Washington Township Health Care District

BOARD OF DIRECTORS' MEETING
Wednesday, May 27, 2026 – 6:00 P.M.
Board Room of Washington Hospital, 2000 Mowry Avenue, Fremont and via Zoom
https://whhs.zoom.us/j/99828662062?pwd=v1jHR839qCAHKCwrbhAgp66ViDaa8T.1
Passcode: 818032

Board Agenda and Packet can be found at:
May 2026 | Washington Health
AGENDA

		PRESENTED BY:
I.	**CALL TO ORDER & PLEDGE OF ALLEGIANCE**	William Nicholson, MD President
II.	**ROLL CALL**	Cheryl Renaud District Clerk
III.	**COMMUNICATIONS**	
	A. Oral *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not on the agenda and within the subject matter of jurisdiction of the Board. "Request to Speak" cards should be filled out in advance and presented to the District Clerk. For the record, please state your name.*	
	B. Written	
IV.	**CONSENT CALENDAR** *Items listed under the Consent Calendar include reviewed reports and recommendations and are acted upon by one motion of the Board. Any Board Member or member of the public may remove an item for discussion before a motion is made.*	William Nicholson, MD President
	A. Consideration of Medical Staff: Orthopedic Surgery Privilege Delineation	*Motion Required*

B. Consideration of Medical Staff:
   - Organizational Performance Improvement Plan FY 2027

V. **ACTION**

VI. **ANNOUNCEMENTS**

VII. **ADJOURN TO CLOSED SESSION**

A. Consideration of Closed Session Minutes of the Meeting of the District Board: April 8, 20 & 22, 2026 — *Motion Required*

B. Reports regarding Medical Audit & Quality Assurance Matters pursuant to Health & Safety Code Section 32155 — *Motion Required*

   - Medical Staff Committee Report

C. Conference Involving Trade Secrets pursuant to Health & Safety Code Section 32106

   - Strategic Planning

VIII. **RECONVENE TO OPEN SESSION & REPORT ON PERMISSABLE ACTIONS TAKEN DURING CLOSED SESSION** — William Nicholson, MD President

IX. **ADJOURNMENT** — William Nicholson, MD President

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact the District Clerk at (510) 818-7401. Notification two working days prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to this meeting.

Washington Health
Medical Staff

MEMORANDUM

Date: May 18, 2026

To: Kimberly Hartz, Chief Executive Officer

From: Aaron Barry MD, Chief of Staff

Subject: MEC Report to Board - Orthopedic Surgery Privilege Delineation (Revision)

The Medical Executive Committee, at its meeting on May 18, 2026, approved the attached revision to the Department of Surgery/Orthopedic Section Privilege Delineation

The attached privilege delineation has been revised to add a new procedure for orthopedic spine surgeons. This procedure, "Percutaneous Radiofrequency Ablation of the Basivertebro Nerve", has been developed in collaboration with the Neurosurgery Section, where this procedure is currently an approved privilege for neurosurgeons. Training and experience criteria were developed and approved by the Orthopedic Section, the Department of Surgery and the Medical Executive Committee.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of this revision to the attached Orthopedic Section Privilege Delineation.

2000 Mowry Avenue
Fremont, CA 94538
510.818.7446

www.washingtonhealth.com

Special Privilege: Percutaneous Radiofrequency Ablation of the Basivertebro Nerve

Description: minimally invasive procedure for treatment of vertebrogenic chronic low back pain

Qualifications

Education/Training	Completion of an ACGME or AOA accredited fellowship training program in orthopaedic surgery of the spine with a letter from the program director that he/she ws adequately trained in the applied for procedure and have manufacturer certification of device used (i.e. Intracept™) **OR** be currently privileged at Washington Hospital for Orthopedic Spine Surgery and have manufacturer certification of device used (i.e. Intracept™).
Clinical Experience (Initial)	Applicant must be able to provide documentation of the provision of a minimum of 5 cases of this procedure (waived for applicants who completed training in the last 12 months).
Clinical Experience (Reappointment)	Applicant must have provided documentation of the provision of a minimum of 5 cases of this procedure during the past 24 months.

Check the Request checkbox to select all privileges listed below.

Uncheck any privileges you do not want to request in that group.

Request	WH
☐	- Currently Granted privileges
☐	Percutaneous Radiofrequency Ablation of the Basivertebro Nerve

FPPE

☐	Two direct observation case reviews
☐	Evaluation of OPPE data collected for review of competency/performance

Washington Health

MEMORANDUM

Date: May 18, 2026

To: Kimberly Hartz, Chief Executive Officer

From: Aaron Barry, MD, Chief of Staff

Subject: MEC for Board Approval – Numbered Memorandum

The Medical Executive Committee, at its meeting on May 18, 2026, approved the attached Numbered Memorandum:

- Organizational Performance Improvement Plan FY2027

The numbered memorandum has been reviewed and/or revised, and approved by all relevant Hospital and Medical Staff Departments.

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval.

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Washington Hospital Healthcare System
SINCE 1948

Memorandum

TITLE: ORGANIZATIONAL PERFORMANCE 7G IMPROVEMENT PLAN FY2027

MEMORANDUM # 0-~~7E~~
Replaces ~~07D~~0-7F

RESPONSIBLE PERSON: Chief Quality Officer

Revised: ~~02~~05/~~06~~15/2026
Original Issue: 06/08/2011

REVIEWED BY:

_X_ Department	**_____ Division**
_____ Medical Staff	**_____ Management Staff**
_____ Administrative	**_____ Other**

PURPOSE: To establish Washington Health's commitment to quality care and continuous improvement of patient safety, quality of care, organizational performance, and to define the structure to accomplish quality and improvement activities.

POLICY:

Washington Health is committed to providing quality health care services to our patients. Washington Health maintains an ongoing systematic data-driven Performance Improvement Program and continuously sets expectations, plans and manages processes to measure, assess and improve the organization's governance, management, clinical and support activities. Performance Improvement activities are integrated across all departments and services are aligned with the organization's strategic goals. The results of performance improvement activities are confidential and protected as defined in the plan.

PROCEDURE:

The attached Organizational Performance Improvement Plan applies to all Washington Health staff and Medical Staff Departments and Services.

ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN FY2027

MISSION OF PROGRAM

Washington Health is committed to delivering accessible and personalized care to all ~~of~~ our patients. As an organization the healthcare system must continually measure, assess, and improve processes and outcomes related to services that are provided.

