CCRMC QAPI 2025 Annual Evaluation						
Area	**Quality and Pt Safety PI Priorities**	**2025 Targets**	**2025 Performance**	**2025 Outcome/Evaluation**	**2026 Target**	**Strategy Summary**
Hospital	Mortality (data only is Observed deaths not O: E)	0	47	No identified opportunities for improvement for CY2025.	N/A	The measure will be removed from the PI priority list, while continuing in-depth reviews of all mortality cases to identify improvement opportunities and ongoing event tracking and trending.
	Fall reduction	Count 80	Count: 128	Target not met. CY2025 saw an increase in falls 128 vs CY2024 94. Identified challenges with psychiatric high-risk and assaultive patients, compliance with consistent rounding, and mobility and post-fall documentation.		Continuing for 2026 pivot to tracking of all falls, measurement based on falls per 1,000 patient days. Continued sustained focus on frequent Purposeful Rounding using 5Ps; implementation of a substance-related falls prevention plan; modification of AM/PM activities and shower schedules for high-risk patients; routine bed alarm checks with an emphasis on early mobility; completion of pharmacy-led post-fall medication reviews and thorough post-fall documentation.
	HAPI PSI 03	Count: 0	Count: 0	Target met for CY2025. There were no reportable HAPIs noted for 2025. Pivot 2026 to all HAPIs CY2025 count 32. 2025 noted skin breakdowns related to lengthy surgical procedures	25% Reduction as compared to CY 2025 Count: 24	Continue the journey to zero harm for 2026. Focus pivot to all HAPIs. Improvement efforts include wound documentation,

				and missed opportunities to identify community acquired cases.		surveillance, timely provider notification, 6-eyes assessment compliance, OR pressure injury prevention devices, and Optiview used to assess skin integrity without disrupting dressings. CY2025 Total HAPIs 32 (CCU – 6, IMCU – 8, 4A – 0, 4B – 12, 5D – 4, OR – 2)
	Sepsis bundle compliance: ED triage time to serum lactate results 1-hr ED triage start time to Abx administration within 3 hrs.	LA 95% Abx 85%	LA 91% Abx 82%	Target not met for both measures. There was an increase in compliance for both lactic acid (LA) CY2025 91% vs CY2024 84% and antibiotic (Abx) administration CY2025 82% vs CY 2024 28%. Many interventions were implemented in 2025: • January 2025 In-patient Sepsis Order Set updated in addition to a new In-patient Sepsis Provider Note (SEPSISDOC) • May 2025 iSTAT started in ED for Lactic Acid (LA) result-by June 2025, iSTAT LA result decreased by an average of 14 minutes • BPA for concurrent monitoring went live on 9.10.25. September 2025 focus pivoted to SEP1 bundle compliance-baseline 47 (2024) %.	SEP 1- Bundle Compliance 67%	September 2025 focus pivoted to SEP1 bundle compliance- baseline Q1 2024 to Q4 2024 - 47%. 54% (Jan-Oct 2025) SEP-1 bundle measure is now pay-for-performance under the CMS Hospital Value Based Purchasing Program (VBP) impacting Medicare payments starting January 2026.

