COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

PSYCHIATRIC HEALTH FACILITY (PHF)
SEMPERVIRENS

SV CONTINUOUS QUALITY IMPROVEMENT WORK PLAN
FISCAL YEAR 2021 – 2022

Approved by SV CQI Committee: 8/19/21

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BEHAVIORAL HEALTH
PSYCHIATRIC HEALTH FACILITY
SV CQI WORK PLAN

I. ORGANIZATION OF THE PSYCHIATRIC HEALTH FACILITY/PSYCHIATRIC HOSPITAL (PHF/PH)

Sempervirens is a 16-bed acute, short-term locked psychiatric health facility and hospital licensed by the California State Department of Health Care Services (DHCS) and certified by the Centers for Medicaid and Medicare (CMS). The inpatient unit operates 24-hours per day, 365 days per year, and evaluates, monitors, and treats all mental health diagnoses included under Medi-Cal guidelines for Specialty Mental Health. Adults and older adults are treated in Sempervirens, and children and youth may only be admitted in emergency circumstances, and only when specifically required provisions are met. Sempervirens utilizes a team approach to treatment, with a treatment team comprised of psychiatrists, physicians, licensed clinical psychologist (as needed) (LCP), nurse practitioners (NP), physician's assistants (PA), registered nurses (RN), licensed and associate clinical social workers (LCSW, ASW), licensed and associate marriage family therapists (LMFT/AMFT), activities therapists (AT), and other ancillary staff.

II. PRINCIPLES/PHILOSOPHY OF CONTINUOUS QUALITY IMPROVEMENT (CQI)

Behavioral health inpatient, outpatient, other System of Care (SOC) services, and a contract provider network are part of a total continuum of care for mentally ill adults and emotionally disturbed children and youth in need of specialty mental health services (SMHS).

- Services will provide opportunities for patient/family participation and involvement in planning and delivery of services in a culturally correct manner.
- Treatment will be based on a team model, involving the input of all levels of staff.
- The quality improvement program will be accountable for defined outcomes as a way of measuring effectiveness and efficiency.
- Services will be responsive to patients through measurement of satisfaction and a defined process for answering patient grievances and requests.
- Confidentiality of individuals and information pertaining to the individual is maintained in all written and verbal communications and is protected under Section 1157 of the California Evidence Code and Section 14725 of the California Welfare and Institutions Code.
- All mental health morbidity and mortality review committees are protected under this CQI Plan.

III. OBJECTIVES OF THE CQI PLAN

The CQI Plan is a planned, systematic, ongoing process for monitoring, evaluating, and improving the quality of key aspects of care which are most important to the health and safety of the patients we serve. The objectives of CQI are:

- To promote effective, safe, and appropriate care.
- To help all staff improve the processes of the Humboldt County Psychiatric Health Facility, thus improving patient outcomes.
- To help the Humboldt County Psychiatric Health Facility use its current commitment, resources,

and approaches to improving patient quality of care more effectively and efficiently.

- To focus on the interrelated governance, managerial, support and clinical processes which affect patient outcomes.
- To use information gained to change system processes as needed.
- To provide an ongoing process for continually improving the PHF's/PH's service delivery and support system.

IV. SCOPE OF CQI ACTIVITIES

A. SCOPE

The CQI Plan incorporates the techniques of monitoring and evaluating data collected from chart review, peer review, and staff participation in order to improve the quality of care. All services will focus on specific monitors.

B. ACTIVITIES

The CQI program reviews and evaluates results of the following quality improvement activities:

1. Peer Review of physician, nursing, and social work documentation
2. Monitoring of environment and safety, including accident/incident and other risk management areas
3. Evaluation of key contracted services, including dietary, pharmacy, medical, and laboratory services
4. Monitoring of medication practices
5. Infection control
6. Medical records monitoring
7. Morbidity and mortality review
8. Utilization management
9. Patients' rights monitoring
10. Complaints, grievances, and satisfaction surveys
11. Other quality indicates as identified on the SV-CQI Indicators Dashboard (Attachment 1)

V. RESPONSIBIILTIES

A. BOARD OF SUPERVISORS

The Humboldt County Board of Supervisors is the Governing Body of the hospital and is therefore legally responsible for the conduct of the hospital as an institution. The hospital's Governing Body must ensure that an effective quality improvement program reflecting the complexity of the hospital's organization and services is implemented and maintained.

