Luminis Health Doctors Community Medical Center
Behavioral Health Pavilion

Quality Improvement Plan Fiscal Year 2021

MISSION

To enhance the health of the people we serve.

VISION

Living Healthier Together

VALUES

COMPASSION: It happens in a hundred different ways every day. Compassion is at the heart of our mission. We are warm, comforting, caring and courteous.
TRUST: Trust is at the foundation of our culture. Co-workers, patients, families and customers know they can depend on us.
DEDICATION: As one of many caring for our patients, families and customers, we take personal responsibility for getting the job done right.
QUALITY: Quality means meeting the high standards of excellence we expect of each other and that our patients deserve. Together we achieve better outcomes and experiences.
INNOVATION: We are at the forefront of advancements in technology and patient care. We seek new ways of doing things to achieve better results.
DIVERSITY: We benefit and draw strength from our differences. Diversity is our daily experience, a journey – not a destination.
COLLABORATION: In partnership with many, we work together toward our vision: living healthier together.

INTRODUCTION

The Luminis Health Doctors Community Medical Center Behavioral Health Pavilion (referred to as the "LHDCMC-BHP" in this document) quality improvement plan represents the understanding of what we must do to provide the best possible care for each patient, be the leader in improving consumers' health, and create a safe environment for our patients and employees. The focus is on the three interdependent and equally critical requirements for achieving our quality goals:

1. Leadership – leadership commitment must be shared by our Board of Directors and all senior leadership to include administrators, directors, managers, and supervisors by making quality care a priority goal for the organization.
2. Culture of Safety – the culture involves three mutually reinforcing imperatives: Trust, Report, and Improve. Efforts toward continuous enhancement of event reporting and response are based on a Just Culture.
3. Process Improvement – adopting quality methods to solve difficult safety and quality care concerns, finding solutions for quality concerns, determining the effectiveness of the solutions, and implementing interventions/programs that work to ensure sustained improvement.

PURPOSE

The purpose of the Quality Improvement Plan is to ensure ongoing excellence in the quality and safety of the care and services delivered. The LHDCMC-BHP leadership and staff are committed to improving the health outcomes and the care of patients and their families. We work to accomplish this by having established performance measures, continually monitoring (measuring) them, and implementing actions that will work to improve excellence of patient care and organizational operations.

LHDCMC-BHP MEDICAL CENTER ORGANIZATIONAL QUALITY IMPROVEMENT AIMS

The purposes of the quality aims are:

1. To select measures that focus on improvements in patient care, safety, and outcomes
2. To show quality improvement/performance of the measures over time

The ultimate goal of the quality improvement efforts at the LHDCMC-BHP is the demonstrated improvement in performance and value of the health services we provide.

KEY DIMENSIONS OF QUALITY CARE/PERFORMANCE/SAFETY

The following key dimensions of quality care/performance/safety provide the LHDCMC-BHP with the framework for quality improvement activities and a balanced and well-integrated quality, cost, and risk perspective. The LHDCMC-BHP has accepted the following key dimensions in the way we think about patient care, what is important to patients, and what is prioritized in performance improvement:

A. Effectiveness
B. Patient and Family-Centered Care
C. Efficiency
D. Safety
E. Equity
F. Timeliness

ORGANIZATIONAL FRAMEWORK

The LHDCMC-BHP leadership's role in quality improvement activities are as outlined below:

Governing Board

It is recognized that the Board of Trustees has the ultimate responsibility for the organization's performance and strategic planning. To fulfill the commitment to quality improvement, the Board delegates the responsibility for developing, implementing and maintaining quality improvement to administration, the medical staff, management, and employees. It is the responsibility of the Board, in conjunction with senior management, to set priorities, allocate resources (staff, information management/data support, time and training), and monitor progress toward achievement of strategic and operational goals. The Governing Board is provided ongoing reports from Medicine Quality Council and/or Mental Health and Substance Use Quality Council, and the Medical Executive Committee as a means of evaluation.

Medicine Quality Council

The Division of Mental Health and Substance Use (MHSU) is a component of the Luminis Health Department

of Medicine. The Luminis Health Medicine Quality Council therefore has oversight for the quality metrics of the MHSU division. This council reviews and approves the MHSU plans for Quality, Patient Safety and Infection Control and receive ongoing reports from the MHSU Quality Council to monitor progress toward the achievement of quality goals.

Mental Health and Substance Use Quality Council

This interdisciplinary committee represents all of senior directors and managers within the organization as well as the services of other groups charged with regulatory or other compliance throughout the organization. The Quality Council meets monthly at least 9 times per year to design, measure, assess, and make recommendations regarding improvement efforts throughout the organization. The committee reports ultimately reports to Luminis Health Department of Medicine and is tasked with making recommendations regarding priorities for quality improvement to include necessary education, resources, and policy changes.