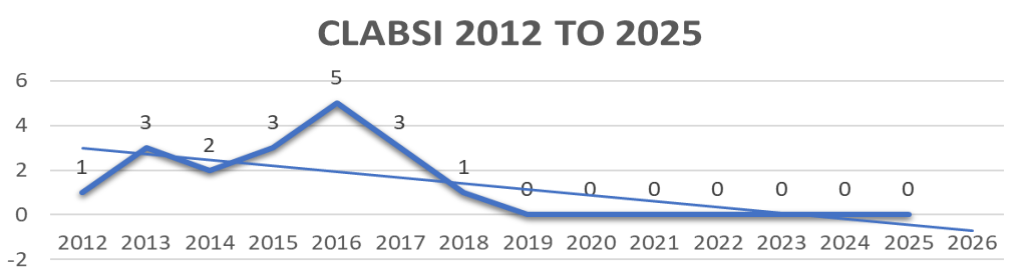
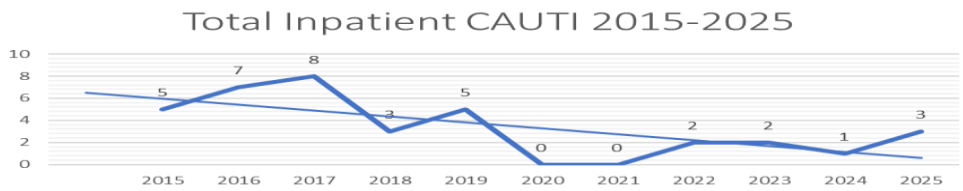
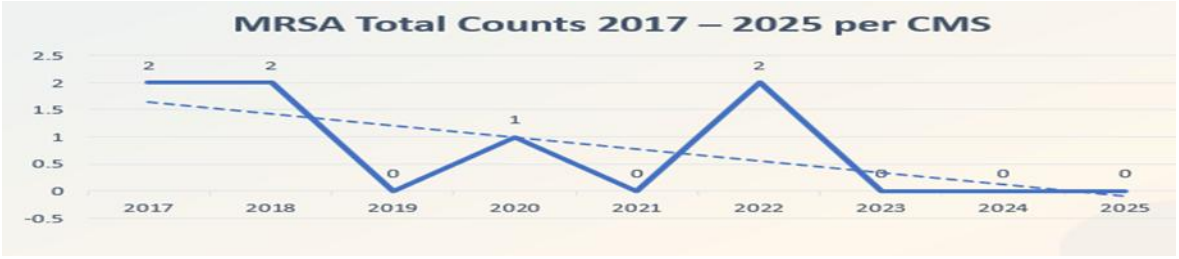
ICU	Decrease the code blue outside of the critical care unit (except ED)	25% reduction from 2024.	Count: 4	CY2025 saw continued favorable trend of increased RRT and decreased Code Blues.	N/A	The measure will be removed from the PI priority list for 2026, while continuing deep-dives for improvement opportunities. Continued improvement strategies include discussing advanced directives with patients and family, RRT rounds on all admits within 24 hrs. to evaluate appropriateness of unit placement, proactively identify patients at risk of deteriorating, allowing for appropriate and timely intervention.
ED	LWBS	<=4.0%	3.2%	Target met for CY2025. Multiple factors related to LWBS – including inpatient bed availability, number of ED arrivals, patient acuity, as well as physician and nursing staffing. The Nurse Program Manager has worked on reducing time in triage, including evaluating workflow and documentation requirements. Physician staffing is also an ongoing effort that impacts this measure.	N/A	This measure will be removed from the 2026 PI Priority list, while ongoing surveillance activities will continue to identify improvement opportunities
	QIP FUM qualified denominator	65%	81.3%	Target met. Measure retired for CY2025.	N/A	Percent of ED visits sent to PES or YSU with a Primary Dx in one of the two value sets in the FUM HEDIS Measure Specification. Follow-ups, tips, information shared with physicians.

