Quality Review of New Mexico Corrections Department

Review Period: December 1, 2016 – November 11, 2017
Report Due Date: June 1, 2018

PHI/PII: This report contains protected health information/personally identifiable information (PHI/PII). Use only secure methods to view and transfer this report. Properly dispose of paper copies and properly secure electronic copies of this report.

Rationale

It is important for inmates in the New Mexico prison system to receive the medical care they need. Since each inmate needs to have an intake screening to determine his/her medical needs upon admission to the corrections system, knowing who did or did not get this intake screening will help NMCD know if inmates are getting the care they need. A quality review of charts for the Intake Performance Measure (IPM) for these inmates will provide information to NMCD on the medical care inmates receive.

Focus Question

Are inmates getting the intake screening that all inmates are to receive upon admission to the corrections system?

Why a Quality Review

The quality review of charts tells us what type of care an inmate received. Licensed and certified health care professionals are trained to create a record and document care that is rendered to a patient or inmate. The assumption is that if the care was documented in the record, then the inmate received that care. Alternatively, if there is no documentation of care in the record, the assumption is that the inmate did not receive that care. Retrospective reviews of medical charts are a cost-effective and reliable way to know, after the fact, that an inmate received the correct care.

Methodology

Creation of Universe

NMCD created a universe (population) from the Criminal Management Information System (CMIS) that included information for each inmate. Data was pulled according to HealthInsight technical specifications. The review period for this assessment was from December 1, 2016 through November 11, 2017. The start date was December 1, 2016, which was the end date of the Centurion grace period of the contract, to November 11, 2017. NMCD delivered the universe to HealthInsight via the ShareFile secure portal.

Universe Parameters

The universe included all inmates that were incarcerated between December 1, 2016 and November 11, 2017. HealthInsight stratified for gender and for those inmates referred to chronic care clinic. HealthInsight stratified for 120 days from the date of admission to the corrections system in order to provide sufficient time for the inmate to have been seen at least once in chronic care clinic (CCC).

Random Sampling

HealthInsight performed a random sample of 203 charts from the universe. HealthInsight communicated to Centurion and NMCD which inmates' charts were selected for the random sample. Upload requests of the selected inmate medical records were staggered over several dates beginning December 28, 2017 through April 23, 2018, in order to provide each facility time to learn the process for uploading records while minimizing the burden of the additional work associated with the project. The initial requests were smaller, totaling approximately 20 charts. Once Centurion staff were familiar with the process of collecting and transmitting the charts electronically, the number of charts uploaded per facility increased on subsequent transmission dates until 203 charts was achieved.

Chart Collection

Centurion staff obtained the charts listed in the random sample. These charts were scanned and uploaded through the secure portal, ShareFile, set up by HealthInsight.

Chart Review

HealthInsight staff downloaded the charts from the ShareFile secure portal and reviewed the charts. Charts were reviewed using the 10 questions for the IPM from the Centurion contract with NMCD, and an additional four questions created by HealthInsight for evaluating the chronic disease clinic referral process.

Review Data Collection

This review data was recorded on a spreadsheet, which was used for observations, findings and recommendations for the final report. The spreadsheet was created to capture the presence or absence of each item from the review of the charts for the IPM and the four questions for the chronic care clinics.

Inter-Rater Reliability

For the current review, HealthInsight staff conducted an inter-rater reliability (IRR) assessment before the file review. The IRR process helped to ensure consistency in scoring between multiple reviewers. It allowed the reviewers to develop a more robust understanding of the questions, the authority citation references and the Centurion document submission in advance of conducting the full review. Two reviewers and the project manager were involved. The team conducted five reviews collectively. Then, the reviewers assessed five additional records in each of their respective sections. After completion of those same 10 records, they were assessed by the project manager. Then the reviewers and the project manager discussed any discrepancies and came to consensus. Revising the review process is part of HealthInsight's ongoing commitment to quality improvement.

Results

In addition to the observations and recommendations shown below, the Continuous Quality Improvement (CQI) tool is an Adobe Acrobat PDF appended to this report, which provides the results of the quality review for NMCD to utilize for their process improvement efforts. The threshold for the results of the evaluation is 90 percent. The external quality review process focuses on understanding and improving systems for inmate quality of care. The benefit of having quality improvement is to create a continuous data driven effort that produces measurable outcomes. Appendix A of this report is the CQI tool with the overall results (scoring) for all charts reviewed for this scope of work.

Observations

Observations do not affect quality scoring but may affect quality of care. The observations may or may not have a recommendation. If there is not enough information for the reviewer to understand what is happening in the health care setting, the reviewer can only make an observation, but not a recommendation. Observations for this review are listed below.

