GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Continuous Quality Improvement		
Policy Number: 507.01.12	**Effective Date:** 4/13/2018	**Page Number:** 1 of 13
Authority: Commissioner	**Originating Division:** Health Services Division	**Access Listing:** Level I: All Access

I. Introduction and Summary:

A Continuous Quality Improvement (CQI) Program has been established and implemented to monitor and improve the efficiency, cost-effectiveness and quality of health care service and includes Peer Review. This policy is applicable to all facilities that house state offenders to include private and county prisons.

II. Authority:

A. Georgia Department of Corrections (GDC) Standard Operating Procedures (SOPs): 508.11 MH/MR Continuous Quality Improvement, 507.01.07 Administrative Meetings and Reports, 507.01.08 Health Care Data and Statistical Reporting, 507.03.01 Licensure and Credentialing Verification, 507.03.08 Nurse Practitioner/Physician Assistant Practice, 507.04.12 Telemedicine, 507.04.27 Sick Call, 507.04.42 Infirmary Care, and 507.04.67 Offender Death and Mortality Reviews;

B. NCCHC 2014 Adult Standard: P-A-06 Continuous Quality Improvement Program and P-C-02 Clinical Performance Enhancement;

C. NCCHC 2015 Juvenile Standard: Y-A-06 Continuous Quality Improvement Program; and

D. ACA Standards: 4-4017, 4-4410 (MANDATORY), 4-4411 (MANDATORY) and 4-4422.

III. Definitions:

A. **Continuous Quality Improvement (CQI)** - A program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care and resolve identified problems.

B. **Statewide Continuous Quality Improvement (CQI) Committee** - A state wide Continuous Quality Improvement Committee charged with the responsibility to carry out the objectives of the Continuous Quality Improvement Program. The committee monitors activities, discusses the results and implements corrective action.

C. **Peer Review** - Peer review is a process whereby the medical practices and management of a given practitioner (M.D., D.O., N.P., P.A., D.D.S., or Psychiatrist) are reviewed by another practitioner at the same or higher level, at set intervals or by special request. Peer review operates under the umbrella of CQI but is a special kind of review that follows specific rules aimed to protect it from discovery.

D. **Credentialing** - A review process whereby the qualifications of health professionals required for employment are verified (E.g., licensure, certification.)

E. **Process Quality Improvement Studies** - Examines the effectiveness of the health care delivery process

F. **Outcome Quality Improvement Studies** - Examines whether expected outcomes of patient care were achieved.

G. **Thresholds** - The expected level of performance (of aspects of health care) established by the quality improvement committee.

IV. Statement of Policy and Applicable Procedures:

A. Authority for the Statewide CQI Program:

1. The ultimate responsibility for the implementation and administration of the Georgia Department of Corrections (GDC) CQI Program rests with the GDC Assistant Commissioner, Office of Health Services. The Assistant Commissioner, Office of Health Services may assign responsibility to the Central Office CQI Committee to carry out the objectives of the CQI Program. The Committee will meet at least quarterly. The CQI plan will consist of three tiers of activity: Institutional CQI Committees, Regional Managers or other vendor representatives, and a Central Office CQI Committee. The GDC Medical Director is the final authority in clinical healthcare matters.

2. For CQI purposes, there will be no distinction between state and vendor or contract employees. It is expected that most CQI Committees will have a mix of these. Vendors or contractors of health care services may create their own

CQI internal review bodies as long as they do not usurp the authority of the various GDC CQI Committees mentioned in this document.

3. The GDC CQI Program is to be implemented in all facilities, including ambulatory and inpatient care, with the understanding that there will not be parallel programs with the intent to replace the State CQI Program at the state, regional or institutional levels whether created by departmental clinicians, vendors, contractors or other parties.

4. Individual institutions will not institute separate CQI programs in addition to the GDC CQI Program but may choose to study additional areas of interest to the institution. All such data will be forwarded to Regional Managers or other vendor representatives and the Statewide CQI Committee. Vendors of health services for the GDC may institute their own internal reviews of institutional CQI data for administrative purposes within the area covered by their contract with the understanding that all data remains confidential and privileged as in any peer review activity.