SUMMARY OF PROGRAM

~~In order to~~To consistently provide quality care, Washington Health systematically and continuously sets expectations, plans, and manages processes to measure, assess, and improve the organization's governance, management, clinical and support activities. Washington Health assures hospital employees are empowered and guided by our commitment to patient care and the community. All decisions made and actions taken are based on what is in the best interest of the patient; it is what unifies us in our never-ending pursuit of ways to support and sustain the good health of the community.

SCOPE OF ACTIVITIES

The Organizational Performance Improvement Plan encompasses organization-wide activities related to quality control, quality assessment, and performance improvement.

A. Patient care is a coordinated and collaborative effort; the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes, and mechanisms that comprise performance improvement activities at ~~Washington Hospital~~Washington Health.
   - The Organizational Performance Improvement Plan, established by the Quality Steering Council (QSC) with ~~the~~ support and approval from the governing body, has as its scope the monitoring of every aspect of patient care and service, including contracted services. Monitoring of care and service extends from the patient's entry into the Hospital through the patient's diagnosis, treatment, recovery, discharge, and care transition. Monitoring is undertaken ~~in order~~ to identify and resolve any breakdowns that may result in suboptimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

   - Collaborative and specific indicators of key processes are designed, measured, and assessed by all appropriate departments, services, and disciplines of the facility in an effort to improve patient safety and organizational performance. These indicators are; objective, measurable, based on current knowledge and experience, community needs and are structured to produce statistically valid, data-driven~~,~~ performance measures. ~~The~~ This mechanism also provides for evaluation of improvements and sustainability over time. Indicators are

compared to available nationall~~y~~ ~~specific~~ standards and benchmarks.

- Lean Methodology is a management system that aims to maximize patient (customer) value while minimizing waste and cost through continuous improvement. Hospital staff and physicians collaborate to identify defects and reduce waste inefficiencies to improve quality and boost productivity.

B. In addition, the scope of the Organizational Performance Improvement Plan includes: monitoring, assessment, and evaluation for the dimensions of performance of patient care. Findings of the QSC, continuous performance improvement activities of the Medical Staff and all appropriate departments, services and disciplines that impact patient care and safety will be reviewed, assessed and evaluated. At a minimum, the organization collects data on measures as outlined by the Joint Commission Standards, the Centers for Medicare and Medicaid Services (CMS), and applicable federal, state and county regulations including, but not limited to:

- Operative/Invasive procedures
- Appropriateness of clinical practice patterns
- Significant deviation from established patterns of clinic practice
- Medication management and significant adverse drug reactions and errors
- Blood and blood product use and all reported and confirmed transfusion reactions
- Behavior management and treatment, use of restraints
- Diagnostic errors
- Equipment failure
- Resuscitation and outcomes
- Mortality review and autopsy screening
- Medical record documentation review
- National ~~Patient~~ Performance ~~Safety~~ Goals (NP~~S~~Gs)
- Adverse events related to anesthesia and sedation
- Patient experience
- Infection and isolation as required
- Hospital-Acquired Conditions
- Hospital readmissions and excess days in acute care
- Healthcare accessibility and disparity reduction

The Hospital also collects data and information for the following areas:

- Staff opinions and needs, perceptions of risks, suggestions for improving patient safety and willingness to report unanticipated adverse events.
- The effectiveness of all fall reduction activities including assessment, interventions, and education.
- The effectiveness of the response to change or deterioration in a patient's

condition.

- Perceptions of care, treatment and services of patients, including their specific needs and expectations, how well the Hospital meets these needs and expectations, how the Hospital can improve patient safety and the effectiveness of overall care to safely transition patients to the next level of care after their Hospital visit.
- Patient flow

C. Relevant information developed from the following activities is integrated into performance improvement initiatives. This process is consistent with any Hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.
    - Risk Management
    - Utilization Management
    - Quality Assurance
    - Infection Prevention surveillance and reporting
    - Hospital-Acquired Conditions:
        1. Hospital-Associated Infections (HAI)
        2. Falls
        3. Pressure Ulcers
    - Research, as applicable
    - Autopsies, when performed
    - Organ procurement
    - Hazardous conditions
    - Staffing effectiveness issues
    - Core measure data

D. Support service processes that impact patient care are monitored. Data shall be obtained via the Electronic Medical Record (EMR) as the main source of truth whenever such data exists in the EMR. Data are systematically aggregated and analyzed. Undesirable patterns or trends in performance are analyzed.
    - Analyses are performed when data comparisons indicate that levels of performance, patterns, or trends vary substantially from expected.
    - Analyses occur for those topics chosen by leaders as performance improvement priorities.
    - Analyses are performed when undesirable variations occur which changes priorities.

E. Finally, the scope of the Organizational Performance Improvement Plan includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and patient safety practices throughout the Hospital.

PRIORITIZATION OF AREAS FOR MEASUREMENT

The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, review of annual data using a risk matrix, regulatory requirements, community needs, opportunities identified in external benchmark projects, opportunities identified through analyses of patient safety event reports and opportunities identified through sentinel events, standard of care findings or "Sentinel Event Alerts." These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory). Priorities are reviewed at least annually, and updated at the fiscal year (FY) (July through June). See Appendix A where the priorities of the objectives are defined.

DEVELOPING MEASURE SPECIFICATIONS

Work groups or committees define the metrics (indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary.

GATHERING DATA

Data is then gathered on a pre-determined timeframe (i.e., daily, weekly, monthly, quarterly, etc.). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due.

The primary goals of Washington Health's Organizational Performance Improvement Program Plan are based on annual performance and are to:

1. Use Lean methodology system to improve quality, safety and value through the elimination of waste.
2. Continually and systematically plan, design, measure, assess and improve performance of priority focus areas.
3. Reduce and prevent medication and health care errors.
4. Incorporate performance improvement throughout the facility.
5. Provide a systematic mechanism for Washington Health staff, departments, and professions to function collaboratively in their efforts toward performance improvement.
6. Provide feedback and learning throughout the organization.
7. Identify patient experience standards and metrics, to evaluate patient perception of care

during their stay at Washington Health.