The goal of the MHSU Quality Council is to support quality and performance improvement at the LHDCMC-BHP. Activities of the Council are documented in minutes and include: conclusions (data analysis), recommendations (improvement strategies), action (implementation of improvement activities or committee assignments), and follow-up (effectiveness of actions). Mechanisms in place for communicating quality improvement activities are: leadership meetings, staff meetings, emails, memos, and newsletters.

Medical Executive Committee

The Medical Executive Committee (MEC) is the governing committee of the Medical Staff. The MEC works with the LHDCMC-BHP to achieve The Joint Commission accreditation, particularly with regard to Medical Staff standards; maintains a continuous assessment of the Medical Staff Bylaws, rules and regulations of the Medical Staff and the policies based on them; develops and recommends appropriate modifications and changes in the Medical Staff Bylaws needed to ensure federally mandated compliance with federal, state, and local laws and The Joint Commission; establishes, develops and recommends appropriate modifications and changes needed in policies and procedures, rules and regulations of the Medical Staff, to ensure compliance with the Medical Staff Bylaws or to assist the departments and services in developing such policies; and coordinates, supervises and enforces the activities and policies, rules and regulations adopted by the Medical Staff, departments, services, integrated programs and committees. In addition, the Medical Executive Committee provides oversight to all Medical Staff performance improvement, risk management and peer review activities to ensure that monitoring and evaluation activities are conducted fairly and aimed at improving patient care; provides leadership in assuring patient safety; works with the Medical Center's Administration in planning and strategic activities, identification of areas to improve, and development of opportunities to enhance practices of Medical Staff members; establishes the priorities for performance improvement activities, as appropriate; takes or directs action to improve the quality of care or services as may be indicated by performance improvement activities; provides oversight in analyzing, assessing and improving patient satisfaction; and develops strategies and plans in support of the Medical Staff in collaboration with the Medical Center.

Senior Director of Nursing, Mental Health and Substance Use

The Senior Director of Nursing, Mental Health and Substance Use has the responsibility to lead and oversee the efforts that are aimed at improving the clinical quality of care and services in the organization. Supported by members of the Executive Committee, the Senior Director makes sure that efforts to improve care are a priority of the organization and that performance efforts meet or exceed the expectations of the community, patients, and staff. The Senior Director has the day to day leadership and management of the

quality improvement plan. This includes the development of the design of the improvement activities, providing support to all groups involved in these activities, serving as a mentor and coach to the staff charged with leading services/committees/teams, making sure that data are appropriately collected and analyzed, following up on areas requiring improvement, and coordinating the communication of results to the appropriate members of the organizational staff. In addition, this individual works with the Medical Director and Program Managers/Directors to design and provide quality improvement education, continuing education, and clinical competency evaluation of all staff.

The Nurse Manager for Inpatient and the Clinical Director for Outpatient Services

These individuals are responsible for maintenance and delivery of quality care. This responsibility includes but is not limited to: recommending clinical procedures/standards/guidelines; involvement in quality improvement activities; clinical coordination of patient care and the achievement of quality patient care to patients; overseeing the preparation, implementation and evaluation of the medical component of the treatment plan and detoxification guidelines approved by the medical team leader; promoting staff participation in quality improvement data collection and analysis of data.

Medical Director

The Medical Director is responsible for the monitoring and evaluating the quality of patient care provided by his/her service, making sure that efforts are integrated with other services and support functions, and are collaborative across disciplines (MD, RN, NP, and ancillary staff). The Medical Director has responsibilities for the day-to-day coordination of these activities as well as for participation in the Mental Health and Substance Use Quality Council.

Employees

The role of the individual employee is critical to the success of quality, performance improvement, and patient safety initiatives. Quality is everyone's responsibility. All employees must believe that every process can be improved and feel empowered to fix and prevent problems, as well as contribute to improvement efforts. Any employee may make a suggestion for quality improvement and patient safety activity by communication through the RL6 event reporting system or a discussion with leadership.