B. Government and Membership of the Central Office CQI Committee:

1. The officers shall be a Chair and Secretary. The Assistant Commissioner, Office of Health Services designee will appoint the chair(s). The chair may delegate administrative responsibilities to a member who is a GDC employee. Subcommittees may act in an advisory capacity to the Committee. Membership in subcommittees shall not be restricted to employees of the GDC.

2. Members shall be invited to serve by the Assistant Commissioner, Office of Health Services or designee. The Committee shall be multi-disciplinary and members will be limited to GDC and contract/vendor employees.

3. Attendance logs and minutes will be kept by the Chair, Secretary or designee.

4. The contractor/vendor will review and approve all credentialing files for their facilities. The contractor/vendor will review the same credentialing files annually for reappointment and monitor the work of the Regional Managers in assuring that current and accurate credentialing files are kept at all institutions.

C. Responsibilities of the Central Office CQI Committee:

1. Coordinate OHS and GDC CQI Programs.

2. Advise the Assistant Commissioner, Office of Health Services of trends, compliance with health care and all other applicable standards and potential quality problems.

3. Collate and aggregate statewide CQI data provided by the Regional Managers.

4. Provide direction for CQI studies to be done at the institutional level.

5. Educate, train, and monitor the Regional Managers, Regional Clinical Coordinators, ASMP Hospital Administrator and other vendor representatives in CQI.

6. Recommend and coordinate institutional staff training in CQI.

7. Submit quarterly CQI Meeting Minutes and an Annual Report of Activities to the Assistant Commissioner, Office of Health Services.

8. Perform an annual review of the effectiveness of the CQI Program.

9. Report on the adequacy of the contractor/vendor credentialing programs.

10. Update the teaching tool to be called CQI located in the “How to” Manual as needed.

11. Develop a program of data validation through a focused institutional collection of samples from appropriate screens at preset intervals with the Central Office CQI Committee monitoring the results.

12. The Central Office CQI Committee reviews the quality of all aspects of medical care, as well as mandates, monitors, and creates the schedule or timetable for the performance of all CQI activities at every institution.

13. CQI activities will be targeted to have an impact on:

    a. Establishing standards for clinical performance and sets Thresholds (e.g., standard practice protocols, standards for care);

    b. Increasing clinical and operational productivity;

    c. Ensuring cost-effective processes;

    d. Monitoring utilization, resource consumption and clinical practice patterns;

    e. Identifying high-risk patients;

    f. Providing quality care;

    g. Timeliness of obtaining services; and

    h. Recommending to the GDC Medical Director, quality issues that may be appropriate for clinical updates, policy and/or procedure change.

14. The CQI Program will include but is not limited to:

    a. Peer review;

    b. Health record review;

    c. Patient satisfaction surveys;

    d. Risk management activities;

    e. Mortality review;

    f. Staff development;

15. Health Service delivery areas to be reviewed include high risk, high volume or problem prone aspects of health care including but not limited to:

    a. Receiving health screening and transfer;

    b. Medical diagnostics and profiling;

    c. Access to Care;

    d. Sick call/Assessment Protocols;

    e. No shows;

    f. Health care refusals;

    g. Health Service denials;

    h. Chronic care clinics;

    i. Therapeutic diets;

    j. Outside referrals and consultations;

    k. Infirmary care;

    l. Emergency services and disaster plans;

    m. Medication distribution system;

    n. Dental services;

    o. Ancillary services;

    p. Mental health services (under the direction of Mental Health);

    q. Infection control;

r. Environmental health and safety;

s. Health promotion programs/patient education;

t. Inmate Grievances;

u. Patient satisfaction surveys; and

v. Other aspects of health care delivery.

D. Regional CQI Activities:

1. The Regional Managers and/or other vendor representatives will consider CQI as one of their priorities and will receive agendas, minutes, and CQI data from the Institutional CQI Committees.

2. The Regional Managers and/or other vendor representatives ensure that the institutions in their region adhere to the published CQI schedule.

3. The Regional Managers and/or other vendor representatives will attend institutional meetings to the extent possible and will personally train and motivate the Institutional CQI Coordinators; will collate the data and forward their summaries and recommendations to the Office of Health Services CQI Committee or to the Assistant Commissioner, Office of Health Services, if so directed. They will also follow and monitor the implementation of institutional corrective action plans (CAPS).

