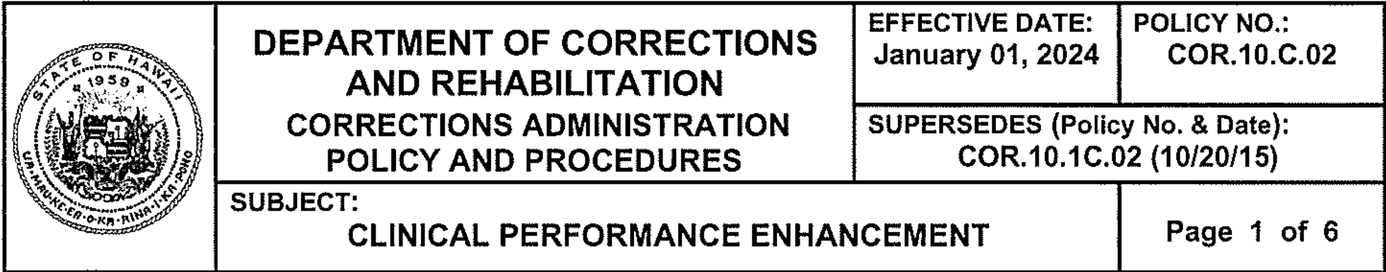


	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.C.02
		SUPERSEDES (Policy No. & Date): COR.10.1C.02 (10/20/15)	
	SUBJECT: CLINICAL PERFORMANCE ENHANCEMENT		Page 1 of 6

1.0 PURPOSE

The purpose of this policy is to ensure that individuals delivering patient care are reviewed through a clinical performance enhancement process.

2.0 SCOPE

This policy and procedure shall apply to all correctional facilities, their assigned personnel, and contract staff.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Department of Corrections and Rehabilitation, Policy and Procedures, ADM.05.01, Access Control to Department Confidential Information.

b. Department of Corrections and Rehabilitation, Policy and Procedures, ADM.05.02, Public Access to Department Information.

c. Hawaii Revised Statutes §671.D, Health Care Peer Review: Hawaii Health Care Quality Improvement Act of 1989.

d. Hawaii Revised Statutes §624-25.5. Proceedings and records of peer review committees and quality assurance committees.

e. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

f. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

g. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

h. Performance-based Standards and Expected Practices for Adult Correctional Institutions. The American Correctional Association. Standards: 5-ACI-6D-03, (2021).

.2 Definitions

a. Clinical Performance Enhancement: The process of having a health professional's clinical work reviewed by another professional of at least equal training in the same general discipline, such as the review of the facility's physicians by the responsible physician. It is not an annual performance review nor a clinical case conference.

b. Independent Review: The assessment of a health professional's compliance with discipline-specific and community standards. The review includes an analysis of trends in a practitioner's clinical practice.

c. Provider: A nurse practitioner, physician assistant, or physician.

d. Quality Assurance Committee: An interdisciplinary committee established by the administrative staff of the Health Care Division whose function is to monitor and evaluate patient care to identify, study, and correct deficiencies in the health care delivery system, with the goal of reducing the risk of harm to patients, improving patient safety, or otherwise improving the quality of care delivered to patients.

e. Responsible Health Authority: The Clinical Services Administrator is the designated individual tasked with ensuring the organization and delivery of all medical and clinical services in the facility.

f. Responsible Mental Health Authority: The Mental Health Administrator is the designated individual tasked with ensuring the organization and delivery of all mental health care in the facility.

.3 Forms

a. Clinical Performance Enhancement Log (attached)

b. Clinical Performance Enhancement Review: Physician (attached)

c. Clinical Performance Enhancement Review: Psychiatrist (attached)

d. Clinical Performance Enhancement Review: Advanced Practice Registered Nurse (attached)

e. Clinical Performance Enhancement Review: Registered Nurse (attached)

f. Clinical Performance Enhancement Review: Licensed Practical Nurse (attached)

g. DCR 0592, Clinical Performance Enhancement Review: Psychologist (attached)

h. DCR 0591, Clinical Performance Enhancement Review: Qualified Mental Health Professional (attached)

i. Clinical Performance Enhancement Review: Dentist (attached)

4.0 POLICY

.1 Clinical performance enhancement reviews are conducted, at a minimum, on all full-time, part-time, or per diem:

a. Providers

b. Registered Nurses

c. Licensed Practical Nurses

d. Psychologists

e. Licensed Clinical Social Workers

f. Dentists

.2 The clinical performance enhancement review is conducted annually.