FY 2021 QUALITY MEASURES

- Depression (PHQ-9) screening on admission and discharge
- GAD-7 on admission and discharge
- Patient experience
- National Database of Nursing Quality Indicators
- HBIPS and other Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) measures
- Restraint/Seclusion
- Readmissions within 30 days
- Drug Abuse Screening Test (DAST-10) for patients that have co-occurring substance use (Addendum A)
- Falls and falls with injury in the geriatric population (Addendum B)

Other monitors include:

- Hand Hygiene

- Medication Errors/Adverse Drug Reactions
- Medication Scanning
- Body Fluid Exposure
- Antibiotic Stewardship/Healthcare (including Hospital) Acquired Infections
- Medication Room Inspection
- Patient Adverse Events

METHODOLOGY

The LHDCMC-BHP utilizes the scientific method of Plan-Do-Check-Act (PDCA) to establish and guide improvement activities

PDCA PROBLEM SOLVING FRAMEWORK

STEP	PURPOSE/OUTCOME OF STEP
1. Plan	***Plan the improvement***
2. Do	***Do the improvement and data collection***
3. Study	Study the results of implementation
4. Act	Act to hold the gain and continue the improvement

PROACTIVE RISK ASSESSMENT

A Proactive Risk Assessment is a technique used to identify and prevent errors and problems before they occur. A proactive risk assessment increases understanding within the organization about the complexities of process design and management and what could happen if the process fails. If an adverse event occurs, the organization may be able to use the information gained from the prior risk assessment to minimize the consequences of the event—and to avoid simply reacting to them.

DATA COLLECTION

Data are collected to monitor the stability of processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement throughout the organization. Data collection is used to identify and prioritize improvement initiatives. In addition, collected data is used to:

1. Establish performance baseline;
2. Describe process performance and stability in measurable terms;
3. Describe dimensions of performance relevant to functions, processes and outcomes;
4. Identify areas for more focused data collection; and
5. Sustain improvement.

The scope of measurement and analysis of activities will be utilized for both prioritizing improvement efforts and ongoing measurement and will include, but not be limited to the following:

1. Priorities identified by the organization's leaders, including but not limited to those processes identified as high risk or problem prone.
2. Performance measures related to The Joint Commission accreditation and other requirements
3. Risk management event data
4. Quality control (i.e., laboratory)
5. Patient, family and staff opinions, needs, perceptions of risks to patients, and suggestions for

improving patient safety
6. Patient satisfaction/ service excellence
7. Financial data
8. Infection prevention, control and surveillance reporting
9. Environment of Care
10. Medication management
11. Medical record documentation, clinical pertinence and delinquency rates
12. Processes that involve risks or may result in sentinel or serious adverse events
13. Process measures

AGGREGATING AND ANALYZING DATA

The LHDCMC-BHP leadership believes that data management and analysis are essential to an effective quality improvement initiative. The LHDCMC-BHP has access to the Luminis Health Quality Team to support us in efforts related to data management. All quality improvement activities must be data driven and outcome based.

Data and performance will be evaluated either by internal comparison over time, comparison with similar processes in other organizations and/or comparison to external sources. External sources are as current as possible and include among others:

1. Recent scientific, clinical, and management literature, including Sentinel Event Alerts and Alerts from the Institute of Safe Medication Practices
2. Best practice guidelines and parameters for Substance Use Disorders
3. Performance measures
4. Reference databases
5. The Joint Commission standards and CMS Conditions of Participation.

ROOT CAUSE ANALYSIS

Root Cause Analysis (RCA) is conducted in response to sentinel events, Level 1 & Level 2 adverse events, and any near miss that warrants a RCA. See Policy QI6.1.01 – Sentinel Event and Root Cause Analysis (RCA).

SPECIAL PROCESS EXAMINATION

An intensive examination may be necessary when serious care or risk concerns occur. Some outcomes that would trigger a special process examination include:

1. Significant life safety issues or violence events
2. Significant adverse drug reactions
3. Significant errors related to medication use
4. Client rights violations
5. Adverse events or patterns of adverse events

DETECTION AND REPORTING OF EVENTS

The leadership of the LHDCMC-BHP encourages reporting of medical errors, adverse events, and potential adverse events as a means to assess and improve and provide a safe environment for patient care. The purpose of the error reporting process helps to determine causation, design process improvements, and mitigate future risks. As part of a Just Culture, staff is encouraged to participate in the detection and reporting of errors, the

identification of the system-based causes of errors, and the facilitation of system enhancements to reduce the likelihood of errors. Thus, the focus of the program is performance improvement, not punishment.

EDUCATION

Quality improvement data often results in the need to provide additional education and/or in-service training programs. Leadership has the responsibility to develop and provide the identified education as a result of data analysis or outcomes. Ongoing education and competency building will work to ensure that the LHDCMC-BHP sustains their quality goals.

CONFIDENTIALITY

All activities set forth in this Quality Improvement Plan are to be held in the strictest confidence, and are to be carefully safeguarded against unauthorized disclosure as per the Health Care Quality Improvement Act and other applicable law/regulation.

