



NEW MEXICO CORRECTIONS DEPARTMENT

Secretary
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CD-170400 Medical Services Administration-Performance Improvement Alisha Tafoya Lucero, Cabinet Secretary	Issued: 9/5/13 Effective: 9/5/13	Reviewed: 5/27/2026 Revised: 2/16/15 <i>Original Signed and Kept on File</i>
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AUTHORITY:

- A. NMSA 1978, Sections 33-1-6 and 14-2-1, as amended.
- B. Policy *CD-010100*.
- C. Policy CD-170000.

REFERENCES:

- A. ACA Standard 2-CO-4E-01, *Standards for the Administration of Correctional Agencies*, 2nd Edition.
- B. ACA Expected Practices, 5-ACI-6D-01, 5-ACI-6D-02 (M), 5-ACI-6D-03 (M), 5-ACI-6D-04, 5-ACI-6D-08, 5-ACI-6D-09, 5-ACI-2A-03, 5-ACI-2F-01 *Performance Based Standards and Expected Practices for Adult Correctional Institutions*, 5th Edition.
- C. National Commission on Correctional Health Care, *Standards for Health Care in Prisons*, 1997.

DEFINITION:

- A. Quality Assurance Committee: In each institution and for each bureau of the Office of Correctional Health Care, an interdisciplinary committee, designated by this policy, is responsible for the compliance of Quality Assurance Program activities.
- B. Quality Assurance Coordinator (QAC): The Registered Nurse who is responsible for the oversight of all Quality Assurance Programs within an assigned institution.
- C. Quality Assurance Program: A comprehensive program to systematically review and improve the quality of medical services, the safety and security of persons receiving those services, and the efficiency and effectiveness of health care staff and resources.
- D. Protected Health Information (PHI): Any information about health status provisional health care, or payment for health care, that can be linked to a specific individual. This is interpreted rather broadly and includes any part of an inmate's medical record or payment history.

PURPOSE:

The purpose of the Continuous Quality Improvement (CQI) plan is to ensure that the Health Services Bureau establishes a structure that develops and uses quality resources and promotes the implementation of CQI. The quality of the delivery of health care in the New Mexico Corrections Department (NMCD) will be monitored through continuous improvement activities, which will include program review, assessment of health care outcomes, assessment of the relationship of health services to other areas of inmate management and educational activities.

APPLICABILITY:

This operating procedure applies to the contract medical provider, including the facility health services administrators and facility key contact staff to ensure program compliance. It is the responsibility of all contract provider staff to implement and use quality tools and concepts at any facility operated by or for NMCD, including those with contracted health services and any privately-operated prisons contracted with NMCD.

FORMS:

None

PROCEDURE:

- A. The health authority meets with the facility or program administration at least quarterly and submits quarterly reports on the health services system and health environment, and submits plans to address issues raised. [**5-ACI-6D-01**]
 1. General Procedures
 - a. The facility Health Services Administrator (HSA) shall ensure that:
 - The HSA/designee shall meet with the facility medical director, warden and other appropriate medical health department staff, and/or program/security support staff, on a quarterly basis to discuss current issues.
 - Health services staff shall meet at least monthly to discuss any issues or aspects of health care delivery in the facility, including policy or procedural changes made by NMCD or ACA. These meetings also may be used as a training opportunity.
 - Minutes of meetings shall be recorded, including attendees and topics discussed. The minutes shall be maintained by the HSA.
 - Topics may include but are not limited to: quality improvement, effective changes and recommended corrective action plans, the review of effectiveness of health care and any other issues related to the care of inmates.
- B. **Statistical Reports:** These will be collected and reported as required by NMCD. A monthly/weekly health services report shall be generated, with copies forwarded to the facility warden and the NMCD Health Services Bureau (HSB) administrator.
- C. **Utilization Data:** Information on the utilization of services shall be collected, calculated, and reported in the form of statistical data and in the manner determined by the HSB administrator. These data shall be collected and reported by each facility to the HSB administrator on a monthly basis.
 1. The information shall include but is not be limited to:
 - Number of inmate encounters

- Number of ER visits
- Number of off-site transports:
 - Visits to community specialists
 - Community outpatient surgeries
- Number of hospital admissions
- Average length of stay in hospital

2. Information to be reported for Dental Services shall include:

- Number of dental exams
- Number of specific dental procedures performed

3. Information concerning certain epidemic/endemic diseases or other situations that threaten the inmate population shall be reported immediately and included in the monthly report and quarterly review.

4. Other data shall be collected and reported as instructed/requested by the area vice president and regional manager for the medical contractor.

5. Informational Logs:

Information collected is used for planning, budgeting, scheduling and documenting services. Individuals must generate information on the clinic log in the same manner so that information is comparable.