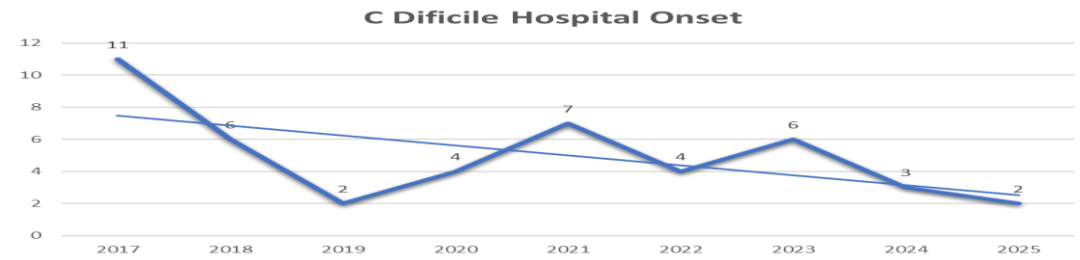
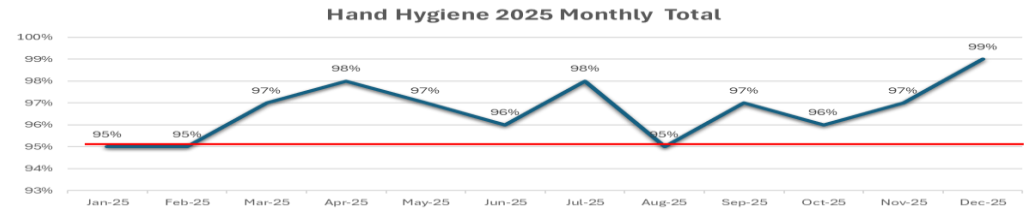
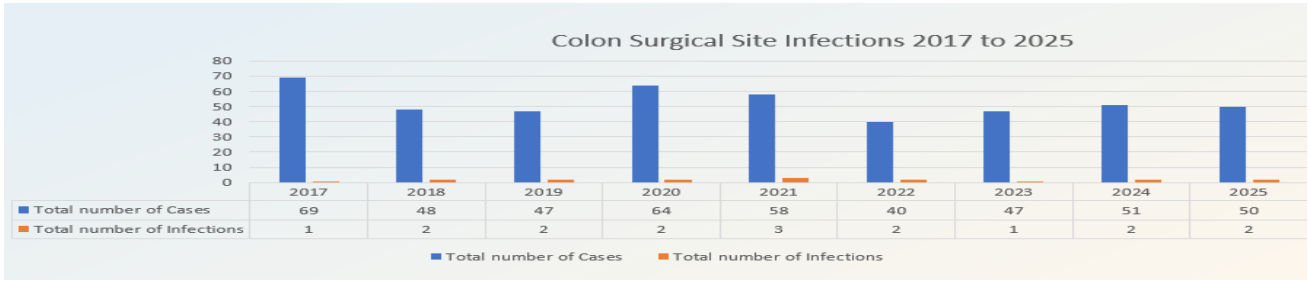
						Report and chart audits are used to score each ED visit; results are updated weekly and shared frequently with stakeholders. This measure will be removed from the 2026 PI Priority list, sustainable processes in place. Continue to track and trend through QIP improvement work.
Psychiatry	Inpatient Psych Fall Rate per 1,000 IP Psych days	<= 1.9 Falls per 1,000 IP Days.	2.98	Target not met CY2025. Deep dives to identify improvement opportunities. Continued focus on frequent Purposeful Rounding using the 5Ps, trialing of shower socks, fall champion, implementation of substance-related falls prevention plan; modification of AM/PM activities and shower schedules for high-risk patients; completion of pharmacy-led post-fall medication reviews.	N/A	This measure will be removed from the 2026 PI Priority list. Organizational focus on all falls will be tracked and trended. Continue to monitor, review, and report risk events related to falls in PES and on inpatient psychiatry units.
	% of PES visits w/ LOS 24+ hrs.	<= 25%	26.8%	Target not met for CY2025. Barriers included wait times for IP bed, SUD clearance time r/t disposition, special placement needs. AB-2242 Behavioral Health Care Coordination Plan was implemented Feb 2025 which likely led to longer stays for patients who arrived on a 5150 legal hold and are discharged after no longer meeting hold criteria.	N/A	This measure will be removed from the 2026 PI Priority list. Will continue to track and trend since the implementation of AB-2242 likely play a role with increase LOS.

