OFFICE OF THE
CORRECTIONS
OMBUDS

POLICY REVISION COMMENTS

DOC 600.000 Health Services Management

Comments Submitted 7/9/2021

GENERAL:

- Certain information regarding job descriptions, documentation requirements, and other areas has been cut significantly.
- There seems to be creation of new positions/tiers of authority that are not clearly defined; different terminology is used in different places that makes the proposed organizational structure unclear.
- Concerns that some language deletions have resulted in unclear definitions or expectations. For instance, language regarding CQIP's responsibilities; language regarding providers being licensed practitioners.

POLICY:

I. Recommend adding "medically necessary and appropriate."

II. Will documentation on CQIP's responsibilities and expectations be identified elsewhere?

DIRECTIVE:

I.B. "Routinely reviewed": This timing seems too vague to be actionable. Recommend identifying specific time intervals for review. NCCHC standards frequently call for annual review of protocols.

I.C.2.a. Patient notification of consult decisions and next steps should occur in person and in writing; this would alleviate patient confusion on terminated or rejected care plans as well as facilitate the patient's ability to move on and establish a new plan (rather than going without care).

I.D. The movement away from proactive provision of information and into providing information "as available" is concerning. NCCHC recommends facilities provide proactive and continuous information regarding healthy lifestyle development and maintenance.

II.A.2. Is there a justification for the addition of "business" plan? Adherence to budgetary goals, or otherwise?

II.A.6. Is there a justification for omitting the CQIP definition in this piece?

II.A.7. Recommend providing definition for "Clinical and Administrative Council." Are these the individuals noted in Section II.C.? Elsewhere?

II.A.8. How does this differ from CQIP goals and duties?

II.A.9. Recommend changing "managing" to "resolving" or something equally results-oriented. Otherwise, there is no policy expectation to do anything beyond keeping record of complaints.

II.B. Unclear why the responsibility for clinical care is shifting from the CMO to "Clinical Directors" who seem to be at the facility level – is this an attempt to decentralize the standard of care? If so, this change is concerning; standardization improves accountability across systems. This is applicable to II.C. with regard to "legal compliance" as well.

II.C. Broadly, this seems like an enormous amount of responsibility for a job that seems undefined. Are these the "council" members mentioned earlier? Is the Clinical Director a role that already exists, or will it be a shift in responsibility for a current role? Recommend additional clarification in this subsection.

II.C.8. Again, NCCHC standards frequently call for annual review of protocols, etc.

II.C.15. Recommend changing "focus" to more action-oriented language; "create standards for," "implement," etc.

II.G.5.a. This section may conflict with above language for different roles. Are the co-chairs for CQIP meetings are HSMs, FMDs, and clinical directors?

II.G.16. Very concerned at the omission of data reporting, as this data is incredibly important to systemic review. Is this process being taken on elsewhere?

II.G.17. Again, concerned about this omission. Where will these duties appear?

II.G.21. Again, concerned about the omission of employee training.

II.H. There is a lack of clarity regarding positions, again – are Clinical Leaders distinct from all aforementioned roles?

II.H.8. Acknowledging that adding more language here won't necessarily translate to more flexibility on the part of staff, but is it possible to expand on the definition of "screen" here? Current language is vague.

III.A. Is this omission due to the tacit expectation that Health Services providers will be adequately licensed? Otherwise, request justification for the omission. Similar concerns with regard to III.D.1. and the omission of the requirement for formal clinical oversight.

III.G. **"Office of the Corrections Ombuds" should be omitted from this list of stakeholders. Routing all communication through HSMs perpetuates inefficiency and miscommunication. This concern has been previously discussed and an alternative procedure has been agreed upon between the agencies.**

III.G.2. Requiring all OCO inquiries be reported to HSMs is a concern for OCO, as it has the potential to further compromise patient confidentiality.

IV. Is there justification for striking this section? Recognizing that many of these requirements are present in DOC 530.100, there may still be a benefit to housing these requirements in 600.000 specifically in reference to medical interns, volunteers, etc. Medical work involves heightened levels of confidentiality, sensitivity, and training, among other elements, that may not be covered in the general volunteer materials.