8. Determine ongoing opportunities for improvement by analyzing Washington Health's performance. Quality metrics are embedded within the Organizational P~~p~~riorities and Strategic Initiatives.
9. Plan and incorporate processes for conducting thorough and credible root cause analyses (RCAs), focusing on process and system factors in response to sentinel events and other critical incidents as defined by the healthcare system.
10. Develop methods for continuously improving measures of patient outcomes and satisfaction.
11. Continuously improve clinical and operational processes that include, and are not limited to:
    - **Safety:** the avoidance of injuries to patients from the care that is intended to help them.
    - **Timeliness:** reducing wait time and sometimes-harmful delays for both those who receive and those who provide care.
    - **Effectiveness:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
    - **Efficiency:** avoiding waste, including waste of equipment, supplies, and energy.
    - **Equity:** providing everyone the fair and just opportunity to attain their highest level of health through addressing social determinants of health (SDOH) (nonmedical factors that influence health outcomes such as access to safe housing, food, transportation, and neighborhoods) and health disparities (differences in access to or availability of medical facilities and services and variation in rates of disease occurrence and disabilities defined by socioeconomic characteristics such as age, gender, ethnicity, geographic location, and socioeconomic status.
    - **Patient-Centeredness:** providing care that is respectful of, and responsive to the individual patient preferences, needs, values and ensuring that patient values guide all clinical decisions.

LEADERSHIP OF PROGRAM

The Governing Body retains ultimate responsibility and accountability for the quality and safety of care provided throughout the organization. ~~Leaders play a central role in fostering improvement~~. The Board of Directors ~~with the assistance of QSC~~ annually approves ~~identifies H~~hospital-wide performance improvement priorities ~~through consensus~~, based on a review of risk assessments, past performance, ~~and~~ strategically selected measures and community needs~~.~~, with recommendations from the QSC. Leaders play a central role in fostering improvement. At Washington Health, leaders include the Board of Directors, the Chief Executive Officer (CEO), the Joint Conference Committee (JCC), the Medical Executive Committee (MEC), the QSC, the Administrative Team, and department managers and supervisors. Leaders foster performance improvement and reduce risk through planning, educating, setting priorities, and providing support such as time and resources. The focus is on indicators that improve health outcomes and

the prevention and reduction of errors. (See Addendum A).

STRUCTURE

Joint Conference Committee (JCC)

The JCC consists of the Chief of Staff (the committee's chairperson), the Chief of Staff-Elect, the Immediate-Past Chief of Staff, the Medical Staff Liaison Officer, the CEO, the Chief of Medical Staff Affairs, representatives from the Board of Directors and other individuals that are identified. The JCC constitutes a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Medical Staff, the Board and Administration. The JCC meets at least once monthly. The Chief of Staff will be responsible for the agenda.

Quality Steering Council (QSC)

The Quality Steering Council is accountable for the development and has oversight of organization-wide performance improvement and the Medication Safety Program. The QSC assures the integration and coordination of Medical Staff, direct patient care, and support services performance improvement activities. Quality is defined as the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and is consistent with current professional knowledge. Improving quality will enhance the overall delivery of care to the patients and community. The QSC also facilitates integration of performance improvement functions by providing necessary resources for training and education and facilitates the development of interdisciplinary teams that assess and improve specific processes and/or systems across departmental lines. In keeping with the organizational mission and values, ~~and the Patient First Ethic,~~ the QSC also prioritizes specific processes for performance improvement team activities. The QSC membership includes: the CEO, the identified Vice Presidents, the Chief of Medical Staff or their designee, the Chief of Medical Staff Affairs, chair of Quality Resource Management, ~~the~~ Physician Quality Advisor, Chief Quality Officer (CQO), ~~the~~ Chief Nursing Officer (CNO), ~~the~~ Patient Safety Officer, and other key medical and operational leaders for the organization. Members and the Chairperson are appointed by the CEO. The chair of QSC will report QSC activities and recommendations to the MEC and to the Joint Conference Committee at least quarterly via the CEO report. ~~The QSC provide quarterly reports to the Board of Directors.~~

Medical Executive Committee (MEC)

The MEC receives and takes action on reports and recommendations from the Medical Staff committees; monitors and evaluates the medical care rendered to patients in the Hospital; reviews and prioritizes clinical effectiveness studies and development of clinical guidelines, based on trending information, including high risk, high volume, and problem prone issues; reviews and approves the Hospital-wide performance improvement plan. The MEC ensures that there is an effective program for Ongoing Professional ~~Performance~~ Practice Evaluation (OPPE) and Focused Professional ~~Performance~~ Practice Evaluation (FPPE) for the Medical Staff. The results

of the Professional ~~Performance~~ Practice Evaluations (PPEs) are considered in the (re)credentialing and privileging process.

Clinical Operation Committees

Each Committee oversees the interdisciplinary operation of a clinical service or clinical product line. Current clinical services provided at ~~Washington Hospital~~Washington Health include, and are not limited to*:*

- Cardiac Surgery
- Critical Care
- Diabetes
- Dialysis
- Emergency Medicine
- Laboratory
- Joint Replacement
- Special Care Nursery / Women and Children
- Spine
- Stroke
- Other service lines as identified by the QSC

The core membership includes the clinical service medical director, clinical expert, an administrative representative and a process owner. Other team members will be appointed by the core team as deemed appropriate. The performance improvement activities for these committees provide an update to the QSC at least annually.

Quality and Resource Management (QRM) Committee

The QRM Committee, represented by members of the Medical Staff oversees, coordinates, and directs performance improvement activities, including patient safety initiatives, prioritizes and charters quality action teams; monitors the results of performance improvement activities and refers priority problems for assessment and corrective action to the appropriate committee and/or department; evaluates sentinel events for potential liability and process improvements; reviews medical necessity of admissions and continued stays; and submits reports and recommendations to the MEC.

Medical Staff Department Committees and Sections

The organized Medical Staff ensures a uniform standard of quality of care for treatment, and services provided. The Medical Staff Committees review, evaluate, and monitor the quality of care and appropriateness of treatment provided to patients within the service, including identifying ongoing indicators and measurements related to the key processes of the Hospital; overseeing ongoing measurement, periodic assessment, and periodic improvement of the key processes; and makes recommendations to the MEC, Professional Practice Evaluation Committee (PPEC), or the QRM.