The NM Correction Department Policy Number 170000 Section for Medical Services requires alignment with the American Correctional Association (ACA) standards to ensure that systems are in keeping with nationally recognized standards of practice. NMCD has implemented the U.S. Preventive Services Task Force guidelines for clinical reference which promotes excellence in public health practices.

#1: The current CQI tools do not fully reflect the most up to date U.S. Preventive Services Task Force guidelines for clinical care.

Recommendation:

a. Update current CQI tools to reflect the most up to date U.S. Preventive Services Task Force guidelines for clinical care.

b. Provide to the medical contractor a comprehensive reviewer instructional tool for completion of the CQI tools to support consistent audit results.

#2: Evidence in the audited charts indicate documentation errors including illegible writing, blank spaces, words with lines through them, and inconsistent military time mixed with standard times.

Recommendation:

a. Provide education on defensible evidence of documentation that is legible, accurate, relevant, concise and complete.

b. Provide policy and procedures to health care staff with standard terminology and acronyms.

#3: Updated NMCD generated forms are not consistently utilized at all prisons. An example is the HIV Form #302, which has HIV Testing as the title of the form, but the footer shows 302 HIV/Hep C Testing; there is no Hepatitis C testing listed on the form – only HIV testing.

Recommendation:

a. Match the title of each form with footer documentation.

b. Utilize a unique name and number for each form.

#4: Health Services Physical Exam Form #104, pages 4 and 5 are specific for women's preventive services. In the charts reviewed, often those pages were left blank.

Recommendation:

a. Consider separating the forms from the general physical exam for all inmates, as the evidence provided did not consistently indicate that women get this done on initial intake.

b. Consider placing the data on a database comparable to the CCC database would help ensure the females are receiving female specific exams in a timely manner.

#5: The Chronic Disease Clinic Form #228 does not have a place to indicate when a diagnosis is not applicable to an inmate during a chronic care visit. Many times, the evidence provided was left blank and it could be interpreted as missed rather than not applicable to the visit. Other times areas of the chart were crossed out to potential indicate that diagnoses that were not applicable.

Recommendation:

a. Revise form to provide an area to consistently indicate when a diagnosis is not applicable to the visit.

#6: The requirement for anticoagulant and diabetic education can be documented on multiple forms: 1) page 5 of Chronic Disease Clinic Form #228; 2) the Anticoagulant Form #307; or 3) the Diabetic Form (no number). It is not consistently documented on any one form.

Recommendation:

a. Discontinue the use of both the Anticoagulant Form #307 and the Diabetic Form. Then document anticoagulant and diabetic education on Page 5 of the Chronic Disease Clinic Form #228.

b. Clarify the process for providing education in the Chronic Disease Clinic.

#7: The Annual Health Maintenance Flow Sheet Form #102 (Goldenrod) has not been updated to reflect recently implemented U.S. Preventive Services Task Force guidelines.

Recommendation:

a. Routinely review and implement U.S Public Services Guidelines to ensure provision of medical care that adheres to current guidelines.

Findings

Findings affect scoring and quality of care and will have a recommendation. Recommendations suggest a best practice or an absolute direction when evidence does not meet or match a rule or regulation. Findings listed in this section reflect those instances where a pattern was identified. For a complete record of all findings identified see Appendix A. NMCD CQI Intake Performance Measure Tool.

#1: A quality and timeliness of care for an inmate with a positive laboratory finding for a communicable disease had a medication ordered by the clinician for treatment. Although the medication was prescribed May 14, 2017, the evidence indicated he was not treated at that time. The CMIS location history listing indicated he was at the intake facility for 27 days. After the chart was reviewed, this finding was brought to the attention of the health services administrator (HSA). The HSA reviewed the information provided by the chart review. As a result of the HSA review, on April 16, 2018, the order was written and medication provided to the inmate.

Recommendation:

a. Implement a process for the review of critical lab values and treatment when indicated.

b. Implement a protocol or provider standing orders so proper treatment and test of cure is provided.

c. Implement standardized processes for reporting communicable diseases.

#2: Pregnancy tests are not consistently documented on Form #202 for female inmates. Sometimes, results were documented by drawing a line. It was unclear what was being communicated.

Recommendation:

a. Educate all clinical staff to document the results of pregnancy tests on Form #202 or prepopulate the names of the labs to be drawn instead of having staff write in the labs on a blank line on the form. This would be for the initial intake only.

b. Educate all clinical staff to consistently document positive, negative or N/A findings with correct wording of positive, negative or N/A. Do not leave the HCG or Pregnancy line blank or with a line.

c. Update the laboratory form with prepopulated positive, negative or N/A wording to be circled by the health care staff to provide uniformity in documentation.

