SCDC POLICY

This policy has been developed in response to and as a portion of the Remedial Plan agreed upon by the parties in the settlement of T.R. V. South Carolina Department of Corrections, No. 2005-CP-40-02925. As agreed by the parties in the Settlement Agreement, it is the understanding and agreement of the parties that implementation and effectuation of the provisions of this policy as a portion of the Remedial Plan shall be phased in over time and all aspects shall not become effective immediately. (See Section 2 - Summary of Agreement and Section 4 (f) - Implementation Phase-In of Settlement Agreement effective May 2, 2016).

Change 1 to HS-19.07: Definitions - QMHP

Change 2 to BH-19-07: Introduction

NUMBER: ~~**HS-19.07**~~ ***BH-19.07***

TITLE: MENTAL HEALTH SERVICES - CONTINUOUS QUALITY MANAGEMENT (CQM)

ISSUE DATE: August 29, 2016

RESPONSIBLE AUTHORITY: DIVISION OF MENTAL HEALTH SERVICES

~~**OPERATIONS**~~ ***POLICY*** **MANUAL:** ~~**HEALTH SERVICES**~~ ***BEHAVIORAL HEALTH*** (Changes in **green** amended by Change 2, dated January 23, 2024 and signed by the Director on March 25, 2024)

SUPERSEDES: SCDC POLICY HS-19.02 (dated July 1, 2008) - NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES:

ACA/CAC STANDARDS: 4-ACRS-5A-08, 4-ACRS-6A-11, 4-ACRS-7D-07, 4-4095, 4-4098, 4-4099, 4-4256, 4-4277, 4-4285, 4-4286, 4-4305, 4-4351, 4-4368, 4-374, 4-4399, 4-4428, 4-4429, 4-4430, 4-4431, 4-4433, 4-4434, 4-4435, 4-4436, 4-4438, 4-4439, 4-4440, 4-4441, 4-4442, 4-4446

STATE/FEDERAL STATUTES: None

PURPOSE: SCDC Mental Health Services Continuous Quality Management (CQM) policy focuses on providing a program that identifies problems, implements and monitors corrective action, and studies its effectiveness in order to improve mental health care delivery.

POLICY STATEMENT: It is a guiding principle of the South Carolina Department of Corrections (SCDC) that CQM is a fundamental necessity, allowing essential mental health program functions to be reviewed on a routine basis so areas for improvement are identified and addressed proactively. CQM allows for streamlined management of processes that promote efficiency, accuracy, and examination of outcomes to determine program effectiveness in the delivery of mental health services.

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SPECIFIC PROCEDURES:

1. PHILOSOPHY AND OBJECTIVES:

1.1 The philosophy of Mental Health Services in regards to Continuous Quality Management (CQM) is "Inspect What we Expect". This policy is applicable to all SCDC institutions that provide mental health care and services to inmates classified as mentally ill.

1.2 Objectives include:

- To continuously improve the quality of care to inmates receiving mental health services by: monitoring clinical activity, identifying opportunities to improve clinical outcomes, identifying educational and training needs of staff, and managing utilization of resources to promote accuracy and efficiency in the provision of services.
- To identify opportunities that support the review, revision, and/or development of protocols, policy, and procedures from the perspectives of Quality Mental Health Professionals (QMHPs).
- To support QMHPs in obtaining guidance, technical support, and training in areas of job performance, agency and divisional procedural standards, regulatory compliance, and quality care services.
- To provide a direct feedback loop between division directors and QMHPs.

2. OVERVIEW:

2.1 Mental Health CQM examines areas identified as problem-prone, high frequency/volume, or involving risk management processes, including, but not limited to, issues of informed consent, screening and evaluations, special needs, segregation, treatment planning, suicide prevention/crisis intervention, discharge planning, and medication administration.

2.2 Quality management is achieved by setting goals and objectives, developing performance indicators to measure the objectives, and collecting data on performance. The results are then analyzed and feedback is provided to program directors, managers, supervisors, and QMHPs, allowing for processes or services to be modified, if necessary, for better achievement of program's goals.

2.3 QMHPs are included in CQM activities (see Appendix A) as this promotes buy-in to corrective action plans and increases the investment of staff in providing quality services that also meet accreditation standards.

2.4 The CQM process creates a foundation that helps solidify the establishment of fair and consistent standards, decreases confusion, creates a positive set of principles that all QMHPs understand, and inspires a "good practice" approach to assist in establishing successful delivery of mental health care within SCDC.