Trauma Performance Improvement and Patient Safety (PIPS) Committee

Trauma PIPS is a multidisciplinary standing committee of the Medical Staff and reports to ~~will be presented~~ the MEC. The charge of the committee is to evaluate the overall care of trauma patients from a clinical and systems perspective and to perform interdisciplinary implementation of improvement strategies. It is responsible for establishing objective criteria for identifying issues for review and determining compliance with standard of care. Membership includes Trauma Division staff, the Trauma Medical Director, Chief Quality Officer, ~~and~~ the Trauma Program Director, and selected additional non-voting members.

Pharmacy Nutrition & Therapeutics (PN&T) Committee

The PN&T Committee is responsible for assisting in the formulation of professional practices regarding medication use in the Hospital, developing and maintaining a formulary, initiating drug use evaluations, and monitoring adverse drug reactions. Members are appointed by the Chief of Staff.

Clinical Evaluation Committee (CEC)

The Clinical Evaluation Committee is responsible for assisting in developing a Hospital-wide Infection Control Program and maintaining surveillance over the program. CEC works with the Health Information Management (HIM) department on matters related to physician documentation~~practices~~. Members are appointed by the Chief of Staff.

Medication Analysis Committee (MAC)

The MAC evaluates the medication use process including the elements of prescribing, order communication, labeling, packaging, compounding, dispensing, distribution administration, education, monitoring and use; develops strategies for process improvement. MAC is comprised of physicians, Hospital Administration, and selected leaders from Pharmacy. It shall submit regular reports to the PN&T Committee. The Chairperson is appointed by the CEO.

Patient Safety Committee

The Patient Safety Committee is responsible for day-to-day operation of the Patient Safety Program Plan including compliance with the NPSGs, implementing risk-reduction strategies to address patient safety issues, promoting a culture of safety and accountability, and communicating regulatory updates related to patient safety. The Committee includes members from the Medical Staff and other Hospital Divisions. The Chairperson is appointed by the CEO.

Quality Department

The Quality Department has the responsibility to support the achievement of Washington Health's goals related to quality and to foster integration of all quality assessment functions, including Medical Staff, Nursing, and ancillary staff and support services. The Quality Department carries out the following functions:

- Assist professional staff in the development of an effective monitoring and evaluation system, a quality assessment and performance improvement plan, and use of statistical control processes for analyses.
- Provide for the integration and coordination of data utilizing automated data sources when available, as well as traditional sources of information.
- Attend Medical Staff, nursing staff, and other clinical staff's quality meetings or Hospital's performance improvement activities as requested to support identification of conclusions, recommendations, actions, and follow-up monitoring and evaluation activities.
- Perform data abstraction and summaries of monitoring and evaluation activities including, but not limited to, surgical case review, blood usage review, core measures, and physician criteria-based indicator studies.
- Report occurrences of significant adverse outcomes and potential adverse trends to the QSC and appropriate leaders.
- Refer cases to the Medical Staff Department, Nursing, Risk Management, and ancillary/support services for peer review or other follow-up when identified through concurrent review, unusual occurrence reports, or other sources.
- Provide educational and resource information related to quality outcomes management and performance improvement.
- Review quality reports and refers identified problems to the appropriate Hospital department or Medical Staff Committee Chairperson for further investigation and follow-up.
- Develop the organization's Performance Improvement Program Plan, coordinate and write the annual evaluation of the plan, and revise the Plan as needed in collaboration with the Hospital Leadership and organized Medical Staff.
- Maintain all performance improvement monitoring and evaluation of data in a secure and confidential manner.
- Provide the Chief of Medical Staff Services with provider-specific quality assurance information sufficient to be used in the evaluation of the Medical Staff and Allied Health Professionals.

Hospital Departments / Ancillary Services

Directors, Managers, and Supervisors of all departments and services (including inpatient, outpatient, and contracted services have responsibility for the quality of the services provided in their area as listed:

- Continuously assessing and improving the performance of care and services provided.
- Integrating the service into the primary functions of the organization.

- Coordinating and integrating inter/intradepartmental services.
- Developing and implementing policies and procedures that guide and support the provision of services.
- Recommending a sufficient number of qualified and competent persons to provide care, including treatment.
- Determining the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners.
- Maintaining quality assurance as appropriate.
- Participating in patient satisfaction reporting and improvement activities.
- Orienting and providing in-service training and continuing education of all persons in the department.
- Recommending space and other resources needed by the department.
- Participating in the selection of sources for services not provided by the department or the organization.
- Integrating contracted services that fall under the department into performance improvement activities and annually review with the Medical Director, if applicable, all outside services and contracted services for quality and performance.

Design of New Processes/Services

When consideration is given to adopting a new process ~~and~~ or service, leadership, in collaboration with stakeholders ~~(including staff)~~, will ensure the process considers the ~~following:~~ ~~Th~~ ~~e~~ organization's mission, vision, values and strategic plan, as well as p~~P~~atient, staff, and community needs and expectations. Information about performance and outcomes of the process or service including ~~utilizing~~ the use of outside reference databases for current knowledge of best practices may include:~~;~~

- Data regarding outcomes and potential risks to patients
- Data relevant to sentinel events, including published Sentinel Event Alerts
- Testing and review to assure improvement after proposed process or service is in place

Clinical Guidelines

Clinical guidelines are considered as part of the Performance Improvement Program Plan at Washington Health.

The selection criteria for when guidelines will be developed and used are the same criteria established in the Performance Improvement Plan for selecting a patient population for a study or a clinical improvement project. When a new clinical project has been selected using these criteria, the process owner and working group will consider use of a guideline in the planning phase of the project. If the working group deems that use of guidelines would be appropriate for a defined patient population, the following may be utilized in consideration of selecting guidelines.

1. Guidelines should be evidence-based, reflecting the most current medical evidence available. Possible conflicts of interest should be considered.
2. External sources for existing guidelines published by professional medical societies, healthcare or physician organizations, or other sources such as the Agency for Health Care Policy and Research (AHRQ), or other healthcare organizations with established and effective pathway tools, should be considered.
3. Suggested resources: American Medical Association (AMA), Journal of the American Medical Association (JAMA), AHRQ, Centers for Disease Control (CDC), National Healthcare Safety Network (NHSN), California Department of Health Care Access and Information (HCAI), a Patient Safety Organization (PSO) that the hospital is formally participating in, or CMS and other pertinent sources.
4. External pathways may be reviewed and modified for use.

