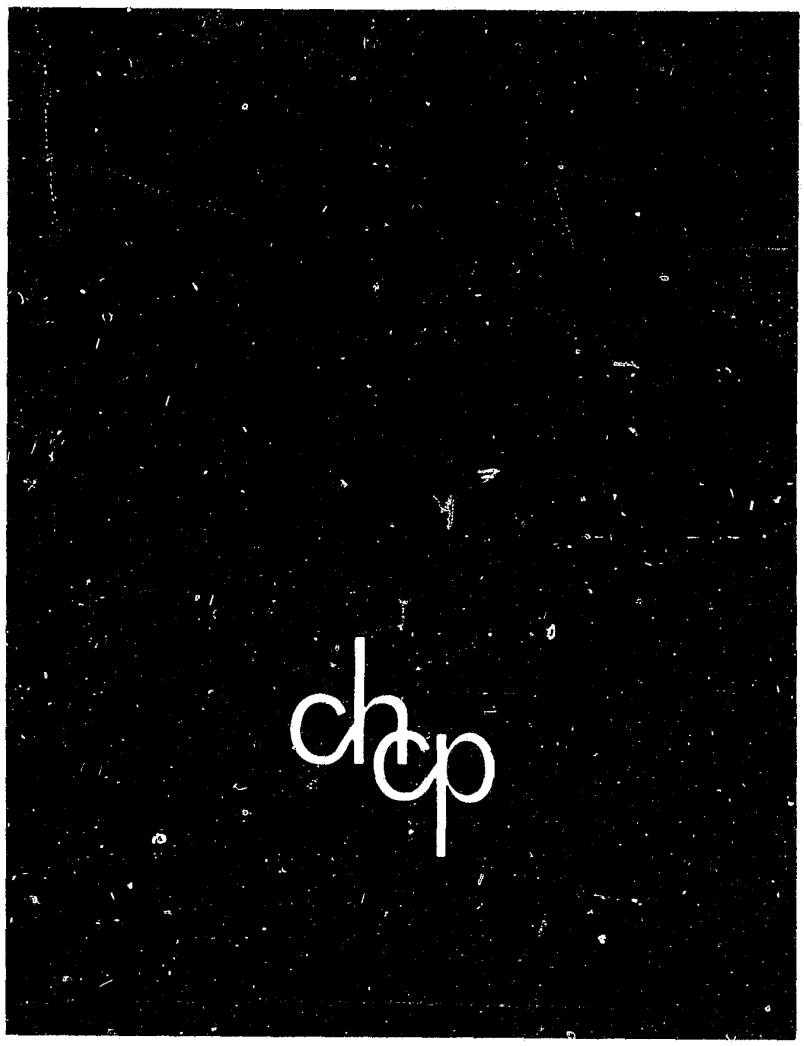

CORRECTIONAL HEALTH CARE PROGRAM

Correctional Health Care Program

RESOURCE MANUAL

QUALITY ASSURANCE:
A BRIEF OVERVIEW FOR THE
CORRECTIONAL HEALTH CARE ADMINISTRATOR

MICHIGAN DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH CARE

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
UNITED STATES DEPARTMENT OF JUSTICE

Correctional Health Care Program
Michigan Department of Corrections
Office of Health Care

QUALITY ASSURANCE:

A BRIEF OVERVIEW FOR THE

CORRECTIONAL HEALTH CARE ADMINISTRATOR

Second Edition

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Resident Guide To Self-Care

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C H C P P R O J E C T S T A F F

Michigan Department of Corrections
Office of Health Care

University of Michigan
School of Public Health
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Department of Community Health Science

American Medical Association
Division of Medical Practice
Program to Improve Health Care in Correctional Institutions

University Research Corporation

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FOREWORD

The issues of adequacy, accessibility, and quality of health care service delivery in correctional institutions are increasingly receiving well-merited attention. Long plagued by neglect and paucity of resources, most correctional agencies throughout the country have recognized the need for clear direction in addressing these issues. The unique characteristics of prison populations and facilities pose a problem in applying directly the standards and policies which prevail in community health care settings. Once the basic ingredients common to good health care practice have been identified, the challenge remains of their adaptation without essential compromise to the correctional environment. Implementation of a system which meets statutory and professional standards is the responsibility of correctional health care administrators in the 1980's.