Perinatal	Eclampsia & Pre-eclampsia w/severe features reduction	6%	6.8%	Target not met for CY2025, though measurable improvement seen in 2025 6.8% vs 2024 8.5%. Continued improvement focus: Management severe range BP, documentation and coding exploration/review.	N/A	This measure will be removed from the 2026 PI Priority list. Organizational focus shifted to other perinatal opportunities. Continue to track and trend for improvement opportunities.
	Postpartum Hemorrhage reduction (without transfusion)	6%	12.4%	Target not met for CY2025; notable progress was made with a rate of 12.4% 2025 vs 2024 13.2%. Continued efforts with early implementation of interventions: Jada device, identifying patients at higher risk for hemorrhage, reassess QBL throughout immediate postpartum period and EMR update to depict risk status throughout perinatal experience.	N/A	This measure will be removed from the 2026 PI Priority list. Organizational focus shifted to other perinatal opportunities. Continue to track and trend for improvement opportunities.
	Primary C-section rate for Black delivering patients	22%	23.3%	Target not met for CY2025 however performance improved with a rate of 23.3% in 2025 vs 30% in 2024. Continued collaboration efforts with CMQCC learning, lap forms completed for each NTSV candidate, Inservice DFAM r/t outpatient interventions and resources available.	N/A	This measure will be removed from the 2026 PI Priority list. Organizational focus shifted to other perinatal opportunities. Continue to track and trend for improvement opportunities.
Peri-Op	SSI reduction abdominal surgery (colorectal, small bowel, abdominal hysterectomies)	<=1 or SIR <= 1.0	2 COLO, 0 SB, 1 HYST	No SB SSI in past 5 years (2022-2025). Target not met for COLO or HYST in CY2025. COLO has had 2 SSIs each year (SIRS >1.0) since 2018, except 3 in 2021.	SSI COLO SIR < 1.0	SSI-SB, SSI-HYST will be removed from the 2026 PI Priority list. Continue to track and trend for improvement opportunities. SSI COLO SIR 1.71 (2025) continued focus for 2026, continue to

				HYST SSI were zero from 2019-2022, with 1 in 2023 and 2 in 2024 and 1 in 2025. Continued focus on ERAS promotion, re-enforce information regarding NHSN definitions and documentation requirements, SPD monitoring, EVS monitoring room turn-over, better blood sugar monitoring for all patients (pre-op, intra-op and post-op) and appropriateness of Pre-Op antibiotics.		promote ERAS , continue to work with Quality and OR leadership, re-enforce information regarding NHSN definitions and documentation requirements, SPD monitoring, EVS monitoring room turn-over, better blood sugar monitoring for all patients (pre-op, intra-op and post-op), appropriateness of Pre-Op antibiotics.
	PSI 12 DVT/PE (Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate)	3.18/1000/DC	0.015	Target met for CY2025. No identified opportunities for improvement for CY2025.	N/A	This measure will be removed from the 2026 PI Priority list. Continue to track and trend for improvement opportunities.
Ambulatory	Access: third next available Primary Care (adult, peds, family medicine)	< 14 Days [Median]	16.8, 6.6, 23.7	Target not met for CY2025. Barriers include population increased with decreased number of PCPs over time.	N/A	This measure will be removed from 2026 PI Priorities list. Continue to track and trend through improvement work, focusing on increased hiring of PCPs, increase Telehealth visits and decreasing cancelled clinics.

Hospital Acquired Infections (HAIs)

CLABSI 	0 CLABSI since 2019 Success is attributed to the following: • Use of alternatives to central lines – mid lines etc • The use of Chlorhexidine wipes for bathing • Chlorhexidine impregnated dressing • Quarterly classes for staff • Weekly monitoring of patients with lines
CAUTI 	3 Cases in 2025, increase from previous year. SIR 2.201 is higher than NHSN predicted (1.8). Continued focus for 2026: Redesign the education – walking in-service, tip sheets, staff meetings etc., daily bathing with emphasis on perineal care, Chlorhexidine bathing for patients with indwelling catheters in place for >3days (start day 4), maintaining patient hydration, Flex Seal for patients with diarrhea, partnership with TCAB-ask managers to appoint a champion, physician collaboration on strategies for patients with urinary retention, invite IC educator to staff meetings on the units and Improve data feedback.
MRSA 	Fifteen Lab ID bacteremia's in 10 patients were reported: 12 were considered community acquired, 3 hospital classified hospital acquired however, review noted all had evidence of MRSA positive cultures at time of admission. • CMS data shows no Positive MRSA- less than NHSN predicted of 1.54