The following process will be followed:

1. Approval process requires review and approval by appropriate committees, which may vary based on the guideline. The following committees should be considered:
    - the QSC
    - the MEC
    - Related Medical Staff Department(s)
    - Relevant Clinical Operations Committee
    - Infection Control Committee
    - Nursing Shared Governance
2. Evaluation, selection and development of a guideline will involve administrative and clinical staff, including Medical Staff, nursing and other discipline representation from areas that are expected to be impacted or involved in the implementation of the guideline.
3. The guideline will be periodically reviewed and revised as necessary to remain current and useful.
4. Measurements to monitor the effectiveness of the guideline will be established, including the review of variances from the guidelines, and modifications made as necessary.

Periodic Assessment and Improvement

Topics and projects for periodic assessment and improvement arise from ongoing measurement, staff suggestions, and from other sources. Specifically, assessment may be triggered by the following situations:

- Important undesirable single events, levels, or patterns
- When the organization's performance significantly and undesirably varies from that of other organizations or from recognized standards
- When the organization wishes to improve notably positive performance

- In response to all major discrepancies or discrepancy patterns between pre-operative and post-operative diagnoses
- All confirmed transfusion reactions
- All significant adverse drug reactions
- All significant adverse Anesthesia outcomes or events during moderate or deep sedation
- All significant medication errors
- Staffing effectiveness issues
- Identified hazardous conditions
- Serious medical errors or adverse patient events
- Issues related to the competence of an individual physician or other independent practitioner will be referred to the appropriate Medical Staff Department Committee for PPE and will be referred to the MEC and the Board of Directors as appropriate issues; related to the performance of Hospital Staff will be referred to the Department Director, Manager or Supervisor and the division Vice President for evaluation

Prioritization

When necessary, the QSC, in conjunction with Hospital and Medical Staff leadership, will prioritize the processes to be evaluated, and the data to be collected. In determining prioritization, the following will be considered:

- The needs of the community
- Patient safety
- Patient satisfaction
- Patient outcomes
- Number of patients affected by the process
- Processes which have been or are likely to be problem prone or high-risk
- The needs and expectations of staff, patients, and other customers

Performance Improvement Methodology

Quality and performance improvement in the Hospital will use Plan, Do, Check, Act (PDCA) as the methodology for improvement and continuous change. PDCA in conjunction with the Lean methodology will be utilized to decrease errors and defects in the care delivery system as well as improvements in patient, physician and employee satisfaction.

PDCA begins with identifying the problem and including an aim/goal statement.
The goal must be specific, measurable, achievable, relevant and time-bound (SMART).
The four phases of the problem-solving system are;

Plan	A written statement of interventions supporting the goal
Do	Implementing the written plan
Check	Observe and review a list of the most influential factors, including any-

unanticipated events

Act Evaluate the plan, monitor results, and adjust as needed.

Improvement activities are reviewed and reprioritized in response to significant events in both the internal and external environment.

1. Failure, Mode, and Effects Analysis (FMEA) Process at least every 18 months The FMEA model may be used to identify potential problems
2. Lean Methodology: Fishbone Diagrams, Value Stream Mapping, including going to Gemba to identify barriers/issues, and Countermeasures may be used to identify proposed solutions
3. Root Cause Analysis (RCA)
    a. The root cause analysis model is used for sentinel events or near miss analysis, followed by PDCA to improve the identified problem and prevent further occurrences. Feedback is provided to Administrative and medical staff leaders on a regular basis. Change is managed and implemented incrementally.

Data Systematically Aggregated and Analyzed

Aggregating and analyzing data means transforming data into information. Aggregating data at points in time enables the Hospital to judge a particular process' stability or a particular outcome's predictability in relation to performance expectations. Accumulated data are analyzed in such a way that current performance levels, patterns, or trends can be identified.

1. Collected data are aggregated, visualized and analyzed.
2. Data are aggregated at the frequency appropriate to the activity or process being studied.
3. Statistical tools and techniques are used to analyze and display data.
4. Data are analyzed and compared internally over time and externally with other sources of information when available.
5. Comparative data are used to determine if there is excessive variability.

Transparency & External Data Sharing

Core Measure Reporting: Core Measures are quality, safety or service metrics that are required or recommended to be reported to either CMS or The Joint Commission (TJC). The current Core Measures reported to CMS and TJC are: Emergency Department (ED) Throughput, Stroke, Sepsis, and Perinatal Care (PC).

Care Compare: CMS posts each hospital's performance on Core Measures, and several quality value-based programs for acute care hospitals. These quality improvement programs include; Overall Hospital Star Ratings, Hospital Inpatient Quality Reporting (IQR), Hospital Value

Based Purchasing (VBP) Program, Hospital-Acquired Condition Reduction Program (HACRP), Hospital Readmissions Reduction Program (HRRP).~~,~~ ~~and~~ CMS has developed additional metrics that are created based on billing data that CMS has access to, and do not require any action on the hospital's part. Some examples of administrative data include 30-day readmission rates, 30-day mortality rates, complication rates, patient safety indicators (PSIs), inpatient quality indicators, hospital-acquired conditions, excess days in acute care (EDAC), episode-of-care payment, and imaging efficiency. Patient Satisfaction is also measured and reported as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

Promoting Interoperability: CMS has initiated a program that encourages hospitals to demonstrate meaningful use of their EMR to improve health outcomes and access to healthcare information through submission of electronic clinical quality metrics (eCQMs). Over time, the Core Measures will be directly pulled from the EMR instead of manual abstraction, and feedback will be closer to 'real time'. Several measures are included for mandatory and voluntary reporting. The current measures include and are not limited to; ED throughput, PC, Stroke, Venous Thromboembolism (VTE) Prophylaxis, Safe Use of Opioids, SDOH, hospital harm, severe hypo/hyperglycemia, etc.

VBP: CMS has initiated a 'pay-for-performance' program that pays for care and services based on the quality and value of care, not only the quantity of services provided. VBP includes clinical outcomes such as mortality, hip and knee surgical complications, healthcare-associated infections (HAIs), HCAHPS surveys and also uses claims-based data such as Medicare spending per beneficiary (MSPB). There are financial incentives to improve our performance as compared to other hospitals.

Patient Safety Organization

The hospital may establish participation in and share quality and patient safety information with an AHRQ accredited Patient Safety Organization (PSO) for the purpose of helping detect state and nation-wide trends in safety events, for collaboration with other participating organizations in the development and promulgation of best practices, to increase collaboration on patient safety between hospital and medical staff, and to obtain relevant benchmarking data on safety events.