Through a grant from the Law Enforcement Assistance Administration, the Michigan Department of Corrections has provided technical assistance to ten states with a view to improving their health care system for residents of correctional institutions. This manual is one of a series published under auspices of the grant. Together, the manuals will support and extend the training sessions and technical assistance efforts of the past two years. Their purpose is to define concisely the major elements which must constitute a comprehensive health care program for a correctional agency.

There is no substitute for proper planning, adequate resources and good management. These manuals can assist in the planning effort to identify the kind of resources which will comprise an adequate program. In addition, they address the alternatives which must be considered, the integration of various components, and establish a foundation for the decisions which must be made by each agency.

The manuals have been compiled by persons who are experts in their professional field and by persons active in the delivery of health services to correctional residents. There are too many divergencies among correctional agencies to permit a single approach to be universally applicable. For this reason, the manuals are intentionally broad in scope and will require careful analysis and specification by each user.

A health care system does not stand alone and isolated from its environment. It can succeed only through a cooperative and carefully planned effort which involves health care personnel, staff of the correctional system, community health resources, and residents as interested consumers of the services. Where multiple institutions exist within a state correctional agency, appropriate central direction and coordination are essential for coherent and consistent form and quality of the services provided. It is at this level, in particular, that the overall planning, resource development and management of policy should occur.

These manuals are written in a simple "how-to" format and are intended to be self-explanatory. Local regulatory agencies and other community and professional health resources can be helpful in their interpretation and application.

The goal which has prompted development and issuance of this manual and of others in the series has been attainment of professional quality health care for residents of correctional institutions comparable to that available in the community. The sponsors will consider their efforts well rewarded if, as a result, changes are implemented which improve access and cost-effective delivery of needed health services.

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1. INTRODUCTION

The purpose of this manual is to provide the correctional health care administrator with a brief introduction to the area of quality assurance. More specifically, it is an attempt to describe key concepts related to quality assurance and to thereby assist the correctional health care administrator in formulating an overall plan for quality assurance.

The quality of the care provided in correctional settings has been a growing concern over the past few years. It has received a great deal of attention from the courts, and a number of professional associations have formulated standards directed at assuring minimum levels of quality for health services in correctional institutions. While administrators of correctional health care programs are themselves committed to high quality in the provision of services, the development of a formal quality assurance program often has had to rank lower in priority than resolving such pressing issues as recruiting the necessary personnel or obtaining resources without which a basic level of services cannot be provided. Given also the problems of recruiting and retaining qualified health care providers in correctional settings, there is an understandable reluctance to risk alienating providers by monitoring the quality of their activities, which some of them might see as an affront to their professional competence.

In what follows, quality assessment and assurance will be shown to operate at many different levels and in many different ways, and not to be necessarily incompatible with other priorities and concerns which the correctional health care administrator might have. The following topics will be discussed: (1) Quality assessment; (2) Quality assurance; (3) Developing an approach to quality assessment and assurance; and (4) The necessary ingredients for a quality assurance program.

2. QUALITY ASSESSMENT -- HOW TO MEASURE QUALITY

In assessing the quality of health services provided to the correctional population several different measures can be used. In general, three types of measures of quality are usually distinguished: outcome measures, process measures, and structural measures.