C-DIFF 	In 2025 a total of 22 positive patients were reported to NHSN: 13 were considered community onset, 5 were considered health care facility associated and 4 were considered hospital onset. • 2 of these were reported from inpatient psychiatry and exclude from SIR calculation and CMS published data
Hand Hygiene 	Overall hand hygiene compliance 97% for CY 2025. Opportunities identified with the following occupations: Respiratory Therapists, Dietician, Diagnostic Imaging and Social Services.
SSI 	Total Infections by type: Superficial 8 infections, Intraabdominal abscess 3 (Only 2 appear in our CMS reported data, 1 was excluded as present on admission).

Strategy Summary

CLABSI- 0 CLABSI since 2019. Success is attributed to the following: Use of alternatives to central lines – mid lines etc, use of Chlorhexidine wipes for bathing, Chlorhexidine impregnated dressing, quarterly classes for staff and weekly monitoring of patients with lines

CAUTI- 3 Cases in 2025, increase from previous year. SIR 2.201 is higher than NHSN predicted (1.8). Identified as PI Priority for 2026

MRSA- CMS data shows no positive MRSA for 2025-less than NHSN predicted of 1.54

CDIFF- 22 Cases reported to NHSN for 2025, 4 considered hospital onset (2/4 exclude from SIR attributed to inpatient Psych)

SSI- 2 total SSIs noted for 2025. SSI- COLO identified as PI Priority for 2026

External Reporting Measures

Inpatient (9)	Outpatient (4)	Psychiatric (8)
Above Target (4) • Safe Use of Opioids – Concurrent Prescribing • VTE1 – Venus Thromboembolism Prophylaxis • VTE 2- ICU Venus Thromboembolism Prophylaxis • HH-ORAE –Hospital Harm- Opioid Related Adverse Events Below Target (1) • SEP1 – Severe Sepsis and Septic Shock CMS Data Not Available (4) • PC2 – Cesarean Birth • PC7a- Severe Obstetric Complications (All) • PC7b- Severe Obstetric Complications (excluding blood transfusions- only) • PCB6 – Unexpected Complications in Term Newborns	Above Target (1) • OPWeb29 - Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (Q1-Q4 2023) Below Target (2) • OP18 b - Median Time from ED Arrival to ED Departure for Discharged ED Patients • OP22 – ED – Left Without Being Seen (Q1-Q4 2023) No Target (1) • OP23 - Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke (too few to report)	Above Target (6) • IMM2 – Influenza Immunization • SMD1 – Screening For Metabolic Disorders • SUB3 – Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge • TR1 – Transition Record with Specified Elements Received by Discharged Patients • SUB2 – Alcohol Use Brief Intervention Provided or Offered • TOB3 Tobacco Use Treatment Provided or Offered at Discharge Below Target (2) • HBIPS2 – Physical Restraint • HBIPS3 – Seclusion

