U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

QUALITY IMPROVEMENT PROGRAM

IHSC Directive: 11-02
ERO Directive Number: 11834.2
Federal Enterprise Architecture Number: 306-112-002b
Effective: July 11, 2023

By Order of the Assistant Director
Stewart D. Smith, DHSc, FACHE STEWART D SMITH Digitally signed by STEWART D SMITH Date: 2023.07.11 09:41:07 -04'00'

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1. **PURPOSE:** The purpose of this directive is to establish a data-driven and outcome-based quality improvement (QI) system through monitoring and implementing improvement measures. The QI system establishes systematic activities to evaluate and improve health care delivery systems and clinical outcomes and create a culture of safety.

2. **APPLICABILITY:** This directive applies to all U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel, including but not limited to, U.S. Public Health Service (PHS) officers, civil service employees, and contract personnel. It applies to IHSC personnel supporting health care operations in ICE-owned and contracted detention facilities (CDFs) and to IHSC headquarters (HQ) staff. This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees supporting IHSC.

3. **AUTHORITIES AND REFERENCES:**

   3-1. DHS Directive No. 248-01-001, *Medical Quality Management.* September 10, 2012.

   3-2. IHSC Directive 11-06, *Risk Management*. August 25, 2021.

   3-3. IHSC National Quality Assurance Committee Charter. November 20, 2018, revised September15, 2022.

4. **POLICY:** The QI Program ensures IHSC delivers high-quality health care to its diverse noncitizen population and adheres to internal and external compliance standards using the Plan-Do- Study-Act (PDSA) methodology. The Medical Quality Management Unit manages the IHSC QI Program.

4-1. IHSC must track and analyze data to identify areas for improvement. The QI program examines data from clinical staff workflows, as well as patient outcomes from national and local performance measures, internal audits, external accreditation reviews, and external performance improvement benchmarks.

4-2. IIHSC-staff facilities must hold quarterly local multidisciplinary (e.g., health care, corrections) QI committee meetings. During these meetings, staff identify and establish clinical and administrative thresholds, and design monitoring methodologies. The QI committee uses a collaborative approach to design, initiate, and monitor site-specific QI activities.

5. RESPONSIBILITIES:

5-1. Chief, Medical Quality Management Unit.

5-1.1 Oversees the national QI, risk management (RM), and compliance programs.

5-1.2 These programs ensure established processes comply with policy, procedures, and standards.

5-1.3 Guides unit efforts to identify opportunities for change, monitor trends, and develop measurable improvements and accomplish program goals.

5-2. National Continuous Quality Improvement Coordinator. Coordinates the QI program with RM and compliance programs. Together, they ensure the QI system includes mechanisms that assess and improve performance.

5-3. Regional Compliance Specialist. Liaises and coordinates with the regional health care HSA, QI, medical, and nursing leadership to identify, implement, and monitor QI, RM, and compliance programs.

5-4. Quality Assurance/Performance Improvement Officer (QA/PIO). Analyzes agencywide data and performance measurements from the IHSC QI, RM, and compliance programs to validate QI initiatives.

5-5. Facility CD or physician designee.

5-5.1 Establishes the local QI (quality improvement) committee. Serves as the responsible facility health authority to identify, develop, and oversee clinical and administrative service area improvement studies.

5-5.2 Completes annual health record reviews to ensure health care provider(s) order, implement, and coordinate appropriate quality medical, nursing, behavioral health, and dental care.

5-6. Facility HSA or designee: Collaborates with the CD or designee, nurse manager, and facility health program manager. Together, they develop and monitor administrative services areas and thresholds, analyze trends using data from national performance measures (NPM), internal audits, external accreditation reviews, and external performance improvement benchmarks.

5-7. Facility Health Care Program Manager (FHPM) or designee.

5-7.1 Chairs the local QI committee to implement and monitor the local facility QI program to improve quality and reduce health care risk.

5-7.2 Develops, maintains, and oversees the facility's quality improvement health care program. FHPMs collaborate with the local quality improvement committee to ensure compliance with IHSC policies and detention standards.

5-7.3 Documents and retains local QI committee meeting minutes or summaries. Emails a link with this information to all appropriate personnel for review.

