Chief Executive Officer
Christ Bjornberg

Board of Directors
Abe Hathaway, President
Jeanne Utterback, Vice President
Tom Guyn, M.D., Secretary
Tami Humphry, Treasurer
Lester Cufaude, Director

Quality Committee

Meeting Agenda

February 20, 2023 1:00 PM
Microsoft Teams Meeting: LINK
Call In Number: 1-279-895-6380
Phone Conference ID: 789 786 981#
Meeting ID: 239 242 977 240
Passcode: M6cuD2

Attendees

Tom Guyn, M.D., Quality Committee Chair
Les Cufaude, Director

Chris Bjornberg, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Tom Guyn, M.D.			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – January 18, 2023		Attachment A	**Action Item**	2 min.
4	**HOSPITAL QUALITY COMMITTEE REPORT**				Report	10 min.
5	**DIRECTOR OF QUALITY**		Jack Hathaway	Attachment B	Report	5 min.
	5.1	CDPH Complaint Deficiency			Report	5 min.
6	**NEW BUSINESS**					
	6.1	QAPI		Attachment C	**Action Item**	5 min.
7	**OTHER INFORMATION/ANNOUNCEMENTS**				Information	5 min.
8	**ADJOURNMENT:** Next Regular Meeting – March 15, 2023					

Chief Executive Officer
Chris Bjornberg

Board of Directors
Abe Hathaway, President
Jeanne Utterback, Vice President
Tom Guyn, M.D., Secretary
Tami Humphry, Treasurer
Lester Cufaude, Director

Board of Directors
Quality Committee
Minutes
January 18, 2023 @ 1:00 PM
Fully Remote Teams Meeting

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

<table>
<tr><td>1</td><td colspan="4">CALL MEETING TO ORDER: Board Chair Jeanne Utterback called the meeting to order at 1:08 pm on the above date.</td></tr>
<tr><td colspan="3">BOARD MEMBERS PRESENT:</td><td colspan="2">STAFF PRESENT:</td></tr>
<tr><td colspan="3">Tom Guyn, MD., Secretary
Les Cufaude, Director</td><td colspan="2" rowspan="2">Jack Hathaway, Director of Quality
Jessica DeCoito, Board Clerk</td></tr>
<tr><td colspan="3">Excused ABSENT:
Chris Bjornberg, CEO</td></tr>
<tr><td>2</td><td colspan="4">CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS</td></tr>
<tr><td></td><td colspan="4">None</td></tr>
<tr><td>3</td><td colspan="2">APPROVAL OF MINUTES</td><td></td><td></td></tr>
<tr><td></td><td>3.1</td><td>A motion/second carried; committee members accepted the minutes of October 19, 2022</td><td>Hathaway, Guyn</td><td>Guyn – Y
Hathaway – Y</td></tr>
<tr><td>4</td><td colspan="4">Hospital Quality Committee Report</td></tr>
<tr><td></td><td colspan="4">Restructuring the quality report templates as we migrate to the ACHC accreditation. Pam Sweet will send out the templates before the next Quality Meeting. The plan is to help the departments with their LEAN projects. Jack will be adjusting the layout so it aligns with the ACHC Accreditation.</td></tr>
<tr><td>5</td><td colspan="4">Director of Quality Report
Written report submitted. Overview of the quality project last year with med errors. Worked with Pharmacist and Nursing leadership to get an education plan together. The plan and remedies that were put into place have shown significant improvement. Our reports are monthly and this is being constantly monitored. We are meeting with ACHC Life Safety Team and our MMHD Life Safety Team to go over what our requirements are. Once we sign on with ACHC, we are going to have a survey within 90 days. QIP (Quality Improvement) program has changed for us with the opening of the Rural Health Clinic. We have access to more data for our QIP program. We are preparing for our audit of the program. We are looking into a program called Bridge that would serve the patients in our area that need opioid help.</td></tr>
<tr><td>6</td><td colspan="4">OTHER INFORMATION/ANNOUNCEMENTS: February Meeting date: February 20th at 1:00 PM</td></tr>
<tr><td>7</td><td colspan="4">ADJOURNMENT: at 2:12 pm
Next Regular Meeting – February 20th at 1:00 PM</td></tr>
</table>