CMS Data Not Available = Data suppressed by CMS for one or more quarters

Inpatient	Outpatient	Psychiatric
Opportunities for Improvement: • SEP1 – Severe Sepsis and Septic Shock **Barriers** Timely serum lactate and antibiotic administration were identified as opportunities for bundle compliance **Tactics to Close Gap** Many interventions were implemented in 2025 : • January 2025 In-patient Sepsis Order Set updated in addition to a new In-patient Sepsis Provider Note (SEPSISDOC) • May 2025 iSTAT started in ED for Lactic Acid (LA) result • By June 2025, iSTAT LA result decreased by an average of 14 minutes • BPA for concurrent monitoring went live on 9.10.25. • Focus pivot to SEP1 bundle compliance Sept. 2025	**Opportunities for Improvement:** • OP18 b - Median Time from ED Arrival to ED Departure for Discharged ED Patients • OP22 – ED – Left Without Being Seen (Q1-Q4 2023) **Barriers** Multiple factors related to these two measures: inpatient bed availability, number of ED arrivals, patient acuity and physician staffing. **Tactics to Close Gap** April 2024 T2 Project (adding a second Triage RN) and improved Physician staffing Fall 2024 leading to reduction in median Door-to-Triage start minutes (from 10-12 /month in 2023 to 7-9 in April-Dec 2024). Sept 2025 rate 3.2%	**Opportunities for Improvement:** • HBIPS2 – Physical Restraint • HBIPS3 – Seclusion **Barriers** Variable based on high acuity of patients necessitating longer time in restraints and seclusion (R/S) Patient and staff safety is the balancing concern and is actively assessed and followed-up by Nursing leadership. **Tactics to Close Gap** RNs and Psychiatrists continuously reassess for justification for continued time in R/S Continued exploration to re-room patients earlier when given sedating medications in a seclusion room- this would entail 1:1 in the patient's room Explore comparable institutions for to improvement strategies • Site visit to John George PES and Inpatient Psych November/December 2025

Strategy Summary

Maintain a continued focus on clinical quality initiatives: Sepsis, restraint, seclusion and enhance ED throughput, all through an equity-focused lens.

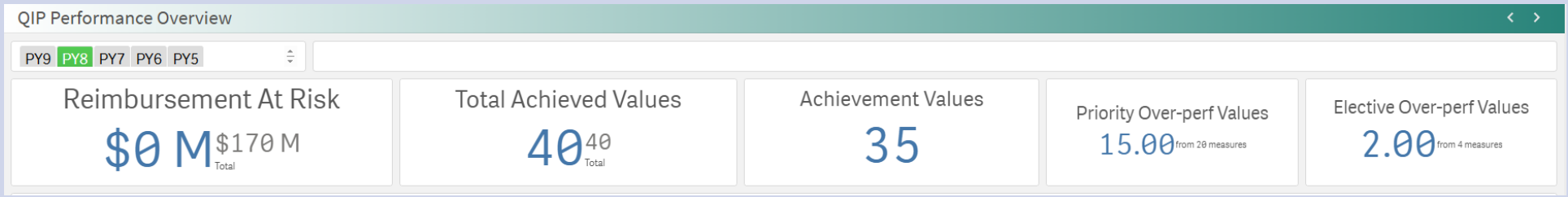
- Continue to apply evidence-based practices to deliver high-quality care and continuously pursue performance improvement with curiosity.
- Continued collaboration with the community partners and resource integration.

QIP CY 2025 Assessment and 2026 Plan

CY 2025 Summary
For CY 2025 QIP Measures- achievement value met with zero reimbursement dollars at risk

Final QIP payments are based on:

- Quality Score: 100% score= 40 Achievement Value (Performance + Over performance)
- Quality Score multiplied by the DPH system's proportion of the total Medi-Cal managed care members, relative to all other participating DPH systems



Improvement Opportunities identified for CY 2026
Requiring additional improvement effort due to either higher 90th percentile or existing gaps

- Child and Adolescent Well Care Visits (WCV)
- Child and Adolescent Well Care Visits (WCV) in AA
- Lead Screening in Children
- Well-Child Visits for Age 15 Months-30 Months
- Controlling High Blood Pressure (CBP)
- Controlling High Blood Pressure (CBP) in AA
- Glycemic Status Assessment for Patients with Diabetes (All 3 suberates)
- Postpartum Care
- Prenatal Care
- Cesarian Birth
- Transitions of Care
- Patient Engagement after Inpatient Discharge

Strategy Summary
Outreach efforts and incentive champaigns have been primarily focused on closing the gaps associated with these measures.