Reporting of Data

The Quality Department will be responsible for assisting the organization with disseminating aggregated and analyzed data throughout the organization and to the community. Process owners will collaborate with Medical Directors, Hospital staff including the Quality Department to ensure the accuracy of data at the unit, department, or committee level.

Data Sources

Data for performance improvement activities can come from a variety of sources. Sources include, and are not limited to:

Patient Specific Data

- Interviews/Observation
- Medical Records Information Patient Complaints/Compliments/Concerns Quality Review Reports (QRRs) / Report Data Entry (RDE)
- Midas/ incident and event reporting system
- EMR (EPIC)
- Chart reviews

Aggregate Data

- Case Mix Index (CMI)
- Cost Accounting System
- Financial Management Reports
- Infection Surveillance Systems
- Patient Satisfaction Surveys
- Reports from Regulatory Licensing or Accreditation Surveys
- Safety and Patient Safety Committee Findings
- Utilization Review Findings
- Safety and Patient Safety Issues

Knowledge-Based Information

- Internet

Comparative Data

Washington Health participates in the following comparative databases:

1. Local, State and Federal Databases

    - Alameda County Public Health Department Database
    - California Maternal Quality Care Collaborative (CMQCC)
    - California Syndromic Surveillance (CalSys)
    - Cardiac Arrest Registry to Enhance Survival (CARES)
    - CMS Care Compare
    - National Health Safety network (NHSN)
    - HCAI – Statewide Hospital Utilization Database
    - HCAI – California CABG Outcomes Reporting Program (CCORP), Transcatheter Aortic Valve Replacement (TAVR)
    - Press Ganey (including HCAHPS)

2. Clinical Databases
    - American College of Cardiology (ACC)
    - Get With The Guidelines (GWTG)
    - MIDAS+
    - National Database for Nursing Quality (NDNQI)
    - Neurovascular Quality Initiative (NVQI)
    - Society of Thoracic Surgeons (STS)

- Tumor Registry
- Vascular Quality initiative (VQI)

Contract Services

All services provided to patients in the facility by contract will be required to provide an annual report on their performance improvement activities to the responsible associate administration.

Confidentiality

~~Washington Health invokes all privileges, immunities and confidentiality rights attached to documentation and discussions generated in the course and scope of business operations, including without limitation Evidence Code section 1157 and the attorney-client and work-product privileges as set forth in Evidence Code section 952, et seq., and Code of Civil Procedure section 2018, respectively. All such documentation and discussions shall be confidential and not subject to discovery unless otherwise required by law. (All individuals participating in such discussions or in the preparation of such documentation shall conduct themselves in a way to preserve confidentiality and all applicable privileges and immunities.)~~

Washington Health invokes all privileges, immunities and confidentiality rights attached to performance improvement and patient safety information, including protections under California Evidence Code sections 1156 and 1157 and the federal Patient Safety and Quality Improvement Act of 2005 (PSQIA). PSQIA established a voluntary reporting framework and Patient Safety Organizations (PSOs), and provides federal privilege and confidentiality protections for qualifying patient safety work-product developed for and reported to a PSO as part of a patient safety evaluation system, subject to limited exceptions. Accordingly, performance improvement and patient safety documentation and discussions generated within the scope of these protected activities are confidential and not subject to discovery except as otherwise required by law.

In addition, depending on the situation, the attorney-client privilege (Evidence Code 954) and the attorney work-product doctrine (Cal Code of Civil Procedure 2018.030) may apply to provide additional protections from discovery.

All employees are expected to act in accordance with the Washington Health Code of Professional Conduct. Members of the Medical Staff are expected to act in accordance with the bylaws, rules, regulations and policies of the Medical Staff. This includes, but is not limited to complying with the obligations under HIPAA (42 USC 1320d et seq.) and the California Confidentiality of Medical Information Act (Civil Code Section 56.01 et seq.).

Evaluation Mechanism

The Performance Improvement Program Plan will be evaluated by the Administration and Medical Staff Leadership on an ongoing basis to assure it meets the objectives of the program. At least annually, all identified measurements and indicators will be reviewed by the Medical Staff Committees, and Hospital Administration. Revisions may be recommended, when appropriate. The plan will be reviewed annually by the QSC, submitted to the MEC, and the

Board of Directors will have final approval.