DRAFT

February 2023 Quality Board Report

As Quality for the District sits today, we are excited to say that we have completed all of the initial groundwork for third party accreditation with ACHC (Accreditation Commission for Health Care) and expect their educational team here for an on-site education and gap analysis in March (13-15 to be exact). This is by far the biggest and furthest reaching news in the department for the 6 years that I have been here.

ACHC will be on site for 3 days with a team of three people – one physician subject matter expert (SME), one fire/life/safety SME, and one nursing/admin SME. We know that the fire/life/safety will take up the lions share of the first 2 days, the nursing and administrative work will be mostly on the last day, and the physician SME will be available all three of the days they are here.

From this gap analysis (or mock survey) process ACHCU (Accreditation Commission for Health Care University) the education arm of ACHC will provide Mayers with a detailed report of all of the potential deficiencies that would be found during a full accreditation survey. Then they will finish the visit by assisting us in creating a plan to address all of the opportunities for improvement found with the deficiencies discovered.

After the onsite education and gap analysis, Mayers will submit the application for accreditation to ACHC and be fully prepared to move forward successfully with third-party accreditation in late April or early May. Of course, the goal is to be fully accredited before the Cerner implementation kicks into full swing, and to be able to build on both the Cerner EHR improvements and ACHCU findings to freeze best practices in place before ACHC returns for our first reaccreditation survey in 2026.

It will be an intense few months, however, the benefit will pay to Mayers 10 fold being that we will be completely accredited before Cerner takes over all of our lives and we will have the opportunity to become completely efficient in our new EHR before ACHC comes back for our reaccreditation in three years. The Quality department is excited to be leading the ACHC work and coordinating with all of the other hospital departments to accomplish this goal. It seems as though the other departments are equally as excited to see where we stand after the education and gap analysis is completed and to understand the work that lies ahead with this single goal.

QIP

DHCS (Department of Health Care Services) QIP (Quality Improvement Program) is in full swing. The QIP program is truly focused on managed care lives (those individuals in our area who are Partnership Health Plan members) and that has caused some issues in the past with our success in the program because we did not have assigned lives. However, with the addition of our RHC now the district has a number of assigned lives that will appropriately fall into the QIP target population.

Currently, the Quality has identified a number of metrics (2 for sure, with potential for growth to 4 or 6 depending on how the measure specifications are published in the future performance years) that show promise to have continued success in the QIP program. The addition of the RHC was critical for this program, and we look forward to seeing what kind of potential comes as the clinic continues to grow and gain Partnership lives.

QAPI

As you will see in your board packets, the updated Mayers Quality Assurance and Performance Improvement (QAPI) for 2023 is available for your review and input. Of course, to save time and avoid reworking a number of things we are waiting to specifically identify some of the Med/Surg and other hospital specific QAPI metrics for the coming year until after our gap analysis work with ACHCU. After their visit the board can expect an updated QAPI plan that will have all of the specifically identified opportunities that were found for Mayers.

The QAPI is being presented to you as a board now – so that you can know the basic foundations of the plan and understand how the information will be presented to you for viewing and approval. You will see in the QAPI that there are a number of Skilled Nursing measures specifically identified. This is how the board can expect to see the rest of the measures presented in future meetings after they have been identified and moving into the future. This way as a board you will know exactly how we are proceeding with quality assurance and performance improvement as a district.

Compliance Hotline

In an effort to jumpstart participation in reporting compliance concerns the Quality department has been working with the CEO in order to find a new and better method of reporting compliance concerns to the compliance officer. The CEO suggested finding an outside group to work intake, removing the potential perception of bias at intake of the concern.