- A log is kept each day for physicians and/or clinic visits.
- The diagnosis can be considered to be the reason for a visit. If the specific data is not available, the chief complaint, symptoms treated or other reason for contact shall be noted.
- Abbreviations approved for use on New Mexico Corrections Department forms include those in ordinary and conventional medical use, as well as the following:

ABBREVIATION	MEANING	ABBREVIATION	MEANING
EMP	Employee	NP	Nurse Practitioner
ER	Emergency Encounter	O	Other Special Provider
FTS	Failure To Show	OHE	Occupational Health Encounter
I	Intake Encounter	PA	Physician Assistant
ID NO	Identification Number	PE	Physical Examination
INP ADM	Inpatient Admission	RN	Registered Nurse
LOC	Location of Inmate's Residence	SC	Sick Call Encounter
LPN	Licensed Practical Nurse	SCH	Scheduled Encounter
LWBS	Left Without Being Seen	SP MD	Specialty Physician
MD/DO	Medical Doctor	UNS	Unscheduled Encounter

Encounter Type Includes:

- 1) Sick Call (SC): Record of each inmate seen during organized specified sick call.
- 2) Scheduled Encounter (SCH): Record of each inmate seen at a specified planned appointment that was scheduled and the inmate notified in advance. Disease/condition specific clinics shall be recorded here.
- 3) Unscheduled Encounter (UNS): Record each non-emergency walk-in inmate outside of sick call hours and appointments. An inmate transferred to a medium security facility from a minimum-security facility to be seen in Health Services and returned to the minimum-security facility shall be recorded in this area. Medication line visits to pick up medications are NOT recorded as an encounter.
- 4) Emergency Encounter (ER): Record of each inmate seen for emergency services. These include, but are not limited to: lacerations, drug overdoses, trauma and heart attacks. A life-threatening situation shall be recorded in this area.
- 5) Intake Encounter (I): When an inmate is received from outside the system, returned from court or transferred (either permanently or temporarily) from another facility, record the inmate as intake.

- Clinician:

- 1) Record the initials of the care provider who completes and signs the encounter record. Most frequently, this will be the most senior level provider seeing the inmate.
 - 2) Record in the clinic log if provider is spending time with the inmate, doing instruction, completing triage or making an off-hours review and referral or obtaining verbal orders. Nurse triage shall be involved using the Health Services Medical Protocols.
 - 3) It is possible for more than one provider to provide significant service during a single encounter. If this occurs, each provider shall initial the clinic log.
- Record the full encounter (i.e., if a nurse triages an inmate, calls the physician assistant and they come into the facility to see the inmate, both nurse and physician assistant shall initial the clinic log).

6. Clinic Log:

- Fill in each inmate's name, number, encounter type and resident unit.
- Complete the diagnosis section with the most accurate information available.
- Indicate the disposition of the inmate by recording in the appropriate box(s).
- Indicate any **FTS** (Failure To Show) or **LWBS** (Left Without Being Seen) in the diagnosis section. Do not count these inmates in the totals. Keep a separate tally for

use by the facility. If possible, note the reason for the FTS/LWBS.

- If a complete physical examination is conducted, mark I for intake, E for employees (e.g., an **OHE**) and A for biannual.
- Indicate the healthcare provider with the appropriate initials under the clinician section.
- Total each column in encounter types, disposition and clinician sections.
- Retain each log sheet for compilation of statistics. Retain log sheets as a part of the permanent files.
- When necessary, use more than one page for the same date and number the pages consecutively.

7. Daily Off-Site Visits:

A written record of off-site visits shall be kept and will include the following:

- Name and number of inmate
- Reason for off-site
- Date of request
- Category of referral,
- Name of specialist and specialty
- Date of off-site visit
- Location of visit,
- If the appointment is canceled, record by whom, i.e., security, inmate, etc.;

8. On-Site Utilization Summary:

The clinic logs will be completed each day and totaled. The health services report will contain a summary report of all totals. At the end of the time period, the grand totals will be entered into the designated sections of the Health Services Report.

A. Primary Care Encounters:

- Total Sick Call Visits: The grand total will be entered from the SC column on the daily summary.
- Do the same for the columns labeled ER (medical emergency), SCH (scheduled appointment visits) and I (intake screens). Subtract the EMP (employee encounters) and enter the EMP and remainder on the form.
- Total Primary Care Encounters: Add all of the visits listed above and enter the total.

B. Physical Examinations:

- A physical exam consists of a full medical history, complete physical exam and appropriate lab work.
- The exam is performed and documented by a PA-C, NP or MD/DO. The number of intake physicals conducted for the time period will be entered, using the totals from the daily summary sheets. Employee physicals and bi-annual physicals will be entered in the same manner. The physical exams will be totaled and the results entered.

C. Support Services:

- The support services visits will be added and the sums recorded.