2.5 Performance Measurement Indicators:

- *Access to Care* - how easily an inmate is able to obtain needed services;
- *Timeliness* - care, intervention, and prevention are provided to the inmate at the most beneficial or necessary time;
- *Documentation* - quality, consistent, and accurate documentation that maintains compliance with legal, regulatory, and divisional/institutional requirements;
- *Effectiveness* - providing up-to-date, evidence-based prevention and intervention responses in an effort to produce a desired, results-oriented outcome;
- *Appropriateness* - care, intervention, and prevention services are relevant to clinical needs and community standards of care, and respectful of individual care and needs; and
- *Continuity* - maintaining ongoing, consistent mental health care, interventions and prevention among practitioners, vendors, institutions and other corrections staff.

3. QUALITY MANAGMENT STANDARDS:

3.1 Responsibility:

3.1.1 The Division Director of Mental Health is responsible for the coordination of SCDC Mental Health, CQM program, and/or services.

3.1.2 The central office Quality Management Director is responsible for the implementation of the mental health CQM activities.

3.1.3 The central office Audit Revision and Conceptualization (ARC) Team - ARC Team members consist of staff selected by the Division Director including, but not limited to, psychiatrists, psychologists, regional managers, program supervisors, QMHPs, nurses, correctional services representatives, etc., who meet at least quarterly. The ARC Team provides assistance by:

- Generating and coordinating ideas to design effective mechanisms that will identify and prioritize problems, assessment, resolution, and evaluation;
- Using appropriate mechanisms to review and analyze aggregate data relevant to practice and performance so that patterns are ascertainable;
- Making recommendations, as appropriate, for corrective action in activities, functions, and /or standards;
- Reviewing educational opportunities relevant to quality management and quality control.

3.2 Monitored Services/Activities:

3.2.1 Record Reviews/Quality Management Projects:

- Performance measurement indicators and identified quality management projects dictate what type of data needs to be collected, including that obtained by record review, and determine the frequency of data collection and record reviews. The RIM report identifies all mentally ill inmates by institution and mental health classification and can be used as a data source from which record pulls can be identified.
- Depending on the issue under study, an appropriate sample size will be collected for review, on an identified schedule, from all pertinent programs, sites, or categories. Where available, at least 10% of records pertinent to the issue at each site will be randomly selected for review.
- Information is compiled, analyzed, and summarized to be presented at the ARC Team CQM quarterly meetings. The ARC Team will develop any necessary action plans and monitor implementation.

3.2.2 Reporting: The Division of Mental Health Services compiles data used to identify a need for improved quality of care and/or better utilization of resources. The data collected is analyzed and then results are summarized to identify trends in mental health care delivery. Examples of mental health reports routinely generated include, but are not limited to, the following:

- Crisis Intervention/Suicide Precaution Daily and Monthly Report;
- Daily Crisis Intervention/Suicide Precaution Report;
- Monthly statistical reporting, which monitors staffing ratios, clinical caseload numbers, group participation, psychiatric clinic statistics, and other pertinent information necessary to ensure quality clinical care;
- Monthly Grievance Report, which provides data on inmate grievances regarding areas of mental healthcare;
- Monthly Lockup Status Report, which is a RIM report that provides information on mentally and non-mentally ill inmates who have been on lockup status from 30 to 90 or more days;

- Monthly Mental Health Disciplinary Treatment Team Report, which is a monthly review of information on inmate disciplinary accountability, lockup status, and issuance of alternative sanctions;
- Mental Health Group Therapy Attendance Report, which tracks attendance of all inmates receiving therapeutic group services; and
- Mental Health Care Services Referral Log, which tracks the number of inmates requesting mental health services.

3.3 Oversight:

3.3.1 Program Services Audits: The Mental Health Services Quality Management Director or designee will conduct on-site audits of mental health services at each facility on a twice annual basis. Additional audits may be conducted as recommended by administrative or clinical staff or the ARC Team. Each audit is designed to systematically evaluate mental health service delivery at each institution by:

- Assessing service components for compliance with current practices, policies and procedures including, but not limited to: a review of service delivery logs, treatment plans, individual and group counseling records, timely and effective case management, crisis intervention follow-up, medication monitoring, and discharge planning.
- Reviewing treatment team staffing logs;
- Reviewing quarterly administrative staff training and meetings;
- Interviewing inmates and staff.