To that end the Quality department has been looking at various groups and solutions that would fit the need for the District and allow us the separation to ensure that all those who have compliance concerns can report them with anonymity knowing their report will be heard and dealt with appropriately.

Cerner Reporting Champion

To the Quality departments delight, the Director of Quality was able to volunteer to be the Reporting Champion for the Cerner build. This is a huge opportunity, and he is looking forward to the role and all that it entails. Being able to manage and create all of the necessary reports for the district in the new EHR will be a huge step forward from where we are today with Paragon and working with the rest of the departments of the hospital to identify what reports will have to be built specifically for Mayers will be a lot of fun as we move forward with our Cerner adventure.

Conclusion

As always, it is a pleasure to work Quality for this District. If any of you have any questions at any time please feel free to reach out to the department directly. All of the necessary contact information is below.

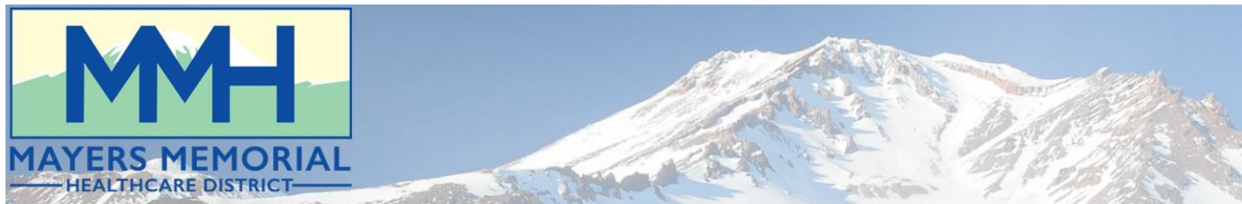
Thank you,

Jack Hathaway | Director of Quality

jhathaway@mayersmemorial.com

Desk: (530)336-7506

Cell: (530)510-1574



Mayers Memorial Healthcare District
Quality Assurance Performance Improvement
(MMHD QAPI)

PURPOSE:

The purpose of the Quality Assurance and Performance Improvement Plan (QAPI) is to provide a framework for promoting and sustaining performance improvement for Mayers Memorial Healthcare District in order to improve the quality of care and enhance organizational performance. The goals of our MMHD QAPI are to proactively reduce risk to those that we serve by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes, and to provide high quality care and services to ensure the best care experience for all those that come to us for help. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, LEAN process and performance improvement, proactive risk assessment, commitment to customer satisfaction, and use of the Just Culture model to promote and improve awareness of patient safety. Mayers Memorial Healthcare District has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

To serve our community by providing excellent care.

VISION STATEMENT

To be the provider of choice for our community

VALUES STATEMENT

Our vision and mission is supported by our values. These include:

Teamwork – working with and helping others to accomplish goals.

Respect – Protecting the dignity of others.

Quality – In the totality of our efforts to operate according to the highest professional and ethical standards.

Compassion – The ability to show compassion and concern for the difficulties of others.

Honesty – Demonstrating professionalism, integrity, and ethical behavior and commitment to the values of the organization.

PERFORMANCE IMPROVEMENT INITIATIVES

The 2023 performance improvement priorities are based on the following priorities:

- Improving the care experience (including quality and satisfaction);
- Improving the quality of care; and
- Reducing harm district wide.

Priorities identified include:

- Support Patient and Family Centered Care through engagement.
- Sustain a Just Culture philosophy that promotes patient safety, openness, & transparency
- Promote LEAN principles to improve processes, reduce waste, and eliminate inefficiencies
- Optimize technology to integrate medical services at all levels of the organization
- Facilitate integrated continuum of care
- Ensure resident safety

Mayers Memorial Healthcare District's vision will be achieved through these strategic priorities. Each strategic priority is driven by leadership oversight and a quality team developed to ensure improvement and implementation.

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all hospital-based departments, services, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

The Board of Directors (BOD) of Mayers Memorial Healthcare District has the ultimate responsibility for the quality of care and services provided throughout the system. The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the District's activities.

