Contra Costa Regional Medical Center
and
Health Centers
Quality and Patient Safety Program Description
Annual Plan and Description
2026

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Section 1 – Quality and Patient Safety Program Overview

Purpose

The purpose of this plan is to provide the mechanism for improving hospital quality and safety and to ensure that Contra Costa Regional Medical Center and Health Center's Board of Supervisors' Joint Conference Committee (JCC), senior leaders, medical staff, and hospital staff demonstrate a consistent and collaborative approach to deliver safe, effective, efficient, equitable, patient centered, and timely care within a quality assurance and performance improvement (QAPI) framework. The activities in this plan are essential to achieving the strategic plan Contra Costa Regional Medical Center and Health Centers. This plan informs the improvement processes for patient outcomes, reducing and preventing medical errors, and applying remediation strategies in response to system or process failures.

The hospital allocates appropriate staff resources to develop and maintain the Quality and Patient Safety Program. The Professional Staff and Hospital operations managers are allocated time, office space, analytical services, and support staff to perform specialized quality roles, which includes participation in process improvement.

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes are:

- An understanding of systems thinking, High Reliability Organizations (HRO), human error and human factors.
- The creation and maintenance of a culture in which reporting takes place in a "Just Culture".
- Proactive and prioritized performance improvements to prevent failure, mitigate hazards, and improve systems and process reliability.
- A model and methodology for improvement that applies PDSA testing, learning and implementation of changes consistent with lean six sigma practices.
- Seeking input from and collaborating with patients and families.
- Assuring compliance with all state and national regulatory, accreditation, and certification standards supporting quality and patient safety.
- Ongoing identification, sharing, and appropriate implementation of successful practices from other parts of the organization, other healthcare organizations, and organizations outside of healthcare.

Mission and Vision

At the core of everything we do is delivering health, which means providing access to affordable, convenient, and high-quality care—while removing the barriers to embracing healthier behaviors. Contra Costa Health makes good health more attainable for all residents and we maintain a strong focus on equity and eliminating health disparities in our communities. Our mission is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems.

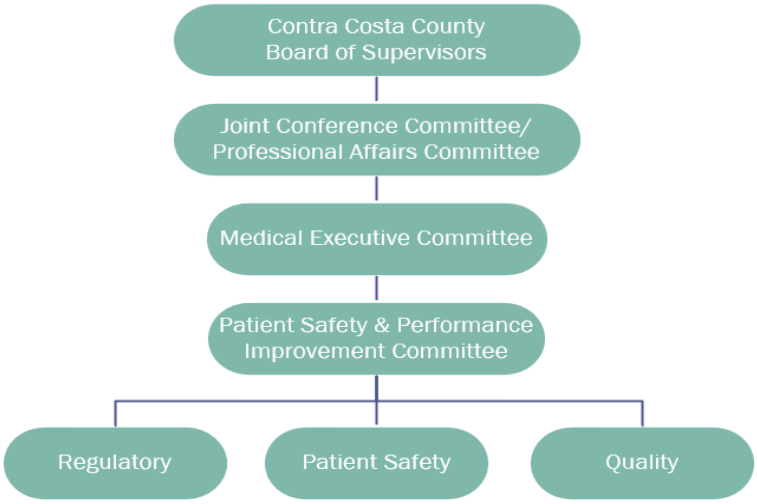
Program Oversight, Authority, and Hospital Governance Structure

The objective of the Quality and Patient Safety Program is to provide a leadership driven framework and organizational structure to achieve the mission and strategic goals of the organization. The Quality and Patient Safety Program structure and oversight ensures that consistent and systematic efforts are maintained to continually measure, assess, and improve processes and outcomes related to services provided.

AUTHORITY AND STRUCTURE

Contra Costa Regional Medical Center and Health Centers (CCRMC&HCs), a division of Contra Costa Health Services (CCHS), is a full-service hospital with 167 licensed beds (124 acute care beds and 43 inpatient psychiatry beds), a 28-bed emergency department, and 14-bed Psychiatric Emergency Department. CCRMC&HC provides outpatient services in 10 community clinics, three prenatal clinics, one respite-based clinic, and mobile clinics. Services provided include school-based health services, healthcare for the homeless, outreach and other public health services. CCRMC &HCs hospital are licensed by the state of California, certified by CMS, and accredited by The Joint Commission. The Board of Supervisors, the governing body, through its Joint Conference Committee (JCC), oversees hospital and Health Center's Quality and Patient Safety Program ("Program"). The JCC assures each hospital's executive and Professional Staff leadership develops the hospital's program consistent with the hospital's mission, vision, and values. The hospital leadership is accountable to the JCC to assure the planning and implementation, including establishing priorities for the Quality and Patient Safety Program with respect to the delivery of existing services and the implementation of new hospital services.