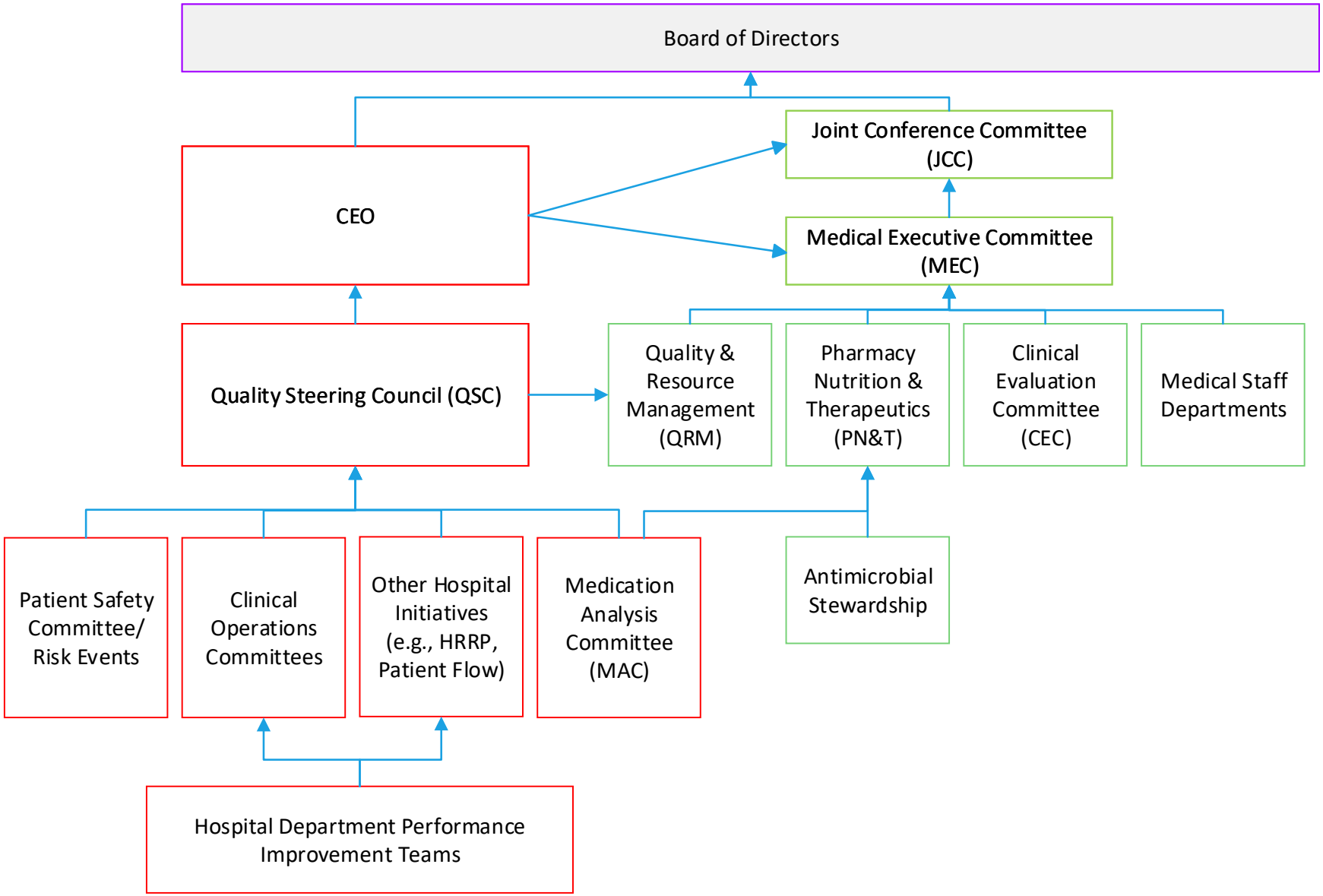
Performance Improvement Education

All employees receive training on the Performance Improvement Plan, Mission, Vision and Values of Washington Health as part of their new hire orientation. Ongoing performance improvement education and "just-in-time training" is provided to the Board, Administrative and Medical Staff Leadership, directors, managers, physicians and employees when PI reports are presented at committee, team and staff meetings or through specially developed educational sessions.

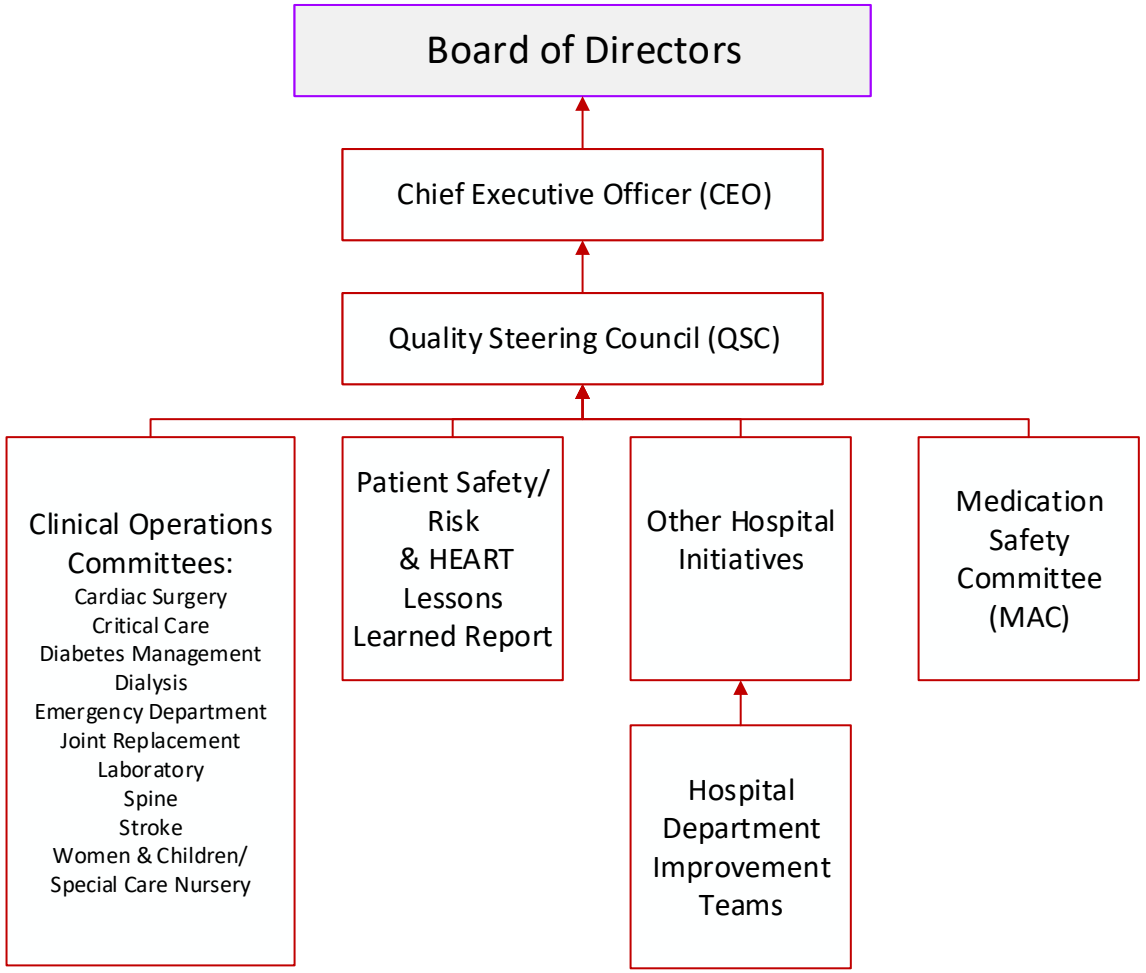
~~Organizational Ethics~~

~~Confidentiality - All employees are expected to act in accordance with the Washington Health's Code of Professional Conduct. Members of the Medical Staff are expected to act in accordance with the bylaws, rules and regulations of the Medical Staff. All performance improvement data/activities and the information disseminated is protected under California Evidence Code Sections 1156 and 1157, California Senate Bill 1211, California Civil Code (Section 56.01 et. seg.), the Federal Health Care Quality Improvement Act and regulations promulgated there under, and any other applicable state or federal statutes, rules or regulations regarding all quality management and patient medical record documentation.~~