The Board:

- Delegates the responsibility for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
- Recognizes that performance improvement is a continuous, cyclical process, and therefore they will provide the necessary resources to carry out this ongoing work;
- Provides direction for the organization's improvement activities through the development of strategic initiatives;
- Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Board Quality Committee.

Chief Team

The Chief Team creates an environment that promotes the goals of quality and process improvement through the safe delivery of care, quality outcomes, and resident satisfaction. The Chief Team sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities. The Chief Team ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

The Chief Team has developed a culture of safety by embracing the Just Culture model and has set behavior expectations for providing no less than Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care. They ensure compliance with regulatory, statutory and contractual requirements.

Board Quality Committee

The Board Quality Committee is to provide oversight for the District QAIP and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

The Medical Executive Committee shares responsibility with the BOD Quality Committee and senior management for the ongoing quality of care and services provided within the Health System.

The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

The Medical Executive Committee delegates some the oversight responsibility for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Board Quality Committee. Other functions such as peer-review remain with Med Staff Quality Committee which meets in conjunction with Medical Executive Committee.

Committees Chairs of the Medical Staff

The Committees Chairs:

- Provide a communications channel to the Medical Executive Committee;
- Monitor ongoing professional performance evaluation and focused professional performance evaluation and make recommendations regarding reappointment based on data regarding quality of care;
- Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

The medical staff is expected to participate and support performance improvement activities. The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of resident care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the District will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

The Director of Quality provides leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the medical staff and District leadership, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the medical staff and engages them in improvement activities. The Director sits the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Leads)

Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Board Quality Committee. Many of these activities will interface with other departments and the medical staff. They are expected to do the following:

- Foster an environment of collaboration and open communication with both internal and external customers;
- Participate and guide staff in the patient advocacy program;
- Advance the philosophy of Just Culture within their departments;
- Utilize LEAN principles and FOCUS-PDCA (Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act) process improvement activities for department-specific performance improvement initiatives;
- Establish performance and patient safety improvement activities in conjunction with other departments;
- Encourage staff to report any and all reportable events including “near-misses”;
- Participate in the investigation and determination of the causes that underlie a “near-miss” / Sentinel/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone’s responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

The Nursing Quality and Peer Review Council consist of registered nurses from each service area. This Council is an integral part of reviewing QAIP data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

Employees are expected to do the following:

- Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect

care experience for patients and customers;
- Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or a Chief Team Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Committee

With designated responsibility from the Medical Executive Committee, the Medical Staff Quality Committee is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The Med Staff Quality Committee is an interdisciplinary committee led by the Medical Director of Quality, which meets monthly in conjunction with the Board Quality Committee. The committee has representatives from each Medical Staff department, Health System leadership, nursing, and ancillary and support services ad hoc.

The Medical Staff Quality Committee:

- Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.
- Regularly reviews progress to the aforementioned plans.
- Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
- Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;
- Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
- Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
- Reviews summaries and recommendations of Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
- Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

Quality Improvement Committee (QIC)

The Board Quality Committee provides direct oversight for the QIC. The QIC is an executive committee with departmental representatives, within the Mayers Memorial Healthcare District, presenting their QA/PI findings as assigned. The goal of the committee is to achieve optimal patient outcomes by making sure that all staff participates in performance improvement activities. Departmental Directors or their designee review assigned quality metrics biannually at the QIC. Performance improvement includes

collecting data, analyzing the data, and taking action to improve. The Director of Quality is responsible for processes related to this committee.

The Quality Improvement Committee will:

- Oversee the Performance Improvement activities of MMHD including data collection, data analysis, improvement, and communication to stakeholders
- Set performance improvement priorities and provide the resources to achieve improvement
- Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
- Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Mayers Memorial Healthcare District utilizes FOCUS-PDCA Rapid Cycle Teams (Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act). The BOD, Chief Team Members, or the Medical Staff Quality Committee charter formal cross-functional teams to improve current processes and design new services, while each department utilizes tools and techniques to address opportunities for improvement within their individual areas.