4. The Regional Managers and/or other vendor representatives will ensure that current and accurate credentialing files are kept at all institutions.

5. Representatives from health service vendors will have access to the data pertaining to the area of service covered by their contract at the institutional level. The data will remain confidential and privileged as in any other peer-reviewed activity. The vendors' Regional Managers and/or other representatives will review institutional data under the same provision.

6. Under directives and timetables published by the Assistant Commissioner, Office of Health Services and the Statewide CQI Committee, data will be collected and aggregated at the institutional level and forwarded to the Regional Managers and/or other designated vendor representatives.

7. Training at the institutional level will be conducted in two tiers. The first tier will be the training to be given to the selected Institutional CQI Coordinator and any other designated staff. Such training will be conducted and/or coordinated by the Regional Managers or other vendor representatives or staff from OHS. The second tier will be the ongoing training of all institutional staff and will be the responsibility of the Institutional CQI Committee and its Coordinator. Training will be documented in the Staff development manual and include the trainer's signature, date and credit hours.

8. Wherever applicable, the Institutional CQI Committees will prepare Corrective Action Plans (CAPs) to identify expected improvements in performance relevant to issues derived from the CQI data.

9. Follow up studies will be done to determine the effectiveness of previous corrective actions.

E. Institutional CQI Committees:

1. The Institutional CQI Committees will meet quarterly. The Institutional CQI Committees must keep agendas and minutes that need to be copied to the appropriate Regional Managers and/or other vendor representatives. In addition, these minutes should be reviewed and signed by all institutional medical staff. The minutes will be kept on file for 24 months and made available for review by the OHS during clinical audits.

2. The Institutional CQI Committees will be the backbone of the CQI program. The responsible physician has a leadership role in the CQI process. The composition of the Institutional Committees will be:

   a. Warden or designee;

b. Institutional security representative;

c. Medical Director;

d. Director of Nursing;

e. Health Service Administrator;

f. Pharmacist, where applicable;

g. Dentist, where applicable;

h. Medical Records clerk, where applicable;

i. Mental Health CQI Coordinator;

j. Other institutional staff as locally determined; and

k. Ex-officio: Regional Manager or other vendor representative.

3. Variances from this mandatory composition are allowed for institutions where the average daily population is less than (<) 500 offenders and/or where some of these positions are not represented in the organizational chart.

4. All institutional staff will participate in CQI activities whether they are CQI committee members or not, including state, vendor, or contract employees.

5. All Institutional CQI Coordinators will chair their Institutional CQI Committees and will be appointed by the institutions' medical administration.

6. The composition of the CQI committee differs from the Mortality and Peer Review Committees, which enjoy protection from discovery.

F. CQI for Institutions with Less Than (<) 500 Offenders: CQI at Boot Camps, Probation Detention and Transitional Centers will follow the same principles

detailed in this SOP, composing Institutional CQI Committees with a CQI Coordinator, etc. The schedules for the performance of CQI activities may vary from those for major institutions. The Statewide CQI Committee will publish simplified schedules for CQI activities at these facilities.

G. Peer Review Activities:

1. The purpose of Peer Review is to evaluate and improve the quality and efficiency of health care services at all institutions.

2. Quarterly Peer Review is to be established at all Institutions:

   a. Peer Review applies to certain licensed providers: MD, DO, NP, PA, DDS, and Psychiatrist. These practitioners will be participating in Peer Review no less than quarterly. Generally speaking, a practitioner at the same or higher level of training must conduct the Peer Review.

   b. PA/NP Peer Review is described in SOP 507.03.08, Nurse Practitioner/Physician Assistant Practice. The remainder of this section describes MD Peer Review.

   c. In many cases, the vendor(s) Medical Director will review physicians working under contract through the vendor(s) of health care services. In other cases, a physician peer from another institution may be selected as reviewer.

   d. The reviewer will document the quarterly Peer Review on Peer Review Forms # (P04-0008.05 for NP/PA and for MD). Copies of the forms will be forwarded to the vendor and GDC Medical Directors with originals kept by the Health Service Administrator on site in a secure location. A summary of the findings and a corrective action plan will be included. As conformation that the review was shared with the individual being reviewed, the individual will date and sign the Peer Review Form.