A. Outcome Measures

The effect of health services on the patient's condition -- the "outcome" -- comes readily to mind as a meaningful measure of the quality of services provided. However, improvement in the health state of a person or a population is often difficult to document, in part because it usually requires special follow-up visits by the patient in order to measure the effects of treatment. In addition, it is widely acknowledged that neither positive outcomes nor negative ones can be uniquely attributed to health services. Other factors, such as genetic characteristics of the population and variability of the disease process from person to person, can be at least as influential in determining the ultimate outcome as the treatment provided to the patient.

B. Process Measures

Since outcomes do not provide an unambiguous measure of the quality of services provided, it is common to evaluate quality of care in terms of how that care was provided; in other words, the "process". Such an evaluation focuses on whether the appropriate actions were taken in a given situation. One might thus examine whether a particular health care provider took all the actions and followed all the steps considered appropriate for a particular clinical situation; or whether abnormal laboratory findings led to corrective actions such as a follow-up visit, further tests, or the initiation of a treatment regimen; or whether a prescription

was checked for possible drug interactions before being filled in the pharmacy.

While such process measures are commonly used to evaluate quality of care, their ultimate value rests on the link between process and outcome. To the extent that it is not conclusively known whether certain clinical procedures do indeed affect the course of the disease or condition being treated, assessing quality in terms of process does not yield a good measure of what is really being achieved for patients.

C. Structural Measures

Since the evaluation of the process of care is often complex and cumbersome, a proxy for evaluating process is to evaluate the characteristics of the people who provide care and of the setting in which that care is provided; in other words, the approach is to evaluate the "structure" within which services are delivered. The assumption made is that given well-qualified personnel and the necessary physical resources, a good process will result.

In practice, however, the emphasis is on the lack of necessary resources. It is assumed that if the necessary structural features, such as well-qualified personnel and adequate facilities, are not present, then the health care delivered under those conditions will be substandard. Most accreditation programs rely heavily on structural measures to ensure that at least the prerequisites are present for providing adequate care. It should be noted, however, that the presence of the necessary structural features does not guarantee that the services provided will be of high quality or that those services will result in desirable outcomes. The presence of those features is only an indication that the potential exists for both the process and the outcomes to meet high standards of quality.

3. QUALITY ASSURANCE -- HOW TO ACHIEVE QUALITY

In the delivery of health services the achievement of desirable levels of quality -- "quality assurance" -- can be seen as taking place at two levels: at the operational level, and at the management and planning level.

A. At the Operational Level

At the operational level of day-to-day delivery of health care services, mechanisms are usually present which assure that the services provided meet specified standards of quality. An example of these mechanisms is supervisors who continually review and observe the activities of others, and who see to it that corrective actions are taken whenever deficiencies are identified. It is characteristic of these mechanisms that adherence to specified standards is being monitored continually, and departures from those standards are remedied without delay. Most such quality assurance activities at the operational level focus on the process of care. They seldom focus on outcomes and they almost never focus on structure.

B. At the Management and Planning Level

Quality assurance activities at the operational level have to be supplemented with quality assurance activities that are part of the overall management and planning of the health care delivery program. The latter are not separate activities from those at the operational level, but rather complementary to them, and they often build on them. For instance, if at the operational level the pharmacist finds repeated instances of information not being entered in patient profile cards when prescriptions are filled, or if a head nurse notes a consistent pattern of physicians' orders not being carried out by clinic nurses, that may indicate the need for more broad-ranging actions than simply correcting the omissions as

they are identified. In particular, it may be necessary to make structural changes, such as reassigning personnel or instituting new procedures.

Thus at this level, in contrast to the operational level, most remedies focus on structural features, and remedial actions are usually taken in response to deficiencies found in either the process of health care delivery or the outcomes of that care. In general, to determine whether those kinds of deficiencies are present, past activities are reviewed. That is often, but not always, carried out by examining medical records to establish whether proper procedures were followed and desirable outcomes achieved.