REVIEW AND UPDATE

The LHDCMC-BHP Quality Improvement Plan is reviewed, updated, and approved annually by the MHSU Quality Council and Luminis Health Medicine Quality Council The review considers the assessment of the adequacy of the allocation of human, information, physical, and financial resources in support of identified quality improvement priorities.

ADDENDUM A

Quality Assurance Plan - Co-occurring Diagnosis

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that people with Substance Use Disorder are "more likely than those without SUDs to have co-occurring mental disorders". Current literature related to co-occurring substance use and mental health disorders highlights that the two conditions occurring co-currently is often the rule, not the exception.

The Luminis Health Doctors Hospital Medical Center Behavioral Health Pavilion (LHDHMC-BHP) leadership recognizes the need to routinely screen patients receiving behavioral health services for substance use disorders so that there can be an adequate assessment, diagnosis, and treatment recommendations that can lead to long-term recovery.

The Quality Assurance Plan for Co-Occurring Diagnosis follows the same guidelines as the overall Quality Improvement Plan. The steps in this plan includes:

METHODOLOGY

The LHDCMC-BHP utilizes the scientific method of Plan-Do-Check-Act (PDCA) to establish and guide improvement activities

PDCA PROBLEM SOLVING FRAMEWORK

STEP	PURPOSE/OUTCOME OF STEP
1. Plan	Plan the improvement
2. Do	Do the improvement and data collection
3. Study	Study the results of implementation
4. Act	Act to hold the gain and continue the improvement

SCREENING

All patients will be screened for co-occurring substance use disorders upon admission.

SCREENING TOOL

The Tobacco, Alcohol, Prescription Medication, and other Substance Use Tool (TAPS) will be completed at admission.

The TAPS Tool has two components. The first component (TAPS-1) is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component (TAPS-2), which consists of brief substance-specific assessment questions (TAPS-2) to arrive at a risk level for that substance. For patients who have a positive screen on the TAPS-1, a brief assessment (TAPS-2) identifies the specific substance(s) use and risk level, ranging in severity from "problem use" to the more severe substance use disorder (SUD).

DATA COLLECTION AND TARGET GOALS

Data are collected quarterly for analysis to identify:

1. Patients that score “1” Problem Use
2. Patients that score “2” Higher Risk
3. Interventions identified in the treatment plan
4. Aftercare recommendations

The goal of data collection and monitoring is to achieve 85% compliance with establishing interventions while in treatment that can help increase the likelihood of abstinence and have a discharge plan that includes aftercare recommendations.

DATA REPORTING

Data are reported and discussed at the Mental Health Substance Use Division Quality Council on a quarterly basis.

QUALITY IMPROVEMENT

Data outcome and trends are reviewed quarterly to identify the need for improvement strategies to meet or exceed the target goal. Increasing the compliance target to 90% will be discussed after 6 months of data collection and analysis.

ADDENDUM B

Quality Assurance Plan – Geriatric Mental Health

Geriatric patients in inpatient settings are often at risk for falls that can cause significant injury, disability, and even death. Geriatric patients in treatment for a mental health disorder are typically started on medications that can increase this risk and require increase observation and care.

The Quality Assurance Plan for Geriatric Treatment Populations follows the same guidelines as the overall Quality Improvement Plan. The steps in this plan includes:

METHODOLOGY

The LHDCMC-BHP utilizes the scientific method of Plan-Do-Check-Act (PDCA) to establish and guide improvement activities

PDCA PROBLEM SOLVING FRAMEWORK

STEP	PURPOSE/OUTCOME OF STEP
1. Plan	Plan the improvement
2. Do	Do the improvement and data collection
3. Study	Study the results of implementation
4. Act	Act to hold the gain and continue the improvement

SCREENING

All patients will be screened for their fall risk upon admission.

SCREENING TOOL

The Schmid Fall Risk Assessment tool will be used to assess fall risk. Patients that score 2 or higher are considered at risk for falls.

DATA COLLECTION AND TARGET GOALS

Data are collected quarterly for analysis to identify:

1. Number of falls with and without injury
2. Patients that score moderate or high risk for falls
3. Interventions identified in the treatment plan to assist in preventing a fall

The goal is to have zero falls that result in injury. Compliance is set at 85% for appropriate interventions in the treatment plan for those patients who score at a moderate or high risk for falls (Fall Treatment Plan).

DATA REPORTING

Data are reported and discussed at the Mental Health Substance Use Division Quality Council on a quarterly basis.

QUALITY IMPROVEMENT

Data outcome and trends are reviewed quarterly to identify the need for improvement strategies to meet or exceed the target goal. Increasing the compliance target to 90% will be discussed after 6 months of data collection and analysis.