5-7.4 Drafts and uploads QI committee meeting minutes to retain documents on the local quality improvement SharePoint page.

5-7.5 Develops and maintains a quarterly quality improvement workplan for all NPMs and local performance measures (LPM).

NOTE: The local QI committee should base NPM workplans on fiscal year and local plans are dependent on time of development.

5-7.6 Documents sustainability, monitoring, and a study period.

5-7.7 Records workplans, accomplished goals, and process and outcome studies.

5-8. Senior Compliance Program Administrator. Reviews and investigates standards, policy compliance, and health care delivery in ICE detention facilities.

5-9. IHSC Health Services Staff. Provide quality of care services and create a safe environment by meeting organizational and professional standards, following identified best/safe practices, and proactively mitigating unsafe conditions or situations.

6. PROCEDURES:

6-1. National Performance Measures and Local Performance Measures Monitoring

6-1.1 Each facility QI committee must identify, address, and monitor clinical services areas of the NPMs based on trends. Sources include internal audits, external accreditation reviews, and external performance improvement benchmarks. The FHPM enters the information on the QI dashboard.

6-1.2 Each facility QI committee must develop LPMs from the 11 applicable service areas. The committee makes their decisions based on the identified health care risks and quality care aspects of the health care program.

6-1.2.a The committee must monitor progress using established thresholds. See the IHSC 11-02 G-01, *Quality Improvement Guide*.

6-1.2.b The committee may use IHSC internal audit findings, external accreditation reviews, and/or health care failure mode and effects analysis that reveal clinical service area deficiencies as a source of local performance measure development.

6-1.3 The FHPM monitors and updates the national and local measures on the Internal Quality Improvement (IQI) Dashboard in SharePoint.

6-2. Workplan Development and Monitoring

6-2.1 The FHPM monitors the quality improvement workplan for each process and outcome study.

6-2.1.a Each facility maintains a workplan for each performance measure for all national measures and local measures that describe targeted goals for the year and method to achieve goals.

NOTE: The local QI committee bases NPM workplans on fiscal year and local plans are dependent on time of development.

6-2.1.b Performance measure workplans must document how the facility plans to maintain measure compliance when the facility reaches its goal (e.g., sustainability with current measure, type of monitoring to continue after implementation of plans, and a time to close monitoring after criteria are met).

6-3. Annual Reporting

6-3.1 Each facility must complete a QI annual report. The committee reviews QI, administrative, and staff meeting minutes and document the status of QI studies, performance measure results, risk management updates, and all local improvement processes for the fiscal year.

6-3.2 Annual reports must document the effectiveness of the QI program with data for that year, to demonstrate effectiveness.

7. HISTORICAL NOTES: This directive replaces the IHSC 11-02*, Quality Improvement Program,* dated August 12, 2019.

7-1. Summary of Changes:

7-1.1 Responsibilities section added to align with IHSC directive template.

7-1.2 Health Record Review tool for IHSC Health System Assessment (IHSA) replaced with the MQMU Health Record review tool.

8. DEFINITIONS: The following definitions apply to this directive only:

8-1. Applicable service areas: High volume and/or high-risk areas related to health care processes.

8-2. Clinical services areas: High volume and/or high-risk areas related to patient care processes.

8-3. Culture of Safety: Attitudes, beliefs, perceptions, and values that staff share in relation to safety in the workplace.

8-4. Indicators: Quality of care markers that measure the extent to which facilities achieve their goals. They are expressed as numbers, rates, or averages that can provide facilities a measure to achieve improvement in care. They measure structure, process, and outcome, either as generic measures relevant for all diseases, or disease-specific measures that describe the quality of patient care.

8-5. Internal Quality Improvement Program: A program that improves processes to increase the timeliness, effectiveness, efficiency, and management control of facility activities. The internal Quality Improvement Plan encompasses all activities in support of the local and national goals. The facility reporting system is designed for rapid identification and correction of problems. This data, when integrated with the facility internal quality improvement activities, helps guide improvement. All staff are responsible for improving network performance.

8-6. **Just Culture:** A culture that is fair to staff who make unintended errors and holds staff accountable for reckless behavior such as conscious disregard of clear risks to patients or gross misconduct. Staff are not held accountable for system failures that contribute to errors and harm.