<u>Performance Improvement Teams</u>

Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

Performance Improvement Teams will:

- Follow the approved team charter as defined by the BOD, Chief Team Members, or Board Quality;
- Establish specific, measurable goals and monitoring for identified initiatives;
- Report their findings and recommendations to key stakeholders, and Board Quality.

PERFORMANCE IMPROVEMENT EDUCATION

Training and education are essential to promote a culture of quality within the Mayers Memorial Healthcare District. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees receive additional annual training on various topics related to performance improvement.

A select group of employees have received specialized manager training in using the Just Culture coaching and investigation process utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the QIC, MSQC and Chief Team Members.

Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Mayers Memorial Healthcare District. During planning, the following are given priority consideration:

- Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
- Processes that affect patient safety and outcomes
- Processes related to patient advocacy and the perfect care experience
- Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
- Processes related to patient flow
- Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

Because Mayers Memorial Healthcare District is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:

- Identified needs from data collection and analysis
- Unanticipated adverse occurrences affecting patients
- Processes identified as error prone or high risk regarding patient safety
- Processes identified by proactive risk assessment
- Changing regulatory requirements
- Significant needs of patients and/or staff
- Changes in the environment of care
- Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

Mayers Memorial Healthcare District designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

- Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
- An external consultant is utilized to provide technical support, when needed.
- The design team develops or modifies the process utilizing information from the following concepts:
  - ✓ It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
  - ✓ It is clinically sound and current
  - ✓ Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards

- ✓ It is consistent with sound business practices
- ✓ It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
- ✓ Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
- ✓ It incorporates the results of performance improvement activities
- ✓ It incorporates consideration of staffing effectiveness
- ✓ It incorporates consideration of patient safety issues
- ✓ It incorporates consideration of patient flow issues

- Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
  - ✓ They can identify the events it is intended to identify
  - ✓ They have a documented numerator and denominator or description of the population to which it is applicable
  - ✓ They have defined data elements and allowable values
  - ✓ They can detect changes in performance over time
  - ✓ They allow for comparison over time within the organization and between other entities
  - ✓ The data to be collected is available
  - ✓ Results can be reported in a way that is useful to the organization and other interested stakeholders

PROACTIVE RISK ASSESSMENTS

- Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. At least one Failure Effect Mode Analysis will be completed every 18 months.
- The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
  - ✓ The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
  - ✓ For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

- ✓ Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.
- ✓ For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.
- ✓ The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
- ✓ The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
- ✓ Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

- Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
- The Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
- The Infection Control Practitioner and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

Mayers Memorial Healthcare District chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:

- Medication therapy
- Infection control surveillance and reporting
- Surgical/invasive and manipulative procedures
- Blood product usage
- Data management
- Discharge planning
- Utilization management
- Complaints and grievances
- Restraints/seclusion use
- Mortality review
- Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
- Needs, expectations, and satisfaction of individuals and organizations served, including:
  - ✓ Their specific needs and expectations

- ✓ Their perceptions of how well the organization meets these needs and expectations
- ✓ How the organization can improve patient safety
- ✓ The effectiveness of pain management

- Resuscitation and critical incident debriefings
- In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
  - ✓ Quality measures delineated in clinical contracts will be reviewed annually
  - ✓ Pharmacy transactions as required by law and to control and account for all drugs
  - ✓ Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
  - ✓ Reports of required reporting to federal, state, authorities
  - ✓ Performance measures of processes and outcomes, including measures outlined in clinical contracts
- Summaries of performance improvement actions and actions to reduce risks to patients

The selected data sets are reviewed regularly by the QIC, MSQC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

Mayers Memorial Healthcare District believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience.