.3 Clinical performance enhancement reviews are kept confidential and incorporate at least the following elements:

a. The name and credentials of the individual being reviewed.

b. The date of the review.

c. The name and credentials of the reviewer.

d. A summary of the findings and corrective action, if any.

e. Confirmation that the review was shared with the individual being reviewed.

NOT CONFIDENTIAL

.4 A log or other written record listing the names of the individuals reviewed and the dates of their most recent reviews is available.

.5 The Responsible Health Authority (RHA) and the Responsible Mental Health Authority (RMHA) implement an independent review when there is concern about any individual's competence.

.6 The RHA and the RMHA implement procedures to improve an individual's competence when such action is necessary.

5.0 PROCEDURES

.1 On an annual basis, clinical performance enhancement reviews shall be conducted for all providers, registered nurses, licensed practical nurses, psychologists, qualified mental health professionals, and dentists.

a. The Medical Director, or their designee, shall perform annual clinical performance enhancement reviews for all providers.

b. The Chief Nursing Officer, or their designee, shall perform annual clinical performance enhancement reviews for all registered nurses and licensed practical nurses.

c. The Mental Health Branch Administrator, or their designee shall perform annual clinical performance enhancement reviews for all psychologists and qualified mental health professionals.

d. The Dentist Manager, or their designee shall perform annual clinical performance enhancement reviews for all dentists and dental health professionals.

.2 Designated reviewers shall complete the discipline-specific standardized Clinical Performance Enhancement Review form and share the review with the individual being reviewed.

a. Clinical Performance Enhancement Review: Physician.

b. Clinical Performance Enhancement Review: Psychiatrist.

c. Clinical Performance Enhancement Review: Advanced Practice Registered Nurse.

d. Clinical Performance Enhancement Review: Registered.

e. Clinical Performance Enhancement Review: Licensed Practical Nurse.

f. Clinical Performance Enhancement Review: Psychologist.

g. Clinical Performance Enhancement Review: Qualified Mental Health Professional.

h. Clinical Performance Enhancement Review: Dentist.

.3 Completed Clinical Performance Enhancement Review forms shall be submitted to the responsible health authority (medical branch and clinical services branch staff), or the responsible mental health authority (mental health branch staff). The responsible health authority and the responsible mental health authority shall label and store the confidential Clinical Performance Enhancement Review forms in accordance with ADM.05.01.

.4 Employee requests for corrections or amendments shall be conducted in accordance with ADM.05.02.

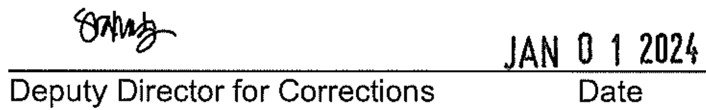
.5 When a need for corrective action has been identified in the Clinical Performance Enhancement review, the Responsible Health Authority or Responsible Mental Health Authority shall ensure that the corrective action is implemented.

.6 The Responsible Health Authority shall maintain the Clinical Performance Enhancement Log for medical branch and clinical services branch staff listing the names of the individuals reviewed and the date of their most recent review. The Responsible Mental Health Authority shall maintain the Clinical Performance Enhancement Log for mental health branch staff listing the names of the individuals reviewed and the date of their most recent review.

.7 When a concern about an individual's competence arises, the Responsible Health Authority or Responsible Mental Health Authority initiates an independent review by notifying the appropriate Branch Chief (i.e., Medical Director, Chief Nursing Officer, Mental Health Branch Administrator, or Dentist Manager) of the concern involving competence. The Medical Director, Chief Nursing Officer, Mental Health Branch Administrator, Dentist Manager, or designee shall then conduct an independent review, as indicated.