Whereas quality assurance activities at the operational level are intended to remedy deficiencies as they are found -- for example, making sure that a test or procedure that did not get done due to an oversight gets done immediately -- at the management and planning level the focus is on using past experience to design new ways of delivering services so as to eliminate the recurring deficiencies found in the past. Such actions, however, can also be taken preventively in order to avoid problems that might otherwise be encountered, especially when a new program or service is being introduced.

4. QUALITY ASSURANCE AND THE CORRECTIONAL HEALTH CARE ADMINISTRATOR -- DEVELOPING AN APPROACH

The concerns of the correctional health care administrator with quality assurance, as those of any administrator of a health service program, have to include all the elements just described: measuring quality in terms of structure, process, and outcomes, and assuring quality both at the operational and at the management and planning

levels. It is likely that any operating program already has within it some of those elements of quality assessment and assurance. In determining what is available and what needs to be done to institute a satisfactory quality assurance program the correctional health care administrator can follow several approaches. The one that will be sketched out in what follows proceeds systematically from concerns about structure to concerns about process and outcomes.

As was mentioned before, it is well recognized that in order to provide health care services of satisfactory quality it is necessary to have certain structural elements in place. They include having the necessary number and type of personnel, and adequate facilities. As was noted, while the presence of such structural elements does not guarantee that the proper level of quality will be achieved, their absence makes the provision of such services either very difficult or impossible.

For the correctional health care administrator the securing of an adequate level of resources -- of the necessary structural elements -- represents a very central concern and is the focus of most quality assurance activities, although that may not be how they are identified. Even when the necessary funds are available, recruiting qualified personnel can still be a major hurdle. From the perspective of quality of care, however, it should not always be assumed that quality can only be achieved by hiring highly trained personnel. There are many instances when equally good results can be obtained by hiring personnel with less training, so long as the necessary structure is provided to assure that all activities meet specified quality standards.

Thus, physicians' assistants and other non-physician personnel can be hired to take on some of the activities traditionally performed by physicians, provided that such persons operate under the supervision of a physician and are guided in the performance of their activities by

standing orders or clinical protocols. It is also important to emphasize that while there may be a need for more operational controls for such less-trained providers, operational controls are necessary with respect to the activities of all health care professionals, including physicians.

As the necessary structural elements and operational controls are put into place, the attention of the health care administrator will shift to concerns about the overall quality of the process and of the outcomes of care. To institute quality assurance at this level, it is necessary to carry out periodic evaluations of all activities in order to identify any deficiencies that require changes in procedures, re-organization, or shifting of resources.

Similarly, as new programs are developed and new services are provided, their design must take into consideration quality assurance concerns that go beyond providing the necessary level of resources. Thought needs to be given to instituting operational controls that will assure that the proper standards are maintained, as well as conducting periodic evaluations to ascertain if the entire structure is appropriately designed.

In developing a quality assurance program, therefore, the functions of the correctional health care administrator include (a) securing the necessary resources; (b) instituting the necessary procedures and operational controls to assure quality; (c) checking periodically on the functioning of all those elements and making adjustments when necessary.

All activities related to the provision of health services to inmates must eventually come under the kind of quality assurance process just described. Overall quality will not be achieved in a correctional health care program if quality assurance efforts are only focused on the activities of nurses or only on activities that take place within certain clinics or within the infirmary. The activites of physicians, dentists,

medical records personnel and pharmacy personnel, should be subject to operational controls and to periodic evaluations, as should the activities of providers outside the correctional system to whom inmates are sent for care.

5. THE NECESSARY INGREDIENTS FOR A QUALITY ASSURANCE PROGRAM -- WHAT THEY ARE AND HOW TO OBTAIN THEM

In order to implement a formal program for the assessment and assurance of quality, several elements are necessary. They include: standards in terms of which quality can be measured; information about the extent to which the standards are being met; and mechanisms for the achievement of the level of quality specified by the standards.

