unit policies and count as part of the audit.
   c. Audit Timetables. The Department of Correction Health and Addiction Services Unit shall, at a minimum, conduct an annual review of all available audit data

submitted by the Health Services Unit to ensure compliance with all polices and applicable administrative directives.

d. Trends analysis. The department shall conduct audits on healthcare and healthcare services of identified trends as deemed necessary by the Chief Operating Officer.

e. Corrective Action Plans. All audits shall require a corrective action plan for any deficiencies noted. A corrective action plan shall be required within 14 days of receiving the written results of the audit. The audit results and the corrective action plan shall be reviewed at the next local QA/QI Committee meeting. The Health Services Unit shall have three (3) months to implement the corrective action plan.

11. ISBAR.

a. Overview. The ISBAR tool (CN81001) shall be utilized by the Chief Operating Officer or designee to identify an area of concern by an identified responsible party within the Connecticut Department of Correction, the Health Services Unit and/or agency providing inmate healthcare services. Utilizing the initial generated CN81001, ISBAR, the identified responsible party must respond in to the originator. The response requirements for the identified responsible party to answer an CN 81001, ISBAR back to the document originator are identified by the following factors:

i. Scope: the measurement of the number of inmates that are potentially or actually affected by delivery of healthcare and/or services.

1. Isolated. When one or a limited number of inmate patients are affected, and/or limited number of staff is involved, and/or the situation has occurred only occasionally or in a limited number of locations
2. Pattern: When more than a limited number of inmate patients are affected, and/or when more than a limited number of staff is involved, and/or the situation has occurred in several locations, and/or the same inmate patient population has been affected by repeated occurrence of practice.
3. Widespread: When the practices are pervasive in a facility or facilities and have affected or potentially will affect a large percentage of an identified inmate patient population and/or represents a systemic failure to adhere to established CTDOC administrative directives, contractual obligations, and/or community healthcare standards.

ii. Severity: The measurement of degree of impact on inmate patients.

1. Level 1: Conduct and/or practice that has resulted in a minor negative impact on inmate patient(s), or has potential for such impact.
2. Level 2: Conduct and/or practice that has resulted in more than a minor negative impact on inmates patient(s), or has the potential for such impact.
3. Level 3: Conduct and/or practice that has resulted in a serious negative impact due to actual harm to the inmate patient(s), or has the potential for such harm.
4. Level 4: Immediate danger to patient(s) health, safety, and well-being that has or is likely to cause serious harm, injury, impairment, or death to inmate patient(s), and/or has threatened or may threaten the safe, secure, and orderly operation of the facility(s).

iii. Timeframe: The amount of time allotted by the originator on the CN81001 to respond and resolve the identified area of concern.

1. Level 1: Timeframe for response and corrective action plan: four (4) weeks
2. Level 2: Timeframe for response and corrective action plan: two (2) weeks

3. Level 3: Timeframe for response and corrective action plan: one (1) week
4. Level 4: Timeframe for response and corrective action plan: twenty-four (24) hours

iv. Action requirements: The recipient of the ISBAR shall provide a detailed corrective action plan to include the identification of a finalized resolution.

1. Approved action requirements: Once the ISBAR is finalized and approved by the Chief Operating Officer, or designee, copies of the completed ISBAR shall be submitted to the local QA/QI committee and the CTDOC monitoring panel for review.
2. Rejected action requirements: If the original ISBAR is reviewed by the Chief Operating Officer, or designee, and the proposed corrective action plans and identified resolutions are not approved, the Chief Operating Officer, or designee, shall contact the Health Services Unit providers to establish acceptable corrective measures.
    a. The ISBAR review process shall continue to occur utilize the Chief Operating Officer, or designee, approves the identified corrective action plan.

b. Administrative review. The Chief Operating Officer or designee shall make any and all issued CN 81001, ISBAR's accessible to each facility specific Unit Administrators for review. On January 15th and July 15th of each year, the Chief Operating Officer or designee shall submit a report to the Commissioner or designee and the administration of the Health Services Unit regarding any previous CN 81001, ISBAR's that have occurred within the designated timeframe and/or any current CN 81001, ISBAR's that are pending action.

12. Forms and Attachments. The following forms and attachments are applicable to this Administrative Directive and shall be utilized for the intended function:
    a. CN 81001, ISBAR

13. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.