3.3.2 The Audit process consists of three (3) phases:

- Pre-Onsite: Includes: a) identifying in writing applicable information necessary to complete the assessment, including anticipated time on-site, space requirements, and preliminary data and documentation needs; and b) review of prior assessment, prior corrective actions, and deficiencies.
- Onsite: Information gathered based on established performance measures through observation and review of documentation, procedures, and compliance with current practices, policies, and procedures.
- Post-Onsite: Analysis of data, information, and supporting documentation obtained through Pre-Onsite and Onsite phases; preparation of a report of findings, and discussion of findings /deficiencies to SCDC MH administration and onsite staff.
- Following completion of the audit process, appropriate staff will be tasked with development of a remediation plan to address any deficiencies.

3.3.3 The CQM Director has the authority to review or authorize review of clinical documentation with or without notice.

3.3.4 Psychiatry, Medical Staff, Mental Health Management, and Clinical Staff are all involved in the review of all suicide and suicide attempts, acute care hospital admissions, emergencies, forced psychotropic medications, adverse drug reactions, use of restraints, and conditions requiring outside medical or mental health services.

3.3.5 Crisis Intervention and Suicide Prevention processes are reviewed with findings being reported at the ARC Team quarterly meeting. The ARC Team will determine if an aspect of mental health care requires additional monitoring and improvement planning.

3.3.6 All use of clinical restraints will be reviewed. This data is presented in summary during the quarterly ARC Team meeting. The team will be responsible for identifying aspects of care that require additional monitoring and change.

3.3.7 At each quarterly Mental Health ARC Team meeting, the committee will review identified problems in service delivery, review selected policies and procedures, assist in implementing and monitoring corrective actions, and examine effectiveness of these corrective actions.

3.3.8 Peer Reviews:

- Peer reviews are conducted every 12 months;
- The institutional Mental Health Supervisor/Manager shall maintain a schedule of required peer reviews and forward an updated list quarterly to the Assistant Division Director;
- Peer reviews will be conducted by a clinical staff member of the same discipline.

3.3.9 Mortality Reviews:

- In the event that an inmate classified as mentally ill dies of any cause, the first mental health staff person advised of the death will notify the Division Director within one (1) hour from the time of notification;
- In the event of an inmate suicide, a suicide mortality review, coordinated by central office, will be completed to review all aspects of mental health care in the case. It will include a review of the mental health record, and other important correctional and administrative review data, as well as interview of pertinent staff members, to assist in determining if any aspects of care, by either omission or commission, could be improved. The review will be completed within three (3) months of the event.
- An AMR note by the inmate's assigned QMHP will be entered in the record stating, "inmate expired, record closed." The note should be dated, timed, and signed.
- The mental health record is to be forwarded to the institutional Supervisor/Manager's office no later than the first working day following an inmate's death and secured in the Supervisor /Manager office for review as necessary by authorized individuals only.
- The Division Director will coordinate a debriefing for staff and separately for any inmates exposed to or involved in the situation.

3.3.10 Improvement Action Plans:

- When problems or opportunities for improvement are identified from any of the above sources, a CQM action plan will be created and documented for each area for improvement identified.
- An identified finding can be determined to be either an individual or system finding (or both). The following actions are then initiated:

    1) Individual: The clinician and the Regional Manager/Program Supervisor complete the development and implementation of an improvement action plan; and

    2) System: The Division Director, the CQM Director, and the ARC Team complete the development and implementation of an investigatory review and corrective action process plan.

- The improvement action plan will specify tasks, suggest completion dates, and parties responsible.

- The improvement action plan should focus on specific findings so as to help prevent the occurrence of similar problems in the same or other areas or individuals. The plan may include, but is not limited to:

    1) policy, procedure, and/or system changes;

    2) designating ways to handle compliance issues;

    3) additional training;

    4) restricting work responsibilities of individual employees for whom there are compliance or competence concerns;

    5) disclosure of the matter to external parties providing assistance; and

    6) recommendation for sanctions or discipline.

- The CQM Director approves the plan prior to implementation and monitors implementation to ensure successful and sustained resolution. If the problem is systemic, the Division Director and/or Deputy Director will also approve the plan prior to any substantial change.
- Improvement actions that involve personnel-specific intervention will require the establishment and monitoring of an individual performance improvement plan.