The Joint Conference Committee of the Medical Staff, which is composed of an equal number of members from the Medical Staff and the Board of Supervisors, is the liaison between the

Medical Staff and the Governing Body. The purpose of the Committee is to consider issues of medical and administrative importance. The Joint Conference Committee reviews reports and minutes from the hospital CQI Committee regarding the effectiveness of the hospital CQI program, and report to the Executive Committee of the Medical Staff and the Governing Body.

B. DIRECTOR OF BEHAVIORAL HEALTH

The Director of Behavioral Health has the authority for assessing continuous quality improvement via establishing, implementing, and evaluating a coordinated, integrated, effective, and ongoing program that monitors, evaluates, and improves the quality and appropriateness of care delivered to patients. This responsibility is delegated to the CQI Committee.

C. QUALITY MANAGEMENT COORDINATOR

The Quality Management Coordinator, or designee, chairs the hospital CQI Committee meetings and is responsible for ensuring that meetings take place as required. The QI Administrative Analyst is responsible for ensuring that minutes of each meeting are documented, that the annual calendar of activities is established and distributed, that the membership rosters of the Committees are updated as necessary, and that recommendations for action result in consistent follow up.

D. CQI COMMITTEE

The CQI Committee assumes delegated responsibility for CQI activities via participation in developing the CQI Plan, designing tools for problem identification/ problem resolution and compliance monitoring, standards development, and CQI Committee function.

CQI Committee members participate in identification of important aspects of patient care or services to which they contribute and for which they are responsible, identification of relevant indicators, planning and implementation of process changes, and monitoring for resolution of identified problems.

The CQI Committee members include:

1. SV Hospital Administrator
2. Medical Director
3. Behavioral Health Director (or designee)
4. Director of Nursing
5. Sr. Program Manager for SV/CSU
6. Quality Management Coordinator
7. Medical Records Manager

VI. STRUCTURE OF ACTIVITIES

Four of the standing committees of the Medical Staff are an integrated part of the CQI program, as follows:

- Continuous Quality Improvement Committee
- Utilization Review Committee
- Pharmacy and Therapeutics Committee
- Infection Control Committee

The CQI Committee meets monthly, at least ten times each calendar year. An annual calendar of activities is distributed to all of the CQI Committee members at the beginning of each calendar year which specifies meeting dates and topics. The following agenda items are monitored and reported at the CQI Committee meeting quarterly:

- Peer Review and Physician Credentialing
- Dietary Services Monitoring
- Medical Records Monitoring
- Documentation Monitoring
- Infection Control Monitoring
- Psychiatric Emergency Services Monitoring
- Environment and Safety Monitoring
- Contracted Services Monitoring
- Morbidity and Mortality Review
- Patients' Rights Advocates Monitoring
- Incident Report trends
- Other quality indicators as identified on the "SV/CSU Agenda Item Tracking" sheet (Attachment 2).

Other CQI activities are reported at the other three standing committees:

- Utilization Management is reported quarterly at the SV UR Committee meeting.
- Monitoring of medication practices is reported quarterly at the Pharmacy and Therapeutics Committee meeting. Data is also reported quarterly at the SV CQI meeting.
- Infection Control monitoring is reported quarterly at the Infection Control Committee meeting. Infection control is also reported monthly at SV CQI meetings.

VII. DOCUMENTATION

Documentation of CQI activities is completed by the Quarterly Summaries which are maintained by the QI Coordinator or designee. Monthly Medical Staff Committee Minutes are completed by the Medical Staff Coordinator and maintained by the Medical Director.