Communications between the hospital and health centers and JCC are bi-directional. Data and reports reach JCC through various mechanisms. The Medical Executive Committee is the authorized body to manage and monitor the quality and safety of clinical care. The Patient safety and Performance Improvement Committee (PSPIC) and executive PSPIC serve as the subcommittees overseeing quality and patient safety performance in operations.



Hospital Leadership:

The hospital leadership team focuses its efforts on hospital operations and strategic priorities The Hospital is managed by the Chief Executive Officer who serves as the hospital administrator. In collaboration with the Medical Staff President, Leadership is responsible for providing a framework for the delivery of quality care and services provided by the hospital based on the hospital's mission, Board of Supervisors' JCC initiatives, and hospital identified opportunities for improvement. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.
The hospital administrator and the Medical Staff President collaborate with the Chief Quality Officer on planning and implementing the Quality and Patient Safety Program.

Leadership is responsible for:

- Ensuring collaboration with community leaders and organizations to design services to be provided by the hospital that are appropriate to the scope and level of care required by the population served;
- Ensuring communication of the organization's mission, vision, values, goals, objectives and strategies across the facility;
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services and/or departments;
- Ensuring uniform delivery of patient care services provided throughout the hospital;
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the hospital walls;
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern;
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events;
- Implementing changes in existing processes to improve the quality of the care provided;
- Establishing quality of care and patient safety metrics, which can be monitored through the hospital's plan;
- Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services;
- Providing ongoing quality, performance improvement and patient safety training for physicians, nurses and hospital staff;
- Promoting a "Just Culture" that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior;
- Ensuring that staffing resources are available, trained, and competent to appropriately meet the needs of the patients served;
- Ensuring the Medical Executive Committee submits reports to the Board of Supervisors' JCC regularly and as requested; and
- Providing routine reporting and special reports as requested to the Board of Supervisors' JCC.

Joint Conference Committee (JCC)
JCC has oversight and responsibility for CCRMC&HCs' quality, patient safety and performance improvement activities. JCC reviews and approves the annual Patient Safety & Performance Improvement program plan, priority quality and patient safety projects and reports from the Patient Safety & Performance Improvement Committee and Medical Executive Committee.

JCC's is responsible for:

- Ensuring standards of care are met.
- Oversight of performance improvement activities to ensure program effectiveness.
- Providing feedback and recommendations for improvement action plans, when needed.
- Ensuring the same level of care is provided throughout the Hospital for equivalent patient conditions.

The **Professional Affairs Committee** (PAC) is responsible for monitoring Medical Staff quality issues and ongoing improvement activities, including:

- Monitoring personnel actions related to Medical Staff performance and quality of care, such as considering the appointment, employment, evaluation of performance and dismissal of public employees;
- Considering matters concerning staff privileges; and
- Reviewing adverse event reports and related Performance Improvement activities of the Hospital and Medical Staff
- Monitoring performance over time for key quality and patient safety performance improvement initiatives

Medical Executive Committee (MEC)

The Medical Executive Committee is responsible to ensure the proper functioning of all departments, committees, and other activities of the Professional Staff and to monitor the effectiveness of Professional Staff activities. The MEC has oversight of the quality of care and patient safety provided to patients and their families. The MEC is responsible for the organization of the performance improvement and patient safety activities of the Professional Staff as well as the mechanisms used to conduct, evaluate, and revise such activities.

The MEC is responsible for Medical Staff (MS) quality. Results from Peer Review, conducted with MEC approved Clinical Indicators, are incorporated into Ongoing Professional Practice Evaluations (OPPE), and may be the basis for Focused Professional Practice Evaluations (FPPE). These processes (OPPE/FPPE) are described in the MS Bylaws and Rules and Regulations. MS Department Heads review the performance of its members, in accordance with the Medical Staff Bylaws and Rules and Regulations, and report annually to MEC.

The MEC oversees contracted services and receives reports from PSPIC on performance improvement metrics at CCRMC&HCs.

The Patient Safety and Performance Improvement Committee (PSPIC)

PSPIC is authorized by, and accountable to, the Board. PSPIC serves as the committee to implement, monitor, and enhance operational systems to ensure quality improvement, performance improvement and patient safety for the hospital. Lean six sigma methods and other key tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care.

The committees facilitate the preparation of reports related to the hospital's quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Supervisors' JCC through the Medical Executive Committee on an ongoing basis and as requested.