D. Total X-rays:

- The number of X-rays taken on-site during the time period will be documented. If an inmate has more than one x- ray, each different procedure will be counted (e.g., chest, elbow, wrist, etc.). Extra views taken of the same area will not be counted (e.g., 3 views of patella equal one procedure). Do count X-rays taken of the same area on different dates.

E. Clinical Staff:

- The number of full-time equivalent employees for each professional category for the time period with clinical responsibilities will be recorded.
- The diagnosis and inmate number of all inmates identified as having a reportable disease during the time period will be documented. The diseases should be reported to the New Mexico Department of Health and will be indicated with an "X" if reported.

F. Total Psychiatric Visits:

- the total number of inmates seen by psychiatry for the time period will be documented

9. Off-Site Utilization Summary:

Off-site Outpatient Visits: using records generated for the time period, the physician providers will be totaled and recorded by specialty. "Others" will be identified by specialty. The space to the right will be used to record more than one.

- The number of out inmate surgeries, emergency room visits, radiology/radiotherapy, EEG's and physical therapy visits as well as hearing evaluations will be documented from the records. "Others" will be identified by title. The space to the right will be used for more than one "Other".
- Using information generated on the off-site admission form, record the number of admissions and the number of discharges. As a subsection of admissions, the

number of admissions that were done on an emergency basis will be documented.

- Inmate Days of Care: This is defined as one day of care given to one inmate. Inmate days of care for a given time period is a total of all the inmate days care given for each day in the time period. (i.e., if two inmates days of care are provided each day for one week, the total inmate days of care for the week will be 14; two inmate days of care times 7 days in the week equal 14)
- Discharge Days of Care: This is defined as days of care given to a medically discharged inmate. An inmate admitted to the hospital on the tenth day of the month and discharged on the sixteenth day of the month would accumulate six discharge days care (16-10 = 6). An inmate admitted and discharged on the same day is considered to have received one discharge day of care.
- Add and record the inmate days of care and the discharge days of care on the form.
- Average Length of Stay: This time is defined as total discharge days for the time period divided by the number of inmates discharged in the same time period. Calculate and record the average length of stay on the form.

The form will be signed and sufficient copies made and distributed no later than the tenth working day following the end of the time period. Persons who should receive the information are the HSA, the warden and regional manager. A copy should be retained on file.

D. **Internal Review and Quality Assurance:** A system of documentation for internal review will be developed and implemented by the facility and regional contracted medical health authority. These necessary elements of the system will include: **(2-CO- 4E-01)**

- a. The medical contractor of the facility or regional medical director contractor shall conduct internal peer reviews as follows:
 1. The facility medical director will complete a peer review for each mid-level medical practitioner every year. **[5-ACI-6D-03 (M)]**
 2. The regional medical director will complete a peer review for the facility medical director and all staff physicians every year.
 3. The regional director of psychiatry will conduct a peer review for each psychiatrist every year. **[5-ACI-6D-03 (M)]**
 4. The regional director of dentistry will conduct a peer review for each dentist every year. **[5-ACI-6D-03 (M)]**
- b. The contract vendor facility departmental director shall review five charts each month for each physician and each mid-level, checking the following criteria:
 1. Encounter documented in SOAP format.

2. Diagnosis is consistent with subjective and objective data.
 3. Treatment is consistent with the diagnosis and follows protocol.
 4. Treatment plan is adequate with proper follow-up or referral, as necessary.
 5. Medical record is legible and complete.
 6. Treatment protocols are countersigned.
- c. These charts shall be chosen at random, with special consideration given to inmates with adverse outcomes, seriously ill inmates and inmates not responding to the care provided.
1. Program changes shall be implemented, as necessary, in response to these findings.
 - a. External peer reviews are conducted in intervals and methods as cited in Contract and elsewhere, but no less frequently than every two years.
- E. A system of documented internal review will be developed and implemented by the HSA. The necessary elements of the system will include: **[5-ACI-6D-02 (M)]**
1. Participating in a multidisciplinary quality improvement committee.
 2. Collecting, trending, and analyzing of data combined with planning, intervening, and reassessing
 3. Onsite monitoring of health service outcomes on a regular basis through:
 - chart reviews by the responsible physician or his or her designee, including investigation of complaints and quality of health records;
 - review of prescribing practices and administration of medication practices;
 - systematic investigation of complaints and grievances; and monitoring of corrective action plans.
 4. Reviewing all deaths in custody, suicides or suicide attempts, and illness outbreaks.
 5. Implementing measures to address and resolve important problems and concerns identified (corrective action plans).
 6. Reevaluating problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired results.
 7. Incorporating findings of internal review activities into the organization's educational and training activities.