Monthly CQI Minutes and Quarterly CQI Summaries (which include information from Utilization Review, Pharmacy and Therapeutics, and Infection Control Committees) are shared with the CQI and Joint Conference Committees. Specific reports of monitoring activities are shared within the organization, including intra- and inter-departmentally, and are forwarded to those responsible for using the relevant information both to improve system functioning and in the appraisal of competence of individual caregivers. Areas pertaining to high risk/safety issues are shared with the Safety Committee. (Attachment 3 – List of Standing Medical Staff Committees and Members).

A. EVALUATION

An annual evaluation of the effectiveness of the CQI Plan and program is conducted by the CQI Committee and results are shared with the Joint Conference Committee, and in turn with the Governing Body.

Evaluation of the CQI Plan includes the following criteria:

1. All departments/services have been monitored, to include:
    a. Physician services
    b. Nursing services
    c. Social Services and activities
    d. Medical Records services
    e. Pharmacy services and medication practices
    f. Dietary services
    g. Laboratory services
    h. Other contracted services, such as physical health care consultations
    i. Infection Control
    j. Utilization Management
    k. Patient Rights
    l. Physical plant: safety and cleanliness

2. Any indicators that fall below standard will result in a plan or recommendation for follow up. These indicators will be identified using the SV CQI Indicators Dashboard.

3. All identified Action Items/Recommendations have documented follow up from the appropriate department/service through a written plan of correction (QI Tracking Form) sent to the appropriate supervisor(s) as outlined in Policy and Procedure 0704.940 (Attachment 4).

The CQI Committee reviews the CQI Plan annually based on the evaluation of the previous year's Plan. Areas documented as effective, compliant, or problem-free during a calendar year may be studied on a focused review basis or not at all. Those issues which have not been documented as effectively resolved will be re-monitored and have an ongoing improvement plan established until resolved. The CQI Plan will be revised as necessary by the CQI Committee.

B. CONFIDENTIALITY

All reports, committee minutes, data and other information created or maintained as part of the Quality Improvement Plan are confidential and are treated as such. Only those individuals who have participated in a particular Quality Improvement initiative or who have oversight responsibility will have access to confidential information. Work done by QI Committee will be part of QI process and will remain confidential and privileged information which is protected under Section 1157 of California Evidence Code and Section 14725 of California Welfare and Institutions Code.

VIII. DHSS-BH SV CQI INDICATOR DASHBOARD FY 21-22

A. CLINICAL INDICATORS

1. Morbidity and Mortality Reviews (M&Ms)

Continue tracking in FY 21-22 as is

a) Number of cases reviewed
b) Number of cases with departure in standard of care

2. Acute Transfers

Continue tracking in FY 21-22 as is

a) Acute transfers per 1,000 patient bed days

3. Medication Reconciliation

Continue tracking in FY 21-22 as is

a) Medication reconciliations initiated within 24 hours
b) Medication reconciliations completed within 36 hours

4. Seclusion and Restraints

Continue tracking in FY 21-22 as is

5. Dietary Reports

Continue tracking in FY 21-22 as is. There is currently not a Registered Dietitian onboard at SV. Continue recruitment efforts and track the following once an RD is hired.

a) Accuracy of dietary rand card
b) CRD was faxed complete nutrition screens for 5 or more
c) CRD response within 24 hours
d) Percentage of high-risk patients with a dietary questionnaire completed
e) Monthly dietary and food quality control inspections completed by RD
f) Dietary staff correctly fills out quaternary ammonium logs, correct label dating and dented can removal

6. SV Documentation Monitoring

Continue tracking in FY 21-22 as is

a) Psychiatric Prescriber Dashboard
b) Social Worker Dashboard
c) Nursing Dashboard

7. Peer Review

Complete Peer Review per Peer Review Plan

a) Number of cases with departure in standard of care

8. Medication

Continue tracking in FY 21-22 as is

a) Number of medication errors per 1,000 patient days
b) Medication adverse reactions per 1,000 patient days