.8 If an independent review results in an adverse finding, the reviewer shall submit the independent review report to the quality assurance committee. The quality assurance committee shall review the facts of the matter and determine appropriate action. If a professional review action is indicated, the quality assurance committee shall consult the Departmental Human Resources Officer and proceed in a manner consistent with the Hawaii Health Care Quality Improvement Act of 1989.

APPROVAL RECOMMENDED:



Deputy Director for Corrections Date

APPROVED:

DIRECTOR Date

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW (Medical Provider)

Medical Provider Name **Credentials** **Date**

Reviewing Provider Name **Credentials**

Reason for Review:

☐Annual CPE Review ☐Sentinel Event ☐Inmate Grievance
☐Competency Issue ☐Complaint(s) ☐Other :

Medical Evaluation / Assessment	Good	Satisfactory	Needs improvement	Not Applicable
Thorough HPI; pertinent positives & negatives documented in HPI/ROS				
History is documented / updated (Medical, Family, Social)				
Focused physical exam is performed				
Imaging and lab results are interpreted				

Management/ Treatment Plan	Good	Satisfactory	Needs improvement	Not Applicable
Diagnoses present in assessment and are added to problem list				
Treatment plan accounts for differential diagnoses				
Management is clinically indicated, supported by evidence-based practices				
Clinical justification for alternative treatments is clearly documented				
Labs and diagnostic imaging are appropriately ordered				
Treatment plan is modified as clinically indicated by diagnostic test results				
Referrals are appropriate and detail the reason for referral				
Frequency of follow-up is consistent with clinical needs, accounting for current condition and status of condition				
When indicated, informed consent is obtained				
Preventative care screening is appropriately ordered per current guidelines				

Summary of Findings:

Corrective Actions:

☐None ☐Provide Education/Training ☐Clinical Supervision
☐Additional CPE (continue to monitor) ☐ Review Relevant Policy ☐ Independent Review
☐Other: ____________________

This CPE review was discussed with this provider on the following date: ____________________

Provider Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(Staff Psychiatrist)

Name: ______________________________ **Date:** ____________________
(Psychiatrist)

Name: ______________________________ **Credentials:** _______________
(Reviewer)

Reason for Review:

☐Annual CPE Review ☐Sentinel Event ☐Inmate Grievance
☐Competency Issue ☐Complaint(s) ☐Other: __________

	Yes	No	N/A	Unclear
Psychiatric Evaluation/Diagnostic Assessment				
Obtains sufficient data for DSM V differential diagnosis?	☐	☐	☐	☐
Obtains psychiatric, substance use, medical, family, and social hx?	☐	☐	☐	☐
Performs an adequate mental status examination?	☐	☐	☐	☐
Includes relevant observations and mental status/behavior changes?	☐	☐	☐	☐
Diagnosis is justified by history and current assessment?	☐	☐	☐	☐
Includes biopsychosocial formulation?	☐	☐	☐	☐
Recognition of need for additional history and collateral info?	☐	☐	☐	☐
Suicide Risk Evaluation				
Screens for suicidal and homicidal ideation?	☐	☐	☐	☐
Identifies risk and protective factors?	☐	☐	☐	☐
Includes summary of relevant information?	☐	☐	☐	☐
Medication/Treatment plan				
Recommended treatment is clinically indicated?	☐	☐	☐	☐
Treatment plan is consistent with diagnosis?	☐	☐	☐	☐
Medication risks/benefits discussed & informed consent obtained?	☐	☐	☐	☐
Labs/diagnostic imaging appropriately ordered & timely reviewed?	☐	☐	☐	☐
Collaboration with PCP, MH, nursing, & other specialties as needed?	☐	☐	☐	☐
Frequency of follow-up is consistent with clinical needs?	☐	☐	☐	☐

Summary of Findings:

Corrective Actions:

☐None ☐Provide Education/Training ☐Clinical Supervision
☐Additional CPE (continue to monitor) ☐Review Relevant Policy ☐Other: __________

This CPE review was discussed with staff psychiatrist on the following date: ________

______________________________ ______________________________
Staff Psychiatrist Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(Registered Nurse)

Name:____ **Credentials:** ___________________
(Registered Nurse)

Name: ____ **Date:** ___________________
(Reviewer)