8-7. **Outcomes Indicator:** A parameter that measures the clinical and administrative outcomes, whether adverse or favorable, of processes used to deliver health care.

8-8. **Outcome Study:** A study that examines whether expected outcomes of patient care were achieved by: (1) identifying a patient clinical problem, (2) conducting a baseline study, (3) developing and implementing a clinical action plan; (4) and restudying the problem to assess the effectiveness of the action plan.

8-9. **Performance Measures:** Standardized indicators that assess a facility's health safety and mitigation of health risk.

8-10. **Plan-Do-Study-Act (PDSA):** A four-step methodology used to guide system and process improvements.

8-11. **Process Indicator:** A parameter that measures the effectiveness and efficiency of the processes used in health care delivery.

8-12. **Process Study:** A study that examines the effectiveness of the health care delivery process by: (1) identifying a facility problem; (2) conducting a baseline study; (3) developing and implementing a clinical action plan; and (4) restudying the problem to assess the effectiveness of the action plan.

8-13. **Quality Assurance:** Monitoring and evaluating a project, service, or facility to ensure they meet nationally recognized standards of care.

8-14. **Quality Improvement:** Systematic and continuous actions that lead to measurable improvement in health care services and the health status of detained noncitizens.

8-15. **Threshold:** An expected level of performance.

8-16. **Quality Improvement Workplans:** An outline of improvement activities planned for a given performance measure.

9. APPLICABLE STANDARDS:

9.1. Performance-Based National Detention Standards (PBNDS):

9.1.1. Part 4: Care; 4.3 Medical Care, Section EE, Administration of the Medical Department.

9-2. ICE Family Residential Standards:

9-2.1. Part 4: Care; 4.3 Health Care, V. Expected Practices; EE. Administration of the Medical Department.

9-3. American Correctional Association (ACA):

9-3.1. 4-ALDF-7D-01, Quality Improvement Practices.

9-3.2. 4-ALDF-7D-02, Quality Improvement Practices.

9-4. National Commission on Correctional Health Care Standards for Jails (2018):

9-4.1. J-A-06, Continuous Quality Improvement Program. (NOTE: Compliance indicator #1 requirement that the quality improvement committee meet at least quarterly is addressed in IHSC 11-02 G-01, *Quality Improvement Guide*; III. Local Improvement Program; A. Local Quality Improvement Committee. This section also quantifies that the committee is a multidisciplinary body. Compliance indicator #2 and #6 are addressed in IHSC 11-02 G-01, *Quality Improvement Guide*; III. Local Improvement Program; B. Local Performance Measures. Compliance indicator #4 is addressed in IHSC 11-02 G-01, *Quality Improvement Guide*; III. Local Improvement Program; A. Local Quality Improvement Committee.)

10. PRIVACY AND RECORDKEEPING: ICE uses detained noncitizens health records and information maintained in accordance with the DHS/ICE-013 Alien Health Records System of Records to provide for the care and safety of detained noncitizens. IHSC limits access to detained noncitizens health records and information to those individuals who need to know the information for the performance of their official duties, and who have appropriate clearances or permissions. IHSC secures paper records in a locked cabinet or room when not under the direct control of an officer or employee with a need for the paper record to perform their duties.

10.1. IHSC staff complete annual training on the protection of patient health information and Sensitive Personally Identifiable Information (PII).

10.2. IHSC staff reference the Department of Homeland Security Handbook for Safeguarding Sensitive PII (Handbook) at DHS Handbook for Safeguarding Sensitive PII for additional information concerning safeguarding sensitive PII.

10.3. All relevant documents produced or provided in accordance with this Directive must be maintained in accordance with an applicable National Archives and Records Administration (NARA) General Records Schedule (GRS) or a NARA-approved agency-specific records control schedule.

If the records are not subject to a records schedule, they must be maintained indefinitely by the agency. In the event the records are subject to a litigation hold, they may not be disposed of under a records schedule until further notification. Prior to the disposition of any records referenced in this directive, ICE Records Officer approval must be obtained.

11. **NO PRIVATE RIGHT STATEMENT:** This directive is an internal directive statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.

12. **POINT OF CONTACT:** Chief, Medical Quality Management Unit (MQMU).