9. **Infection**

Continue tracking in FY 21-22 as is

a) Community acquired infections (CAI) per 1,000 patient days
b) Hospital acquired infections (HAI) (Nosocomial) per 1,000 patient days

B. UTILIZATION REVIEW

1. **Admission and Length of Stay**

Continue tracking in FY 21-22 as is

a) Average number of admissions
b) Average length of stay

2. **Readmissions**

Continue tracking in FY 21-22 as is

a) Number of readmissions to SV in 7 days
b) Readmission Rate to SV within 7 Days
c) Number of readmissions to SV in 30 days
d) Readmission Rate to SV within 30 days

3. **Short-Doyle denials and Medical Necessity**

Review which items are tracked in FY 21-22

a) Short Doyle denial days per 1,000 patient bed days
b) No medical necessity days per 1,000 patient bed days

4. **Follow-up Med Support**

Continue tracking in FY 21-22 as is

a) Percentage of follow-up medication support appointments after SV discharge within 7 days

C. PATIENT SATISFACTION

1. **Patient Satisfaction Surveys**

Continue tracking in FY 21-22 as is

a) Response rate
b) Number/percent of patients selecting the best possible score

SV CQI Agenda Item Tracking

Agenda Item/Report	Reported by:	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Reported at SV CQI													
Seclusion and Restraint Data	Beverly Long, RN, QI	7	8	9	10	11	12	1	2	3	4	5	6
Infection Control data (# of staff fit tested for N-95 masks; # of immunizations offered and # given, health screens, patient infections.) -- A Tag audit Infection Control Dashboard	Pam Prindle	7	8	9	10	11	12	1	2	3	4	5	6
QI Tracking Forms (Show outstanding forms report)	QI	7	8	9	10	11	12	1	2	3	4	5	6
Contract Monitoring, including nature and scope			8										
Food suppliers	Kayleigh Emry		8										
Medical consult	Kayleigh Emry		8										
Medical supplies	Kayleigh Emry		8										
Transport	Kayleigh Emry		8										
Security	Kayleigh Emry		8										
Clinical Services	Kayleigh Emry		8										
Laboratory	Kayleigh Emry		8										
Pharmacy	Kayleigh Emry		8										
Dietary	Kayleigh Emry		8										
St. Joseph's Hospital	Kayleigh Emry		8										
CQI Plan Review (prior year)	Committee		8										
CQI Plan Review (new year plan)	Committee		8										
Dietary Monitoring:	Dietary Specialist		8			11			2			5	
SV Documentation Monitoring:			8			11			2			5	
Psychiatrist	Beverly Long, RN, QI		8			11			2			5	
Social Worker	Teri Vodden, LCSW		8			11			2			5	
Nurse	Cyanne Brocious, DON		8			11			2			5	
Status of Fire and Disaster Drills	Jessica Jabbour			9			12			3			6
Life Safety Monitoring: (CAFM Rpts)					10						4		
Hood Cleaning Report	Jessica Jabbour				10						4		
Emergency Lighting (Annual - 90 minutes)	Jessica Jabbour				10						4		
Emergency Lighting (Monthly - 30 seconds)	Jessica Jabbour				10						4		
Fire Alarm Pull Stations	Jessica Jabbour				10						4		
Smoke Detector Sensitivity	Jessica Jabbour				10						4		
Outlet Tension & Polarity	Jessica Jabbour				10						4		
Generator Testing & Inspections (Monthly)	Jessica Jabbour				10						4		
Report on daily inspection of SV	Jessica Jabbour				10						4		
Medical Care Evaluation (MCE) Study	MCE COPP Team			9			12			3			6
Med Recs # Chart Corrections >30 days	Scott B. Irvin		8			11			2			5	
Med Recs # Incomplete DC Summs >30 days	Scott B. Irvin		8			11			2			5	