#3: TB test has a date but not consistently a time, or a time but no date.

Recommendation:

a. Educate all clinical staff to consistently document findings correctly.

b. Collaboration of NMCD with Centurion to provide training and education.

#4: TB form has a two-step process and many times only the first test completed. In several instances, the second TB test was not read within 72 hours or the second TB test was placed, but never read.

Recommendation:

a. Update the form and testing process. Reflect recently implemented U.S. Preventive Services Task Force guidelines on new forms.

b. Educate all clinical staff to consistently document findings correctly.

#5: The RDC Intake/Annual Inmate TB screen Form #306 currently provides space to document a two-step TB screening. In the charts reviewed, often the second step was left blank. Also, the form only contains a line to record the date but not the time of the test. Without the time of the test documented on the form, it is impossible to determine if the test was read in a timely manner.

Recommendation:

a. Determine a standardized process for TB screening, document in a policy, and educate staff.

b. Update the RDC Intake/Annual Inmate TB screen Form #306 to add space for documenting both date and time of the test.

#6: The Lab Test Encounter Form #202 not consistently used. Sometimes, certain labs are listed to be drawn and sometimes no routine lab draws are listed to be drawn. Specifically, pregnancy tests were not listed to be drawn on this form when applicable. Also, this form was not always used when drawing labs for the intake assessment.

Recommendation:

a. Consistently use an updated laboratory form that reflects the required labs that need to be drawn as part of the intake assessment.

b. Consider adding the HIV permission verbiage to this Lab Test Encounter Form #202 to improve efficiencies, decreasing extra paperwork filing, and providing consistency in getting the lab drawn.

#7: Health Services Physical Exam Form #104 has multiple areas for the nurse or clinician to sign and date. Some of the pages have blanks or two signatures on one line.

Recommendation:

a. Clearly indicate area for nurse and clinician to sign and date with separate lines for each signature.

b. Eliminate multiple entries of clinician signature on every page. Consider initialing Pages 1 and 2, and requiring a signature on Page 3.

#8: In several instances, the intake form for the time period being reviewed was not provided. An intake form from a prior encounter was provided.

Recommendation:

a. Educate staff that an intake form must be completed for all inmates.

b. Implement procedures to ensure that all forms are filed in the record in a timely manner.

c. Work with staff preparing the files for review to be sure they provide the appropriate intake form.

#9: The Health Assessment form for the time period being reviewed was not always provided. The Health Assessment form provided was for a prior encounter.

Recommendation:

a. Educate staff that a Health Assessment form must be completed for all inmates.

b. Implement procedures to ensure that all forms are filed in the record in a timely manner.

c. Work with staff preparing the files for review to be sure they provide the appropriate Health Assessment form.

#10: The Health Assessment was not always completed within 7 days.

Recommendation:

a. Educate staff about timeframes for completing the Health Assessment.

b. Implement a process to ensure reasons are documented if there are circumstances that prevent the Health Assessment from being completed in a timely manner.

#11: On some intake forms, there was an indication that the inmate has medication therapy (medical or psychiatric). There was a notation stating “see transfer sheet”, “see MAR” and/or “see psych encounter form”. The transfer sheet, MAR or psych encounter form was not provided. In many of these cases, the entry on the Health Assessment under medications will say “see intake sheet”.

Recommendation:

a. Educate staff about the importance of accurately documenting inmate medications.

b. Implement a process that would require the person reviewing the medications to initial the form (transfer sheet, MAR, psych encounter form) when they have reviewed the medications.

#12: Sometimes, medications were reviewed and ordered more than 12 hours after the intake assessment**.**

Recommendation:

a. Educate staff on the importance of reviewing and ordering medications in a timely manner.

#13: For some charts, no labs were provided for the review.

Recommendation:

a. Implement procedures to ensure that all forms are filed in the record in a timely manner.

#14: The problem list is not always updated at the time of intake. Not all pertinent conditions were noted on the problem list.

Recommendation:

a. Define for the staff at what point in the intake process the problem list should be completed.

b. Educate staff on the importance of completing the problem list in a timely manner.

Appendices

Attached to this report is Appendix A. HealthInsight Quality Review SFY2018- Intake Performance Measure CQI Tool. It includes the scoring data for all charts reviewed for this scope of work.

For additional information concerning this report, contact:

External Quality Review Department

5801 Osuna NE, Suite 200
Albuquerque, NM 87109-2587
www.healthinsight.org

PHI/PII: This report contains protected health information/personally identifiable information (PHI/PII). Use only secure methods to view and transfer this report. Properly dispose of paper copies and properly secure electronic copies of this report.