Executive Session of PSPIC (Exec PSPIC)
The Executive PSPIC strives to reduce risk, improve patient safety and quality outcomes in the delivery of health services across all settings of care. These two committees work in tandem to monitor the effectiveness of the corrective actions taken in response to an adverse or sentinel event to ensure that the risk reduction strategies achieve the expected results. Executive PSPIC supports the process for ongoing patient safety improvement for physicians, nurses, and hospital staff. The Executive PIC Committee shall submit reports related to patient safety to the Medical Executive Committee regularly and as requested.

Other committees: Other Professional Staff Committees, departmental committees, and specifically focused committees and work groups have been given, by leadership, the responsibility to develop, implement, and monitor performance effectiveness for the services and processes within their scope. These committees and work groups report up through the quality structure.

Section 2 – Performance Improvement

Performance Measure Overview

Performance measures are based on the strategic objectives each year. Process, outcome, and balancing measures* are selected to reflect important aspects of care at the hospital, department and unit level and align with the organizational program goals for hospitals. The Board of Supervisors' JCC has also set an expectation that this hospital will plan for and implement processes needed to meet these outcome measures.

Priority measures reflect the diversity of services offered by CCMRC, include externally reported measures such as CMS core measures and NHSN and registry metrics for improvement as part of program accreditation. A list of 2026 measures is attached in appendix B.

The Board of Supervisors' JCC has set an expectation that the hospital administrator in partnership with the Medical Staff President will identify, prioritize, and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration of the hospital administration and the hospital Medical Executive Committee. Hospital leadership shall report these issues and their remediation on an annual basis in the hospital's annual quality and patient safety evaluation.

*Process measures are the specific steps taken to improve outcomes.
Outcome measures are high level metrics that reflect the overall care provided.
Balancing measures are metrics to ensure an improvement in one area isn't negatively impacting another area.

Patient Safety

To permeate responsibility and mutual accountability for patient safety throughout our organization, Contra Costa Regional Medical Center and Health Centers will continue to implement activities broadly aimed at becoming a highly reliable organization by achieving the following six strategic themes.

Core Theme	Description
Safe Care	Ensure the actual and potential hazards associated with high-risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward high reliability and the ultimate objective of ensuring our patients are free from unnecessary harm.
Safe Culture	Create and maintain a strong, unified patient safety culture with patient safety and error reduction embraced as shared organizational values and acknowledged pre-requisites of "quality you can trust."
Safe Staff	Ensure staff possesses the knowledge and competence to safely perform required duties, improve system safety performance, and reduce workplace injuries. Develop new knowledge and provide ongoing education on patient and workplace safety for individuals and teams throughout the organization.
Safe Patients	Engage the patient and their family, as appropriate, as a partner in safety and in reducing medical errors improving system safety performance, and actively participating in their own safe care. Strive for collaborative relationships with patients/members/families in all aspects of the organization.
Safe Place	Design, construct, operate, and maintain a safe environment of care as well as evaluate, purchase, and utilize equipment and products in a way that promotes the efficiency and effectiveness with which safe healthcare is provided.
Safe Systems	Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This includes knowledge sharing networks, responsible reporting, and meaningful measures of risk and safety.

CCRMC's risk manager identifies patient safety priorities annually based on these dimensions of safety. Risk and Patient Safety priorities are assessed utilizing the risk matrix based on severity and frequency with rating ranging from very high to very low. Priority initiatives are included in overall quality and patient safety priority initiatives.

		Risk Frequency		
		Likely/Almost Certain	Possible/Occasional	Rare/Unlikely
Risk Severity	High	Very High	Very High	High
	Medium	High	Moderate	Moderate
	Low	Low	Low	Very Low

Annual Quality and Patient Safety Program Evaluation

Annually, responsible hospital and Professional Staff leaders evaluate each component of the Quality and Patient Safety Program, evaluate performance against targets and develop work plans for the ensuing year. The evaluation specifically:

- Evaluates the effectiveness of activities and actions taken in the previous year;
- Draws conclusions from those activities and actions.
- Performs an analysis of the barriers; and
- Identifies priorities for improvement based upon evaluation and other data available.

Hospital leadership shall report outcomes of the program on an annual basis to the Board of Supervisors' JCC.

See Appendices for reference:

- Appendix A CCRMC and HC 2025 QAPI Annual Eval and Strategy Plan
- Appendix B CCRMC and HC 2026 PI Priorities
- Appendix C 2026 PSPIC Reporting Calendar

Contract Evaluation and Oversight

At least annually the hospital assesses the quality performance of the agencies, organizations, and individuals with which it contracts for the provision of care, treatment, and services provided to the hospital's patients. The Medical Executive Committee annually reviews the hospital's clinical contracts based on quality and performance data.