3.4 Records Retention:

3.4.1 Continuous quality management documents are maintained in a confidential, secure manner under the control of the CQM Director or designee and consistent with the SCDC record retention process.

3.5 Confidentiality:

3.5.1 Continuous quality management records are confidential and privileged and shall not be disclosed to any person or entity except as provided by the specific exceptions within SCDC policy.

3.5.2 Records of internal review activities must comply with legal requirements on confidentiality of records.

3.5.3 Any questions regarding the appropriateness of release of such confidential materials are directed to the department's Chief Legal Counsel.

3.5.4 All quality management records are marked as "Confidential."

3.5.6 All participants in ARC Team and Continuous Quality Management Program activities sign a Statement of Confidentiality for Quality Management agreeing to maintain the confidentiality of all information emanating from these activities.

4. DEFINITION(S):

Audit Review refers to feedback and summation of strengths, concerns, recommendations, and observations collected during the review process for the purpose of improving processes, correcting deficiencies, and providing additional assistance in meeting quality standards.

Audit Revision and Conceptualization (ARC) Teams refers to a multidisciplinary "Continuous Quality Management" Committee tasked with identifying problems, monitoring service delivery; recommending, implementing, and monitoring corrective actions; and examining the effectiveness of these corrective

actions at the central and regional levels. The central committee will have representation from each regional Continuous Quality Management Committee. Each Regional Continuous Quality Management Committee will have representation from the regional institutions it serves.

Compliance refers to adherence to divisional, institutional, and Agency standards, practices, policies, and procedures at identified threshold.

Compliance Audit refers to a quality management review designed to improve clinical processes, correct deficiencies, and provide additional assistance in meeting quality standards.

Compliance Issues refers to areas needing improvement.

Continuous Quality Management (CQM) refers to the process used to objectively and systematically evaluate quality and appropriateness of mental health services, identify and correct problems, and pursue opportunities to improve care.

Director of Quality Management refers to an individual tasked with the responsibility for oversight of all quality management programs within a designated service area.

Indicator refers to data collected or monitored to provide information about the performance of a clinical process, service, function, or outcome.

Mental Health Procedure Manual refers to a handbook of current written policy and procedures applicable to methods, programs, and services directed at assisting Qualified Mental Health Professionals (QMHPs) in providing quality mental health care.

Monitoring and Evaluation refer to a planned, systematic, and ongoing process involving observation and collection of information on the delivery of mental health care services.

Qualified Healthcare Practitioner (QHP) refers to a physician, physician's assistant, or nurse practitioner.

Qualified Mental Health Professional (QMHP) - Licensed Psychiatrist, Licensed Psychologist, Licensed Professional Counselor, Licensed Professional Counselor-Supervisor, Licensed Independent Social Worker, Licensed Martial and Family Therapist (LMFT), Psychiatric Nurse Practitioner. Also, includes Licensed Master Social Worker, LMFT-Intern and Licensed Professional Counselor-Intern with appropriate supervision. ***A QMHP may also include a person with a master's degree in social work, applied psychology or mental health counseling who is eligible for licensure in the State of South Carolina pursuant to the following conditions being satisfied: 1) must prove eligibility for licensing at time of hire; 2) must become licensed prior to the 12th month from hire or be terminated from employment; 3) must be provided on-site weekly clinical supervision by a licensed clinician and monthly reviews of documentation; 4) clinical activities will be restricted to individual counseling, group therapy, treatment team participation, restricted housing unit rounds and mental health assessments; 5) license-eligible staff will be restricted from engaging in duties related to crisis intervention and shall not work in Crisis Stabilization Units or Psychiatric Inpatient settings.*** (Changes in BLUE are amended by Change 1 Memorandum, dated April 19, 2023, and signed off on by the Director on April 26, 2023.)

Quality Assurance (QA) refers to monitoring of compliance with policies, procedures, regulations, services, and standards for the purpose of meeting divisional goals and objectives and supporting continuous quality management in accordance with SCDC philosophy.

Quality Management Records refer to any record or document created during the CQM process of any of its activities, or forms identified as a quality management form in the Continuous Quality Management policies, protocols, or directives.

Resource and Information Management (RIM) refers to the Agency's Division which supports the effective use of information technology throughout SCDC internal operations; provides application

system development, desktop support, LAN (local area network) management, and maintenance of all technological services.

SIGNATURE ON FILE

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s/Bryan P. Stirling, Director

Date of Signature

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.