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SV CQI Agenda Item Tracking

# Med Orders Returned in 24 hrs	Scott B. Irvin		8			11			2			5	
Medical Records Tracking Report	Scott B. Irvin		8			11			2			5	
Credentialing Reports Physicians SV Staff	Teresa Chase Glen Guidry	7			10			1			4		
Medication Monitoring Plan Review	Committee		8										
Morbidity & Mortality: Deaths within 30 days of DC	Mariette Franklin, RN, QI	7			10			1			4		
Morbidity & Mortality: reviews	Mariette Franklin, RN, QI	7			10			1			4		
Patients' Rights Advocate Monitoring: Certification Hearing Results	Melody Beltz			9			12			3			6
SV Staff Training Completion Report (#/% of staff who have completed all assigned training v. those that still have training due? And for those with training due, how much they have completed (e.g. average % completed and range of % completed).	Mitch Finn, QI			9			12			3			6
Peer Review: Psychiatrist	xxxxx xxxx, RN, QI	7			10			1			4		
Peer Review: Social Services	xxxxx xxxx, RN, QI	7			10			1			4		
Peer Review Plan Review (annual)	Kayleigh Emry		8										
Medical Staff Credentialing	RN, QI			9						3			
JCC & QI Communication	Kayleigh Emry			9						3			
UR Plan Review	Committee	7											
Patient Satisfaction Survey Report	Alex Olivera, QI	7			10			1			4		
Acute Transfers	Mariette Franklin, RN, QI	7			10			1			4		
SV Indicator Dashboard Review	Committee				10								
SV Indicator Dashboard	Glen Guidry, QI		8			11			2			5	
Medication Reconciliation	Mariette Franklin, RN	7			10			1			4		
Timely access to follow up appt after SV discharge	Glen Guidry, QI		8			11			2			5	
SV Policy Update **Link to PnP tracking document**	Jessica Jabbour			9			12			3			6
Policy and Procedure Committee Update	Charla Rowe						12						6
Reported at SV UR (quarterly)				9			12			3			6
# Admissions & Readmission to SV	Glen Guidry, QI			9			12			3			6
SV Daily Census	Glen Guidry, QI			9			12			3			6
SV Hospital Bed Days by Category	Glen Guidry, QI			9			12			3			6
3rd Party Denials & Appeals	Glen Guidry, QI			9			12			3			6
Average LOS	Glen Guidry, QI			9			12			3			6
Types of admissions (legal hold)	Glen Guidry, QI			9			12			3			6
UR accuracy reviews	Beverly Long, RN, QI			9			12			3			6
SV All Bed Days Dashboard \\all.co.humboldt.ca.us\dhhs-files\Managers\SV Bed Days\SV BED DAYS REPORTS 2020\HISTORICAL REPORTS	Jessica Jabbour, AA,Admin			9			12			3			6

SV CQI Agenda Item Tracking

Reported at P&T			8			11			2			5	
Concurrent Medication Review on SV	Patrick Cloney, RPh		8			11			2			5	
Retroactive Medication Review	Patrick Cloney, RPh		8			11			2			5	
Medication Errors	Cyanne Brocious, DON		8			11			2			5	
Medication Adverse Reactions	Marta Pruesser, CYFS		8			11			2			5	
Status of Medication Storage on SV & CSU	Cyanne Brocious, DON		8			11			2			5	
Disposal of Medications	Cyanne Brocious, DON		8			11			2			5	
Outdated, Mislabeled or Otherwise Unusable drugs	Cyanne Brocious, DON		8			11			2			5	
Pharmacy Policies & Policy Manual Update	Committee					11							
Recalled Medications	Cyanne Brocious, DON		8			11			2			5	
Formulary Changes	Committee											5	
Reported at Infection Control			8			11			2			5	
# reported & actual infections on SV	Pamela Prindle		8			11			2			5	
# Nosocomial infections	Pamela Prindle		8			11			2			5	
Antibiotic Use Report on SV	Pamela Prindle		8			11			2			5	
MRSA Report	Pamela Prindle		8			11			2			5	
Infection Control Manual Review/Update	Committee								2				