The leaders will select the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor's nationally recognized accreditation or certification status;
- Review of information about the contractor's licensing or certification status:
- Direct observation of the provision of care;
- Audit of documentation, including medical records;
- Review of incident reports;
- Review of periodic reports submitted by the agencies, organizations or individual providing services under contractual agreement;
- Collection of data that address the efficacy of the contracted service;
- Review of performance reports based on indicators required in the contractual agreement;
- Input from staff and patients;
- Review of patient satisfaction studies;
- Review of results of risk management activities.

The individual assigned responsibility for each contract is accountable to review the contract expectations and establish appropriate quality and operational indicators and monitoring frequencies, and to report performance through the established quality structure. If contracted services do not meet expectations, leaders take steps to improve care, treatment, and services.

Section 3 Credentialing and Peer Review

The Hospital's Quality and Patient Safety Program includes the methods for assessing and continuously improving the care delivered to hospital patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

The Medical Executive Committee of the Professional Staff reviews and recommends practitioners seeking privileges and acts on results of focused practitioner performance evaluation (FPPE) and ongoing practitioner's performance evaluation (OPPE), and trends identified by peer review.

Credentialing and Privileges

Credentialing and privileging activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, privileging, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation (OPPE). Recommendations for Professional Staff membership and/or clinical privileges are made by the Medical Executive Committee whose recommendations are further submitted to the Board of Supervisors' JCC for final approval consistent with the process delineated in the Professional Staff Bylaws.

The processes for renewal of clinical privileges and/or reappointment to the Professional Staff incorporate data from quality of care, professional conduct, quality assessment, peer review, professional liability experience, resource utilization, patient satisfaction, patient complaints, and the six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice). A separate confidential quality file is maintained for each practitioner. Credentials and quality files are available to individual practitioners, chiefs of service, peer reviewers, and the Medical Executive Committee at each step of the credentials and privilege processes.

Peer Review

Peer Review is an ethical and legal cornerstone of the medical profession and the process by which a practitioner's clinical performance is examined and critiqued by one or more individuals who have comparable professional education, training, knowledge, and experience. Peer review is conducted in accordance with written policies and procedures which are approved by the Medical Executive Committee on behalf of the Professional Staff. All medical staff departments participate in the Hospital's quality program that includes peer review.

The objective of the Peer/AHP Review Program is to:

- Assess and improve the care provided to patients;
- Determine if standards of care are met; evaluate and improve individual performance;
- Determine education and training needs to improve skills and outcomes;
- Establish consistent, comparable, and actionable, information reflecting the practice of peer review monitoring activities;
- Demonstrate trends, opportunities for improvement, and actions taken to improve the quality and safety of care provided to patients;

- Identify and prioritize areas for systems improvement;
- Monitor trends through aggregate data; and
- Promote a “Just Culture”, in which practitioners and the organization learn from unanticipated outcomes.

The primary information used to identify issues requiring peer review include sentinel and other serious adverse events (actual or close call), department-specific monitoring, electronic monitoring of complication reports, mortality reports, infection control data, risk and utilization management data, contract management, customer service (patient concerns), and regulatory findings. Supplemental focused reviews are conducted as necessary to provide greater detail and empirical support regarding a particular area of practice and practitioner performance. Focused reviews may lead to the development or refinement of standards of practice or processes that can be used to improve clinical performance and as well to evaluate clinical competence.

Chairs of departments, based on peer review findings may recommend activities to improve performance that include but are not limited to:

- Education programs including patient safety education and/or strategies,
- Focused Professional Practice Evaluation (FPPE),
- Additional training and/or monitoring,
- Interdepartmental collaboration,
- New protocols/guidelines or modification of existing protocols,
- Modification of measures for review,
- Acquisition and use of new equipment/technology,
- Individual counseling of a practitioner,
- Additional data collection and trending,
- Performance improvement plans for individual providers.

Peer review data and information is considered by the Medical Executive Committee in carrying out the functions of credentialing and privileging and in the assessment of the competency of the Professional Staff.

Section 4 Confidentiality

All Quality and Patient Safety Program data, committee minutes, reports, recommendations, memoranda, and documented actions created under the auspices of the hospital’s Quality and Patient Safety Program and its peer review processes are considered quality and patient safety work-products/documents and, therefore, subject to the protection of laws governing the confidentiality of peer review and/or quality assurance information. These documents are maintained in accordance with applicable confidentiality policies and procedures.