Data is analyzed in many ways including:

- Using appropriate performance improvement problem solving tools
- Making internal comparisons of the performance of processes and outcomes over time
- Comparing performance data about the processes with information from up-to-date sources
- Comparing performance data about the processes and outcomes to other hospitals and reference databases

  Intensive analysis is completed for:

- Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
- Significant and undesirable performance variations from the performance of other operations
- Significant and undesirable performance variations from recognized standards
- A sentinel event which has occurred

- Variations which have occurred in the performance of processes that affect patient safety
- Hazardous conditions which would place patients at risk
- The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

- Significant confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- All major discrepancies between preoperative and postoperative diagnosis
- Adverse events or patterns related to the use of sedation or anesthesia
- Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
- Staffing effectiveness issues
- Deaths associated with a hospital acquired infection
- Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the Board Quality Committee on a quarterly basis. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the Board Quality Committee and Medical Staff annually.

The MSQC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis. The Medical Executive Committee, Quality Medical Director, or the Director of Quality will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

Mayers Memorial Healthcare District also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in voluntary quality reporting initiatives.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157

ANNUAL ASSESSMENT

The Quality Improvement Program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The Quality Assurance program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

The Quality Improvement Plan will be reviewed, updated, and approved annually by the Board Quality Committee, the Medical Executive Committee, and the Board of Directors.

2023 PILLAR GOALS

District
Reduce registry cost by 25% overall from Fy22
Successful Cerner implementation
ACHC accreditation completed for CAH
Meet facility program deliverables for master planning
Improve communication throughout the district

CAH
ACHC Accreditation

SNF
Percentage of residents whose need for help with activities of daily living has increased
Percentage of residents whose ability to move independently has worsened
Percentage of residents experiencing one or more falls with major injury
Hand hygiene

Clinic
Increase Partnership lives by 50%
Increase pediatric population to 400 within this physical year
Become a CHDP provider
Be a Family Pact provider
Complete contracting process with Beacon (telehealth mental health provider)

Retail Pharmacy
Bring PDC to annual average of 70%
ADDS (Alternative Drug Delivery System) available in clinic

Attachment A

Mayers Memorial Hospital District Skilled Nursing 2023 QAIP Reporting Measures

SKILLED NURSING FACILITY	**Responsible**	**Benchmark**	**4th QTR 22**	**1st QTR 23**	**2nd QTR 23**	**3rd QTR 23**
Percentage of residents who experience a UTI						
Percentage of residents who experience significant weight loss						
Percentage of residents whose need for help with activities of daily living has increased*						
Percentage of residents whose ability to move independently has worsened*						
Percentage of high risk residents with pressure ulcers (sores)						
Percentage of residents who have/had a catheter inserted and left in their Blatter						
Percentage of residents experiencing one or more falls with major injury*						
Percentage of residents who self-report moderate to severe pain						
Percentage of residents who receive antipsychotic medications						
Number of resident visits to the emergency department						
Percentage of catheter related UTI's						
RN hours resident days						
Total Nursing hours per resident day						
Rate of COVID-vax Administered						
Rate of Flu-vax Administered						
Rate of Pneumovax Administered						
QUALITY	**Responsible**	**Benchmark**	**4th QTR 22**	**1st QTR 23**	**2nd QTR 23**	**3rd QTR 23**
Resident Safety Index Detail						
Medication error rate						
Percentage of residents that develop pressure ulcers						
Resident falls						
Long Term Care						
Percent of residents who develop pressure ulcers						
Residents with a urinary tract infection percentage						
Percent of residents who experience unplanned weight loss						

Attachment A

Mayers Memorial Hospital District Skilled Nursing 2023 QAIP Reporting Measures

Percentage of Falls						
SNF 5-Star Quality Rating						
RISK	**Responsible**	**Benchmark**	**4th QTR 22**	**1st QTR 23**	**2nd QTR 23**	**3rd QTR 23**
Total number of resident safety events						
FALLS						
Total # non-resident (visitor) falls						
Total # of resident falls						
Rate of resident falls with injury						
Skin breakdown / deceits						
Total # of hospital-acquired pressure ulcers						