Reason for Review:

☐ Annual CPE Review ☐ Sentinel Event ☐ Inmate Grievance
☐ Competence Issue ☐ Complaint(s) ☐ Other: _____________

	Yes	No	N/A	Unclear
Assessment				
Subjective Data is accurate, relevant, and thorough?	☐	☐	☐	☐
Objective Data is accurate, relevant, and thorough?	☐	☐	☐	☐
Physical exam is accurate, relevant, and thorough?	☐	☐	☐	☐
Clinically indicated Nurse Protocol/P&P used?	☐	☐	☐	☐
Adhered to Nurse Protocol/P&P?				
Diagnosis				
Diagnosis is justified by current assessment?	☐	☐	☐	☐
Diagnosis is relevant?	☐	☐	☐	☐
Planning				
Treatment plan is consistent with diagnosis?	☐	☐	☐	☐
Treatment plan is individualized & based on available resources?	☐	☐	☐	☐
Treatment plan adhered to Nurse Protocol/P&P?	☐	☐	☐	☐
Treatment plan is within scope?	☐	☐	☐	☐
Treatment plan is cosigned by Provider with verbal orders?	☐	☐	☐	☐
Implementation				
Intervention is consistent with treatment plan and diagnosis?	☐	☐	☐	☐
Intervention completed thoroughly and accurately?	☐	☐	☐	☐
Intervention is implemented in a timely manner?	☐	☐	☐	☐
Intervention and care are documented?	☐	☐	☐	☐
Intervention is within scope?	☐	☐	☐	☐
Evaluation				
Evaluate response to intervention and documents, as indicated?	☐	☐	☐	☐
Adapts plan of care based on new assessment data?	☐	☐	☐	☐
Referred to Provider, when clinically indicated?	☐	☐	☐	☐

Summary of Findings:

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

Corrective Action(s):

☐ None	☐ Provide Education/Training	☐ Clinical Supervision
☐ Additional CPE (continue to monitor)	☐ Review Relevant Policy	☐ Other: _____________

This CPE review was discussed with the RN on the following date:

______________________________ ______________________________
Registered Nurse Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(Licensed Practical Nurse)

Name:____________________________________ **Credentials:** ________________
(Licensed Practical Nurse)

Name: ____________________________________ **Date:** ________________
(Reviewer)

Reason for Review:

☐ Annual CPE Review ☐ Sentinel Event ☐ Inmate Grievance
☐ Competence Issue ☐ Complaint(s) ☐ Other: __________

	Yes	No	N/A	Unclear
Assessment				
Subjective Data is accurate, relevant, and thorough?	☐	☐	☐	☐
Objective Data is accurate, relevant, and thorough?	☐	☐	☐	☐
Physical exam is accurate, relevant, and thorough?	☐	☐	☐	☐
Planning				
Collaborates with RN? Participates in ongoing development and modification of the treatment plan?	☐	☐	☐	☐
Implementation				
Intervention is consistent with treatment plan and diagnosis?	☐	☐	☐	☐
Intervention completed thoroughly and accurately?	☐	☐	☐	☐
Intervention is implemented in a timely manner?	☐	☐	☐	☐
Intervention and care are documented?	☐	☐	☐	☐
Intervention is within scope?	☐	☐	☐	☐
Evaluation				
Evaluate response to intervention and documents, as indicated?	☐	☐	☐	☐
Collaborates with RN to Adapts plan of care based on new assessment data?	☐	☐	☐	☐
Referred to Provider, when clinically indicated?	☐	☐	☐	☐

RE_

Summary of Findings:

Corrective Action(s):

☐ None ☐ Provide Education/Training ☐ Clinical Supervision

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

☐ Additional CPE (continue to monitor) ☐ Review Relevant Policy ☐ Other: _____________

This CPE review was discussed with the LPN on the following date:

_______________________________ _______________________________
Licensed Practical Nurse Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(Clinical Psychologist)

Name:____ **Credentials:** ___________________
(Licensed Mental Health Professional)

Name: ____ **Date:** ___________________
(Reviewer)

Reason for Review:

☐ Annual CPE Review	☐ Sentinel Event	☐ Inmate Grievance
☐ Competence Issue	☐ Complaint(s)	☐ Other: _____________

	Yes	No	N/A	Unclear
Psychological Evaluation/Assessment				
Is thorough (in terms of purpose)?	☐	☐	☐	☐
Includes relevant observations and mental status/behavior changes?	☐	☐	☐	☐
Includes psychological testing, as clinically indicated?	☐	☐	☐	☐
Diagnosis is justified by history and current assessment?	☐	☐	☐	☐
Suicide Risk Evaluation				
Identifies risk and protective factors?	☐	☐	☐	☐
Includes summary of relevant information?	☐	☐	☐	☐
Provides rationale for level of risk?	☐	☐	☐	☐
Recommended treatment is clinically indicated?	☐	☐	☐	☐
Intervention				
Treatment plan is consistent with diagnosis	☐	☐	☐	☐
Frequency of contact is consistent with clinical needs?	☐	☐	☐	☐
Therapeutic approach is supported by case conceptualization?	☐	☐	☐	☐
Documentation relates to the identified problem?	☐	☐	☐	☐

Summary of Findings:

Corrective Action(s):

☐ None	☐ Provide Education/Training	☐ Clinical Supervision
☐ Additional CPE (continue to monitor)	☐ Review Relevant Policy	☐ Other: _____________

This CPE review was discussed with the LMHP on the following date:

______________________________________ ______________________________________
Licensed Mental Health Professional Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(QMHP)

Name: ____ **Credentials:** __________________
(Qualified Mental Health Professional)

Name: ____ **Date:** __________________________
(Reviewer)

Reason for Review:

☐ Annual CPE Review ☐ Sentinel Event ☐ Inmate Grievance
☐ Competence Issue ☐ Complaint(s) ☐ Other: _____________

	Yes	No	N/A	Unclear
Assessment				
Post Admission Mental Health Assessment is complete?	☐	☐	☐	☐
Segregation Mental Health Review is complete?	☐	☐	☐	☐
Mental Health Rounds include important observations?	☐	☐	☐	☐
Mental Health Crisis Assessment is complete?	☐	☐	☐	☐
HPA Mental Health Status Report is complete?	☐	☐	☐	☐
Intervention				
Treatment plan is consistent with diagnosis and symptoms?	☐	☐	☐	☐
Discharge Planning is complete?	☐	☐	☐	☐
Safety Plan is complete?	☐	☐	☐	☐
Conducts sick-call with relevant documentation?	☐	☐	☐	☐
Provides follow-up mental health services? (PREA, suicide prevention, caring contact, etc.)	☐	☐	☐	☐
Conducts relevant psychosocial treatment group activities?	☐	☐	☐	☐
Patients are appropriately referred for additional levels of care?	☐	☐	☐	☐
Documentation relates to the identified problem?	☐	☐	☐	☐

Summary of Findings:

Corrective Action(s):

☐ None ☐ Provide Education/Training ☐ Clinical Supervision
☐ Additional CPE (continue to monitor) ☐ Review Relevant Policy ☐ Other: _____________

This CPE review was discussed with the QMHP on the following date:

____ ____
Qualified Mental Health Professional Signature Reviewer Signature

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

CLINICAL PERFORMANCE ENHANCEMENT REVIEW
(Dental)

Name: ______________________________ **Credentials:** ________________
(Dentist/Dental)

Name: ______________________________ **Date:** ______________________
(Reviewer)

Reason for Review:

☐ Annual CPE Review ☐ Sentinel Event ☐ Inmate Grievance
☐ Competence Issue ☐ Complaint(s) ☐ Other: ___________

	Yes	No	N/A	Unclear
Evaluation/Assessment	☐	☐	☐	☐
Management/Treatment Plan	☐	☐	☐	☐

Summary of Findings:

Corrective Action(s):

☐ None ☐ Provide Education/Training ☐ Clinical Supervision
☐ Additional CPE (continue to monitor) ☐ Review Relevant Policy ☐ Other: ___________

This CPE review was discussed with the Dentist/Dental Team on the following date:

______________________________ ______________________________
Dentist/Dental Team Signature Reviewer Signature