   e. At a minimum, quarterly review of no less than 5% patient-provider encounters are needed for each clinician on staff. The documented review

should include, but is not limited to, legibility of notes and signature; encounter notes in SOAP format with a full set of vital signs and dated, timed and signed; appropriateness and thoroughness in addressing the chief complaint; documentation and appropriateness of the physical findings, laboratory and diagnostic data and thoroughness of the care plan which should address all abnormal findings; documentation of patient education on his/her condition, treatment and need for follow up; and documentation of the need for consultations, where applicable.

3. Focused Peer Review consists of a Peer Review in addition to the quarterly scheduled reviews.

    a. Focused Peer Review may be conducted by the GDC Medical Director or the vendor(s) Medical Director, usually with the purpose of investigating allegations, inferences, or direct observation of practice which may not be compatible with existing standards of care or for other reasons.

    b. The GDC Statewide Medical Director should be notified in advance of all planned focused Peer Review Meetings and forwarded complete, confidential copies of all proceedings. One or more peers or physicians may participate in this process.

    c. In some cases, the GDC Medical Director may request or conduct a Focused Peer Review and include the vendor(s) Medical Director for possible attendance.

    d. Documentation of focused Peer Review will be retained by the GDC and/or vendor Medical Directors and filed in a secure location.

    e. Letters of Inquiry:

        i. In most cases, letters of inquiry will be generated by the GDC Statewide Medical Director in response to reported incidents, audit findings, mortality reviews and the like. The GDC Statewide Medical Director will address the letter of inquiry to the appropriate vendor Medical Director. This type of Peer Review correspondence is only a

letter of inquiry. Most letters of inquiry receive a satisfactory response and the matter is closed. The Peer Review process is needed for letters of inquiry so as to ensure the confidentiality of the clinical information exchanged.

ii. The letter of inquiry will describe a perceived clinical problem or problems, and instruct the vendor Medical Director to send it to the involved physician, with instructions to the practitioner to respond to the vendor Medical Director in 20 days or less. After receiving the responses, the vendor Medical Director may leave them as they are or add his/her own response to the issues presented, together with corrective actions and plans as appropriate.

iii. Note that if the institutional physician agrees with the Office of Health Services (OHS) determination that an error or omission or commission occurred, it should be so stated, together with a plan of institutional staff education to prevent the occurrence of such errors in the future. The institutional response should therefore include, for all points and issues raised by the OHS and agreed upon by the institution:

1) An acknowledgement that a problem occurred;

2) A review of its causes;

3) A lesson plan, with its remedies;

4) A date for the staff education with a roster of who attended; and

5) Minutes of what was discussed.

iv. These Peer Review documents should not be distributed to anyone. To investigate certain allegations, the vendor Medical Director or the institutional physician may need the help of non-physicians, such as nurses, administrators, clerks and the like. It is permissible to transcribe some of the information in the original letter of inquiry to convey the essence of issues in question, but clinicians must not forward to or copy

anyone with letters of inquiry or any other Peer Review materials or documents. Peer Review meetings should be attended by physicians only.

v. The entire Peer Review process is educational and aimed to document that the OHS and vendor Medical Directors did look into the matters in question and that the institutional response covered the corrective actions.

4. All documentation regarding Peer Review activities should be stamped "Peer Review" and filed in a secure place, with no unauthorized copies circulating. In general, following these procedures will shield the documentation from discovery and allow for more candor. However, it is not an absolute, and Peer Review documentation may be discoverable under certain limited circumstances.

5. Provider Peer Review may lead to corrective actions to be taken by the vendor(s) or GDC Medical Directors. The GDC Medical Director may suggest and request corrective action as well. The corrective action may take the form of oral or written counseling, reduction in privileges, suspension, or separation. All applicable laws and regulations regarding reporting of sanctions or privilege reductions will be followed with communications to the appropriate Boards and Authorities and the GDC Medical Director.

6. Mortality Review, a form of Peer Review, is covered under SOP 507.04.68, Mortality Review.

V. Attachments: None.

VI. Record Retention of Forms Relevant to this Policy: None.