APPENDIX A

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

CQM ACTIVITIES

MENTAL HEALTH PROGRAM AREA	SAMPLE ISSUES TO BE MONITORED
Reception and Evaluation	Processing period and quality of P-SERC information including but not limited to: initial mental health screen, secondary and psychological evaluations, and appropriate resolution and classification documentation.
Crisis Intervention, Residential Care, and Outpatient Care	Processing period and quality information including but not limited to: mental health transfer screen, secondary and psychological evaluations, appropriate resolution and classification documentation, and risk assessment.
Crisis Intervention, Residential Care, and Outpatient Care	Timely updates, justification of need, appropriateness, interventions, and continuity of service provisions based on inmate problems, goals, and objectives on the Individual Treatment Plan.
Crisis Intervention, Residential Care, and Outpatient Care (*CI/SP logs also reviewed at R&E*)	Treatment team logs, crisis intervention logs, medication logs, and on-call logs ensuring accuracy, appropriate documentation, and continuity of care as needed.
All Program Areas (*no group sessions at R&E*)	Timely individual and group therapy sessions, appropriate documentation format, quality and appropriateness of content, and continuity of care.
All Program Areas	Timely scheduling of Psych Clinic according to inmate LOC and/or need, appropriate documentation and follow-up accompanying missed appointments, medication changes, diagnostic changes, and updates of treatment care and services.
All Program Areas	Accurate, timely, and effective treatment, documentation, follow-up, and continuity of care for inmates placed on crisis intervention/suicide precaution to include information from clinical, medical, and uniform staff.

Crisis Intervention, Residential Care, and Outpatient Care (*applicable to R&E for short-term inmates*)	Completion of discharge plans addressing the effectiveness and appropriateness of mental health treatment care and services, and ensuring continuity of care upon program or Agency release.
All Program Areas	Timely, accurate, and effective follow-up care involving inmate treatment including hospitalization and aftercare, PREA screening, medication non-compliance, disciplinary hearings, and requests to staff.
Crisis Intervention, Safe Cells	Cleanliness of cells, appropriateness of temperature, and standard use of mattresses, blankets, and smocks.
Segregation	Elimination of disproportionate use of segregation for mentally ill inmates; improve cleanliness and assure appropriate temperatures in segregation cells; assure adequate recreation and shower time for inmates in lockup.
All Program Areas	Monitor disproportionate uses of force against mentally ill inmates.
All Program Areas	Eliminate pill lines before 6:00 a.m. Review quality and accuracy of Medication Administration Records.
All Program Areas	Monitor quality and effectiveness of training of correctional officers in dealing with mentally ill inmates.

APPENDIX B

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

AUDIT REPORT OUTLINE

AUDIT REPORT OUTLINE	DESCRIPTION
Date of the Audit	Date institutional audit is conducted.
Prepared By	Name and title of the person preparing the report with the office address of the preparer.
Audit Region/Facility	Name of the region, name of the facility, or multiple names of facilities if audit covers more than one facility.
Audit Subject	Name of audit tool used (90 day review tool, Annual Compliance Tool, Other).
Randomization Criteria (based on the type of review and a maximum of [20%] of clinicians caseload at time of review)	How the sample was selected and the number of records selected, as well as the number of records audited. Describe the methodology, materials audited, and analysis.
	Description of the source of the audit, such as whether it is a departmental directive (policy), a contractual issue, a routine audit per the audit calendar, a targeted audit resulting from an

Reason for Audit/Audit Focus	identified problem area, a follow-up audit to a previous one that had adverse findings, etc. Identify the focus of the audit (MAR, Sick Call, Intake, etc.).
Materials Audited	Description of the materials used in the audit such as logs, medical records, inmate interviews, etc.
Analysis	Completion of the results found in the audit.
Summary	Provide a brief analysis of audit findings and recommendations; and complete report distribution.

APPENDIX C

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

CQM INDICATORS

A list of CQM Indicators to be tracked each year will be developed with input from central and regional committees, department heads, and administrative staff, and maintained and monitored by the central Continuous Quality Management Committee.

CQM Indicators may be standing or changed as problem areas are identified and as compliance is achieved and maintained for an identified period. Indicators will support the monitoring of high risk and high volume issues and activities. For each indicator, a threshold for compliance is identified, and how compliance is assessed, including specification of what data is collected, how data is collected, frequency of data collection, who is responsible for collecting the data, the analysis process, and where and to whom results will be distributed.