8. Maintaining appropriate confidential records (in other words, meeting minutes) of internal review activities.
 9. Issuing a quarterly report to be provided to the health services administrator and facility or program administrator of the findings of internal review activities requiring a provision that all internal review activities comply with legal requirements on confidentiality of records.
- F. A documented peer review program for health care practitioners and a documented external peer review program will be used for all physicians, psychologists, and dentists every two years. **[5-ACI-6D-03 (M)]**
- G. Facilities will use a health care staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope of services. A staffing plan is developed and implemented from this analysis. There shall be an annual review of the staffing plan by the HSA to determine if the number and type of staff is adequate. **[5-ACI-6D-04]** The NMCD HSB administrator and designated support staff at NMCD shall provide this review, after discussion and consultation with health services contractor.
- H. The medical program has established measurable goals and objectives that are reviewed at least annually and updated, as needed. **[5-ACI-6D-08]**
- I. There is an internal system for assessing the achievement of goals and objectives and that documents findings. Program changes are implemented, as necessary, in response to findings. **[5-ACI-6D-09]**
- Operations and programs should be implemented as outlined in the policies and procedures.
 - An audit system providing timely and periodic assessment of the various agency operations will reveal the degree of compliance.
 - The internal administrative audit should exist apart from any external or continuing audit conducted by other entities.
- J. Each policy, procedure, and program in the health care delivery system shall be reviewed at least annually by the appropriate health care authority and revised, if necessary. **[5-ACI-6D-10]**
- K. Adequate space shall be provided for administrative, direct care, professional, and clerical staff. This space shall include conference areas, a storage room for records, a public lobby, and toilet facilities. **[5-ACI-2F-01]**
- L. **Supplies and Equipment: [2-CO-4E-01] [5-ACI-2A-03]**
1. Equipment, supplies and materials for health services are provided and maintained as determined by the HSA. The examination rooms shall be checked every 24 hours by the nursing staff on duty. The following shall be done:
 - The crash cart supplies will be checked and restocked as necessary.

- The automatic external defibrillator (AED) will be checked for proper functioning and the battery will be recharged.
 - The O2 and suction units will be checked for proper functioning.
 - The drug refrigerator temperature will be checked.
 - The emergency response bag/O2 kit will be checked.
2. Quarterly inventory: Inventory of medical and dental supplies shall be prepared with stocks replenished as needed.
3. Radiological Services: Facilities equipped with a radiology unit shall meet the following guidelines:
- The radiographic facilities and equipment shall comply with the New Mexico Standards and Regulations for the Licensure of Hospitals and Related Institutions.
 - Procedural manuals and reference guides shall be maintained in the radiology unit.
 - Routine periodic maintenance shall be performed on all X-ray and film processing equipment to insure proper functioning of the equipment. This shall be done by trained personnel of a radiographic equipment and maintenance company.
 - To ensure the safety of the radiographic facilities, inspections of the equipment shall be conducted by the New Mexico Environment Department. Copies of the inspection reports shall be maintained by the HSA.
 - All personnel working in the radiology unit shall be trained and certified. They must wear safety badges which measure the exposure to ionizing radiation. Badges shall be changed regularly and submitted for monitoring.
 - A log shall be kept of all radiographic examinations performed. Information recorded shall include name, inmate number, type and number of x-rays taken and the date the x-rays were taken. This log shall be kept in the radiology unit and shall consist of a ledger book.
 - No x-rays shall be taken without the written or verbal order to the X-ray technician from a physician, physician assistant or nurse practitioner.
 - A form shall be used for ordering and for the written interpretation of all X-rays. One copy of the report shall be filed in the inmate health record and one copy shall be filed in the x-ray film envelope.
 - All x-rays, after initial review by the on-site medical staff if appropriate, shall be sent to a contracted radiologist for interpretation. After interpretation, the X-rays shall be kept on file in the radiology unit.
 - Equipment and supplies in the radiology unit shall be maintained.

4. Laboratory Services: Facilities equipped with a laboratory shall meet the following guidelines:
- The laboratory shall be maintained and adequately equipped to meet basic needs.
 - Procedural manuals, reference guides and safety manuals shall be maintained in the laboratory for all laboratory equipment.
 - Arrangements with an off-site clinical laboratory shall be maintained to provide for those services not provided on site.
 - A log shall be kept of all laboratory specimens collected. Information recorded shall include inmate name, number and tests ordered. The log shall be kept in the laboratory unit.
 - No laboratory specimens shall be collected without a written or verbal order from a physician, physician assistant or nurse practitioner.
 - Equipment and supplies in the laboratory unit shall be maintained.
 - Some onsite diagnostic testing with immediate results will be available, at a minimum, multiple test dip stick urinalysis, finger stick blood glucose test and stool blood testing equipment.
 - Provisions shall be made for the timely obtaining of STAT laboratory tests.