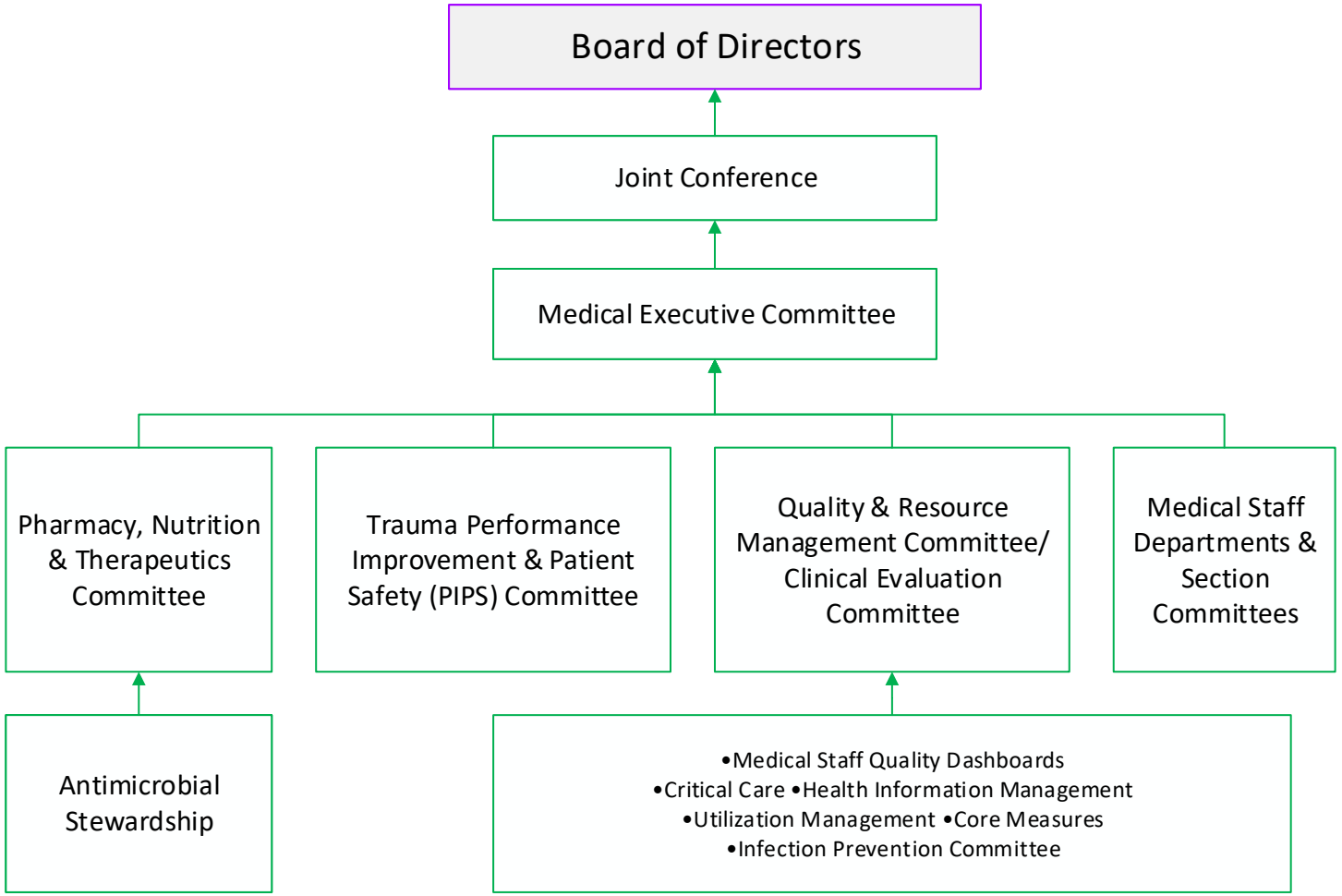
Addendum A: Organizational Performance Improvement Structure



Addendum B: Hospital Performance Improvement Structure



Addendum C: Medical Staff Performance Improvement Structure



Appendix A: WHHS PRIORITIZATION MATRIX FY2027

Quality and Patient Safety Goals									
Opportunity	High Risk	High Volume	Problem Prone	Customer Satisfaction	Staff Satisfaction	Provider Satisfaction	Community Need	Regulatory	Total
Prioritization 1 = low, 2 = medium, 3 = high									
Hospital Associated Events	3	2	2	3				3	13
Patient Safety Events	3						3	3	9
Falls	3		2	3			2	2	12
Medication Errors	3		3	3		3	3	3	18
Access	2		2	3			3	3	13
Improve Resource Utilization									
Opportunity	High Risk	High Volume	Problem Prone	Customer Satisfaction	Staff Satisfaction	Provider Satisfaction	Community Need	Regulatory	Total
Prioritization 1 = low, 2 = medium, 3 = high									
Patient Throughput	3		2	3					8
Reduce Readmissions	3	3	3	3			3	3	18
Reduce Excess Days	3	3	3	3				3	15
Improve Customer Experience									
Opportunity	High Risk	High Volume	Problem Prone	Customer Satisfaction	Staff Satisfaction	Provider Satisfaction	Community Need	Regulatory	Total
Prioritization 1 = low, 2 = medium, 3 = high									
Customer Experience	3		2	3	3	2	3	3	19
Reduce Hospital Acquired Infections									
Opportunity	High Risk	High Volume	Problem Prone	Customer Satisfaction	Staff Satisfaction	Provider Satisfaction	Community Need	Regulatory	Total
Prioritization 1 = low, 2 = medium, 3 = high									
Catheter Associated Blood Stream Infections	2		1	3				3	9
Catheter Associated Urinary Tract Infections	3		3	3				3	12
C. Dificile	3	2	2	3				3	13
Hand Hygiene	2	3	2	3				3	13
MRSA	3		3	3				3	12
Surgical Site Infections	3		2	3				3	11

Mary Bowron, DNP, RN, CIC, CNL Chief Quality Officer	Date Approved
Brian Smith, M.D. Quality Advisor, Chair, Quality Steering Council	Date Approved
Khalid A. Baig, M.D. Chair, Quality & Resource Management Committee	Date Approved
Aaron Barry, M.D. Chief of Medical Staff	Date Approved
Kimberly Hartz Chief Executive Officer	Date Approved
~~Michael Wallace~~William Nicholson, M.D. President, Board of Directors	Date Approved