A. Standards

In order to evaluate either clinical activities, structural features, or outcomes of care, it is necessary to have standards. Usually, it is preferable to have explicitly stated standards, although evaluations of clinical activities are sometimes carried out by asking experienced clinicians or other experts whether, based on their own experience -- and thus on their own internalized standards -- the care provided is acceptable or unacceptable.

In the area of correctional health services, standards have been developed over the past few years by a number of national organizations which include the American Public Health Association, the American Correctional Association, and the American Medical Association. Those, however, are for the most part quite general, minimal standards concerned primarily with structural elements. They do not provide the specific standards and criteria that are necessary for review of clinical activities and of other health care functions. Such detailed standards, as a general rule, should be ones that are recognized as valid by the persons whose activities will be judged by those standards and therefore the health care

staff should be involved in developing them. To make the task of formulating such standards as simple as possible, however, standards and protocols available from other programs should be used as a starting point.

B. Information for Quality Assessment and Assurance

Once standards are defined, it is necessary to obtain information that will make it possible to evaluate to what extent the standards are being complied with. Some of that information must be obtained continuously, as when it is used for operational control; some only periodically, as when it is used for management and planning control.

In all cases it is important that the information be obtained with minimal interference with clinical activities. The collection of data for quality assessment and assurance has to be integrated as much as possible with the collection of all other information used for clinical purposes. Extensive data collection requirements that only serve quality assurance needs will seldom be complied with, because providers resist being burdened with recording functions that do not relate directly to their clinical activities. Devising imaginative ways of gathering the necessary information and of handling it are therefore an important element in the success of any quality assurance program.

C. Mechanisms for Monitoring and Action

The development of a quality assurance program requires that specific mechanisms be designed to monitor quality of care and to take action when necessary in response to findings. While all such mechanisms require that there be explicit standards as well as information that is geared to those standards, they differ in terms of their timing.

The evaluation of clinical and other activities can take place concurrently -- almost immediately after the activities have taken place -- or retrospectively, some time after the activities take place. In general, concurrent evaluation is associated with operational controls whereas restrospective evaluation is more commonly used for management and planning controls.

As was already noted, corrective mechanisms can similarly vary in terms of whether they are simply meant to correct an isolated deficiency, or whether they are designed to alter a pattern of deficiencies that has been encountered over time. Occasionally it is also necessary to evaluate the validity of the standards themselves, either in light of the experience accumulated from using them, or as a result of changes in the field as to what is considered appropriate.

In general, quality assurance activities are not confined to obtaining information from patients' records and focusing on evaluating the activities recorded in those records. While that should be a very important element of quality assurance in any correctional health care program, other activities must also be included, such as those that take place in the pharmacy or in the medical records department.

D. References for Additional Information

The foregoing is only a brief overview of a relatively large and complex area, one that is increasingly important in the administration of correctional health care services. To develop a program within the framework presented here, additional, more specific information will have to be obtained.

A particularly useful reference that complements and extends this manual is a guidebook that has recently appeared and is directed

at quality assurance of ambulatory care services. Entitled Ambulatory Care Evaluation Primer, it can be especially useful to the correctional health care administrator since ambulatory care accounts for most of the care provided to the correctional population. The guidebook is available from the ACE Project, School of Public Health, University of California, Los Angeles, CA., 90024. The cost is $3.50 per copy.

Several of the CHCP manuals in this series are also relevant to the development of a quality assurance program. "Information Systems for Correctional Health Care Programs" provides useful guidance with respect to defining and gathering the information needed for quality assurance. The issue of assuring quality when using non-physician providers to deliver care is addressed in "Establishing Protocol-Directed Health Care." Standards for quality assurance in dental care and in the pharmacy are discussed, respectively, in "Dental Health Programs for Correctional Institutions," and in "Pharmacy Services in Correctional Institutions." Since many standards used for quality assurance must become part of an institution's or a system's policies and procedures, "Development of Policy and Procedure Manuals for Correctional Health Programs" is also relevant to this area.